

Annelén Bredholt Nilsen

**Brain drain of nurses from sub-Saharan
Africa:**

**A study of causes, implications and policies in sending and receiving
countries.**

Abstract

There is a global competition for health workers. Apparently, those in most need of health care workers are also the biggest losers in this competition. There are 57 countries in critical shortage of health workers globally, and 36 of these countries are in sub-Saharan Africa. In this region, health care resources are dire and at the same time bear the most distressing health indicators on the globe. Health workers, in this case nurses, suffer from unbearable working and living conditions in their country of origin and seek elsewhere for better salaries, safer working conditions, better living conditions and a better life. This has for several years created a brain drain of skilled labour from where it is most needed, leaving already fragile health systems even more vulnerable.

This study examines different theories concerning why nurses choose to migrate to more industrialized countries in the West, which also represents the theoretical framework of the study. The underlying idea is that theories of migration must be addressed in order to successfully manage to reduce the migration and brain drain from developing countries. The theoretical framework is used to assess policies developed and implemented in both sending and receiving countries, as well as on an international level, in order to change this trend.

In order to study the policies, the framework 'stages heuristic' was applied, as it was found logically justifiable in this setting, giving a structured overview of the policies included. The countries represented are Norway, the United Kingdom, Ghana and Malawi, as well as the World Health Organization and the European Union.

The results of the study explain the outcome of different policies implemented in the countries included and how it has contributed to changes in the trend of nurse migration. It fosters the interaction between countries, and clarifies the importance of cooperation between governments, as well as ways forward in dealing with brain drain from low to high-income countries.

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Part 1: Introduction and structure

Part one aim at presenting a systematic overview of the theme in the thesis, starting with the trends in nurse migration, addressing the effect on health care and economy in developing countries, as well as the research question. Further, the research design and the theoretical framework are presented.

1. Introduction

1.1 The global trend in nurse migration – an overview

According to the World Health Organization (WHO) the world is facing a global health workforce crisis. At least 1.3 billion people worldwide lack access to the most basic health care and estimates suggest a global shortage of 4.3 million health workers in order to be able to reach the UN Millennium Development Goals (MDGs) (WHO, 2006). The crisis primarily affects developing countries, but the health worker shortage is prominent in most developed countries as well. The health care workforce represents several important professional groups, but this thesis focus mainly on the global shortage of nurses.

Traditionally, nurse migration tended to be a North-North or South-South phenomenon. African nurses typically migrated between African countries, European nurses within European countries and so on. The passed decades witnessed a rapid increase in emigration of nurses, notably to countries in the Organization of Economic Cooperation and Development (OECD, 2010). It is estimated that 30.000 nurses and midwives educated in sub-Saharan Africa are now employed in seven countries within the OECD (WHO, 2006). Surely, the international migration has become more prominent, and therefore an area of increasing attention both in media and on policy level (ibid, 2006).

The causes of migration are many and complex, and often influenced by both sending and receiving countries. Theories of migration among nurses constitute the theoretical framework of this thesis, with the intent to look into factors that contribute to migration (push/ pull factors). Additionally, factors that prevent nurses from migrating from their source country, as well as return to their source country after they have migrated will be discussed (stay/stuck factors).

Some of the most frequent causes of nurses migrating are wage differences, political unrest, working conditions, lack of opportunities, possibility for professional development, active recruitment, better quality of life and personal safety (Kingma, 2007). Reasons why nurses stay are often based on commitment and moral, culture, linguistics and good governance in the home country. Nurses that do not return to their country of origin is often caused from lack of incentives and information about opportunities at home, non probability of pensions and so on. Nursing can be seen as a mobile profession as the aim of the nursing community worldwide is based upon the same professional goals. Nevertheless, each country has different requirements for the nursing education and practice that needs to be fulfilled in order for foreign nurses to be granted work permit and authorization in the receiving country. The great demand for nurses in most countries makes the authorization process more efficient in receiving countries and thousands of nurses – the vast majority women – migrate each year to obtain labour abroad (ibid).

The OECD reports that higher demands in health care, aging populations, a increase in chronic diseases and lack of recruitment to the nursing profession are factors that leads to increased need for nurses in developed countries. Simultaneously, the average age of working nurses have been increasing, and a growing proportion is expected to retire in the next decade or so, believed to aggravate the problem of nurse shortages even more (OECD, 2008). Today, there are allegedly few countries prepared to meet the increased need for nurses by using only their own personnel resources. According to employment projections, the United States (US) will need more than 1.2 million newly qualified and replaced nurses by 2014 (Kingma, 2007; Hecker, 2005). Therefore, being unable to meet domestic need and demand, many industrialized countries have been looking abroad for a solution to their national nurse shortage.

Despite the increasing need for nurses in OECD countries, it is no doubt that the poorest countries are the biggest losers in the global competition for health care. The sub-Saharan African region is most affected by the shortage of nurses worldwide, having the poorest health indicators; carrying 25 per cent of the worlds disease burden, yet possessing only 1.3 per cent of the health care professionals in the world, including nurses (WHO, 2006). Out of 57 countries with a desperate need of nurses worldwide, 36 are sub-Saharan African countries. There are various contributory causes to the nurse shortages in Africa in general, but low training capacity, poor

working conditions and attrition out of the health sector are the most influential factors (ibid). Nurses who migrate to industrialized countries often leave behind an already disadvantaged health system worsening working conditions for those who stay, leaving them with heavier workloads, often contributing to low morale and reduced work satisfaction. This again results in high absenteeism among nurses, which leads to decreased quality of care for patients. Numbers from Ghana and Malawi at the beginning of the millennium shows that in 2000, over 500 nurses left Ghana for employment in industrialized countries, which is more than twice the number of new graduates from nursing programs that year (Kingma, 2007; Zachary, 2001). In Malawi, between 1999 and 2001 over 60 per cent of the registered nurses in a single tertiary (114 nurses) left for employment in other countries (Kingma, 2007; Martineau et al. 2002).

When multitudes of trained professionals emigrate from their country of origin it drains the country of skilled individuals. The International Organization for Migration (IOM) defines brain drain as: "Emigration of trained and talented individuals from the country of origin to another country resulting in a depletion of skilled resources in the former" (Glossary on Migration, 2011, 15). This thesis addresses brain drain as a social problem looking at possible solutions that can turn the migration of nurses into more beneficial scenarios, such as brain gain, brain circulation or reduce the overall migration. Brain drain, brain gain and brain circulation are all possible scenarios that may result from nurse mobility.

1.2.1 Research question

When nurses migrate from the poorest countries with the most distressing health indicators in the world it is likely to assume that the lost resources may have dire consequences for population health and the fragile health systems in the sending country. The WHO Assistant Director General, Dr. Timothy Evans addresses the health worker shortage as:

Not enough health workers are being trained or recruited where they are most needed, and increasing numbers are joining a brain drain of qualified professionals who are migrating to better-paid jobs in richer countries, whether those countries are near neighbours or wealthy industrialized nations. Such countries are likely to attract even more foreign staff because of their ageing populations, who will need more long-term, chronic care (WHO, World Health Day, Homepage, 2006).

This thesis focuses on nurse migration as the main factor of nurse shortage, and based on the above, the aim of this thesis is to look into different policies made to restrict nurse migration and

brain drain from low to high-income countries. Policies developed in sending and receiving countries, as well as on international level will be examined. Evidence show that there need to be a more equal distribution of nurses worldwide in order to be able to meet the MGDs and at least provide minimum standard of health care to people in the worst affected areas (WHO, 2006). Improving population health promotes development and growth for a country, benefiting the society as a whole. In order to secure a decrease in brain drain from low to high-income countries, different factors that stimulate migration needs to be addressed. Policies need to be developed in line with these factors so nurses find it more attractive to stay in the country of origin and less attractive to migrate. In that respect, I will look at previous policy interventions and the possible outcome of the interventions. Therefore, the following research questions are asked: *What policy options have been introduced to restrict health worker migration in order to prevent brain drain from low-income to high-income countries? What are the possible outcomes of these policy interventions?*

1.2 The impact of migration

Nurse migration is widely publicized and regarded as a major issue, with profound ethical, socioeconomic- and of course health- implications (Kingma, 2007). Although it is difficult to assess the effect of migration on population health and to a certain extent on economy, it seems essential to look into some facts concerning these issues.

1.2.1 Effect on health care

Data presented by the WHO strongly support the direct link between positive health outcomes and the density of professional health care workers (Kingma, 2007; WHO, 2006). It is important to recognize the difference between domestic and international migration, as both represents different outcomes for health care delivery in a country. Living and working in rural and urban areas in low-income countries often constitutes a major difference. In sub-Saharan Africa the distribution of health workers has huge disparities between rural and urban areas as nurses have lower working preference for rural areas (Mills et al. 2009). Dovlo supports this by the fact that the poorest citizens living in the remoter areas are the ones who are affected the most by health worker migration (Dovlo, 2005). However, this thesis mainly focuses on international migration. This is because the thesis aims at addressing nurses leaving the country and no longer practice nursing in the country that they were trained.

Staff shortages are the most direct effect of nurse migration, meaning that the health systems are often unable to deliver critical services (Dovlo, 2007). The sub-Saharan African region has an estimated 600.000 health care workers to serve a population of 682 million people, having one tenth of the nurses for their population, compared to Europe. An assessment of health-care worker availability against health system reveals stark gaps, with an estimated 670.000 nurses needed in Africa to bridge the void (WHO, 2007). Additionally, sub-Saharan Africa is the epicentre for the HIV/AIDS epidemic, with 26 million people infected with the virus. In severely affected countries, mortality is one of the major contributors to health-care worker shortages.

The WHO states that the severe shortage of health workers is impairing provision of essential life saving interventions such as childhood immunization, safe pregnancy and delivery services for mothers, and access to treatment of HIV/ AIDS, malaria and tuberculosis. Each year, there are at least 10 million deaths due to infectious diseases and complications of pregnancy in Africa, and better access to health care workers could prevent many of those deaths. The WHO also states that clear evidence show that as the ratio of health workers to population health increases, so in turn does infant, child and mother survival (WHO, 2007).

Nevertheless, many nurses do return home after a period of working abroad and are often equipped with new skills and work experience. Hence, they may be able to serve as a greater resource for health services, helping strengthen health systems and thus health in general in their countries of origin (Haour-Knipe et al. 2008).

1.2.2 Effect on economy

When highly qualified and educated individuals from low-income countries emigrate from their country of origin, much of the investments made in education may be lost and will neither contribute to the economic development of their home country, nor benefit the populations' health. According to WHO's estimates, in 2004 Ghana lost approximately \$35 million to the UK in investments and training of health workers. In comparison, the UK saved \$65 million in training costs between 1998 and 2002 due to immigration of health workforce. Voluntary Service Overseas Internationals (VSO) estimates suggest a loss of \$184.000 for each health care worker who emigrates for an African source country (VSO, 2010).

Nevertheless, according to The World Bank, more than 215 million people live outside their country of origin. This contributes to the fact that remittances, money sent home by labour

migrants, is three times the size of official development assistance, and provide an important lifeline for millions of poor household in the developing world. In 2010, there were sent an estimated \$325 billion in remittances to developing countries, but the actual amount, including unrecorded flows through formal and informal channels, is believed to be significantly larger (IOM, 2010).

The overall economic gains from remittances in sending countries are substantial, but the discussion involves whether or not remittances contribute to gain population health. The Lancet (2005) stresses the idea that repatriated overseas income will find its way into investment in health is unrealistic, particularly without professionals to advocate the issue. Nevertheless, countries such as Nigeria, Cuba and India have a history of producing health workers for export to developed countries in order to gain economic benefits from remittances sent to the home country. In that case, countries with an oversupply can assist countries with shortages. Private remittances are believed to have a positive influence on savings and investments in households. Additionally, remittances that are used by governments to build public schools and clinics have a positive effect on the general growth of society (Ratha, 2003).

When this is the case it is logical to assume that the private economic gains of remittances along with the public gain of schooling and clinics will enhance population health. The aspect of educational opportunities is also evident to the contribution of poverty reduction and health promotion. But even though remittances may have positive effect on the households' private economy, it may also have adverse effects on the quality of domestic governance. It may contribute to increased corruption, as governments find corruption manageable for households when receiving remittances to the private economy. Therefore, the government engages in more corruption and diverts resources for personal purposes (Abdih el al. 2008).

1.3 Definition of key concepts

1.3.1 Nursing

The purpose of the nurse education is to train professionals eligible for practicing as a nurse in all aspects of the health service, and in collaboration with other professionals. Nursing is based on a

holistic view that emphasizes that all human beings are of equal and fundamental value. The International Council of Nurses (ICN) defines nurses as:

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles. (ICN, Definition of Nursing: Homepage, 2010).

This study focuses on flows of registered nurses. International nurses, in the context of this study, are nurses who were trained in developing countries, but now have authorization enabling them to practice in other countries than their country of origin.

1.3.2 Migration

There are more people on the move in the world today than in any other time in human history. People migrate for several reasons, both within and out of country borders. The IOM defines labour migration as: “Movement of persons from one state to another, or within their own country of residence, for the purpose of employment” (Glossary on Migration, 2011, 62).

Additionally, the thesis focuses on skilled personnel who migrate from their source country to obtain work elsewhere. The IOM defines a skilled worker as:

A migrant worker who, because of his or her skills or acquired professional experience, is usually granted preferential treatment regarding admission to a host country (and is therefore subject to fewer restrictions regarding length of stay, change of employment and family reunification) (Glossary on Migration, 2011, 91).

1.3.3 Policy

Social policy is “[..] the term used to refer to the practice of social interventions aimed at securing social change to promote the welfare and wellbeing of citizens” (Becker et al. 2004, 4).

Further, the focus is on policies concerning reducing or restricting the migration of nurses, preventing brain drain, and eventually improve population health. Therefore, I define health policy as:

Health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society. An explicit health policy can achieve several things: it

defines a vision for the future which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups; and it builds consensus and informs people (WHO, Health topics: Homepage, 2012).

1.4 Aspects not considered/ Limitations

When starting to prepare the thesis, I came across several aspects that will not be considered in this thesis. This is mainly due to time and space inconsistency when writing the thesis, but also trying to keep the theme narrow and specific. As mentioned initially, the focus is on international migration of nurses, not internal. Health worker migration often starts with internal mobility from rural to urban areas or from the public to the private sector, and then moves to countries of increasing levels of development (Haour-Knipe et al. 2008). Internal migration also constitutes a major concern, nevertheless reasons for migrating from rural to urban areas are often related reasons for migrating internationally.

The declaration of human rights is a central aspect in the case of migration, keeping in mind both the right to health care and the freedom to move, but this is not a topic I will pursue further.

Finally, I want to mention that my attention is directed at reducing nurse shortages for those who are worst off. There is a global shortage of nurses and most OECD countries struggle with shortages as well, apparently at another dimension. Therefore, the need for nurses in developed countries is not a part of the research question or a focus in this thesis. Migration of health workers can be classified into three categories: those who go overseas for training and fail to return after completing their studies, those who migrate overseas for advanced training, return to work for some time after their studies and then migrate, and those who are trained locally and emigrate after the completion of their program or after working for some time. The latter category is the focus of this thesis.

1.5 Previous findings

There has been conducted much research in this field recent years, due to the growing magnitude of the problem. In 2007, Mona Klokkerud wrote her thesis on the migration of health workers.

With this thesis I intend to take the policy study further, with increased focus on the outcome of these policies and their effect on the migration trends.

Because this is a global problem, each country has a different stance and most experience the shortage of nurses in one way or the other, in a larger or smaller degree. There have been developed policies and strategies to reduce the problem both on national and international level. It is difficult to find concrete numbers comparing before, during and after interventions in different countries, which may be a shortfall in this thesis. There will be a comparison of interventions implemented in Ghana and Malawi (see chapter 2.4 Choice of Countries, 11) and after my knowledge there exist facts on some African countries concerning outcomes of implemented policies, but I have not found any comparison of policy outcomes in this specific geographical area. I have also included stick/ stay factors to the theoretical framework, which few other studies that I have found do. This is to get a more complex picture of the reasons why nurses migrate, why some choose not to migrate and why some do not return to their country of origin.

2. Research methods/ tools for analysis

2.1 Literature review

The methodology adopted in this study is a systematic review of scientific/scholarly literature. Due to the time frame available and the wish to assess the documented outcomes of policy interventions, it was not possible to do primary data collection. Different search engines were used to identify relevant literature. These search engines included Medline, Google Scholar, PubMed and Academic Search Premier. I also searched some relevant references from scientific articles I found. Additionally, I have visited websites of different organizations, mainly The World Health Organization, International Council of Nurses, International Center of Nurse Migration, International Organization of Migration, International Labour Organization, The World Bank, Sykepleien, Den Norske Sykepleieforening, African Union and others. Hence, the data in this thesis is from both scientific papers published in scientific journals, but also reports and research conducted by the organizations referred to above, government documents from Norway, England, Ghana and Malawi (see chapter 2.4 Choice of countries, 11), as well as from books dealing with the topic of interest.

When searching for literature I have used both broad and more specific search terms, such as migration, health worker migration, nurse migration, brain drain, migration policy, theories of

migration and others. From the specific countries I wanted to draw examples from, I added the countries names to the search terms. I have looked into different government papers in these countries. I have also looked into different international agreements and codes of practice that has been developed by international organizations and the European Union.

The data I have utilized in this thesis is therefore secondary data. Both quantitative and qualitative studies were used. All the literature I have gathered and used in the thesis was thoroughly read and necessary information extracted. I have tried to assess the validity and reliability of the data as much as possible, by critically assessing what the information put forward was based upon and how the authors have addressed these issues in their papers, as well as using new research that is as relevant as possible for the thesis. I have used the different theories of migration for a better analysis and discussion of the data.

2.2 Theoretical framework for policy study

Policy studies are useful both retrospectively and prospectively in order to understand past policy failures and successes, as well as to plan for future policy implementation. Since the aim of the thesis is to look at the different policies and the possible outcomes of these policies I find it suitable to use a method that is a combination of policy analysis and program evaluation, called policy studies.

In order to do so I will use the policy cycle, ‘stages heuristic’ as a tool for analysing the development of the policies. This is the best-known public policy framework and are originally made by Lasswell in 1956, and later developed by Brewer and deLeon in 1983 (Walt et al. 2008). ‘The stages heuristics’ has received criticism for not being a causal model and that it fails to provide a clear basis for empirical hypothesis testing. Nevertheless, ‘the stages heuristic’ offer a way to think about public policy in concept and operation. It represents a policy process and the crucial stages in the policy process, rather than specific issue areas (Peters et al. 2006). I chose this framework on the background that I find ‘the stages heuristics’ logically justifiable in this setting, giving a structured overview of the policies, as well as it has the quality to bring forward the data desired in this context. The 3 stages of ‘the stages heuristics’ included in this thesis is:

Table 1: The stages heuristics

1. Agenda Setting	The process by which problems come to the government’s attention and
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	recognizing that there is a problem.
2. Policy formulation	How the policy options are actually created. The policy alternatives must fit within the political spectrum of the party implementing it, and it must be economically viable. This stage can also include an estimate of the likelihood of a policy's success or failure.
3. Implementation	The stage at which the policy is carried out and the planned process to implement the policy is clarified.

(DeLeon et al. 2001; Kaufmanis, 2001; Howlett et al. 2005, McNutt 2008).

2.4 Choice of countries

I will pursue relevant policies implemented in Norway and the UK separately. The choice fell on Norway because it is the health care system I am the most familiar with and in which I have practiced nursing. Additionally, in 2012 Norway was granted the “Health Worker migration Policy Council 2012 Innovation Award”, which is given to countries that have done a particular effort in the work of facilitating in a way that secures all countries worldwide sufficient access to health personnel. I therefore believe it will be interesting as well as justifiable to choose Norway as a receiving country in this thesis. The choice also fell on the UK because it has been one of the major importers of nurses globally by actively recruiting from low-income countries. Hence, I find it interesting to look into how the UK manages the problem and take responsibility to reduce nurse migration, instead of recruiting. Norway and the UK has profound differences, as the UK are both member of the European Union (EU) and The Commonwealth of Nations, which places the UK in a more unique position in relation to both the EU and several developing countries, as well as it creates more complex challenges to manage the problem of migration.

Nevertheless, the aim is not to conduct a comparison of Norway and the UK, but to examine their strategies, regardless of language and basis because both Norway and the UK experience nurse shortages, as well as being an interesting destination for foreign nurses seeking work.

Further, the choice fell on comparing policies in Ghana and Malawi. There were several countries of interest, but it was natural for me to choose Ghana as I have worked there in a local hospital as a nurse. Additionally, when searching for material, Ghana appeared to have some data from reliable sources, which can be challenging to come by from developing countries. This was also my initial reason for digging deeper into Malawi; I found data and information concerning

different policies and programs that has been implemented in both Ghana and Malawi. Another reason for choosing Ghana and Malawi is the common linguistics and that both countries are Member States of the Commonwealth of Nations. Ghana achieved independence from UK in 1957 and Malawi in 1964. Linguistics is important for the choice of country to migrate to, as it is easier for nurses to migrate to an English speaking country, if that is their first language. Additionally, there are certain circumstances that make it easier to migrate between countries that are members of the Commonwealth. It is of interest to look at nurses with similar background and opportunities for migrating. Nevertheless, the findings will always differ depending on the mix of countries and variables selected (Kennett, 2006, 269).

Both Ghana and Malawi has Christianity as their dominant religion, but has different local religions as well. Neither of the countries is part of the OECD and are developing countries. Ghana has achieved more development and democracy than Malawi, although they share the same political orientations. Malawi also has worse health indicators than Ghana, HIV/ AIDS and Malaria are more widespread, child mortality higher and they have a smaller density of health workers, but they share the same burden with lack of nurses and the continued and increased migration of nurses from the country. I keep in mind that all countries are likely to have a very heterogeneous structure. But, with shared backgrounds and some of the same cultural aspects and perceptions I focus on what has been done to reduce the migration of nurses in these two countries and how it worked. Finally, policies and agreements developed internationally by the EU and WHO will also be presented.

2.3 Choice of policies

The policies studied in the thesis will be in line with the theoretical framework and theories of migration. There has been developed several strategies and policies to fight brain drain, and the policy interventions linked to the main causes of migration are used due to relevance and potential to successfully decrease brain drain, as they address the specific problem.

Beneath is a schematic overview of the policies pursued in receiving countries (table with overview of sending countries on page 32):

Table 2: Overview of policies in receiving countries: Norway and the UK

Country	Norway	UK
Policy	1. "A solidarity policy for the recruitment of health professionals", 2007.	1. The Commonwealth Code of Practice, 2003.
Policy	2. The WHO Global CODE of Practice on the International Recruitment of Health Personnel, 2011.	2. Code of Practice for National Health Service Employers, 1999 and 2004.
		2. Memorandum of Understanding, 2003.
Policy		3. Africa and EU strategic Partnership, 2000.

(Source: Helsedirektoratet, 2007, 2011; The Commonwealth Secretariat, 2003; National Health Service, 1999, 2004; Memorandum of Understanding, 2003; European Union, 2000).

2.5 Comparison as a method

Studying with comparison is important for understanding and explaining political and social phenomena. According to Kennet (2006), attempting to define comparative social research seems somewhat fruitless. Driven by the idea that there is considerable knowledge and insight to be gained from looking across countries, I will use cross-national comparison as a method in this thesis. I will use it to look at policies implemented in Ghana and Malawi and the different outcomes, if any, of migration policy interventions implemented in order to reduce brain drain. Comparison is seen as offering a good opportunity to seek explanations of societal phenomena and offer theoretical propositions and generalizations (ibid).

I will use statistical data to assess the trend of nurses that migrated before, during and after the policy implementations. This will give an indication on the effect and outcome of the interventions, although there are other factors in receiving countries that may as well impact on the numbers. This has the advantage of presenting data in a compact and visual effective manner, so that similarities and dissimilarities are visible through statistical representation. It also helps to compare and explain long-term trends and patterns of nurse migration, as well as offering a prediction of future trends. It will be a focused comparison as I take up a small number of

countries (2) and concentrate frequently on particular aspects of the countries politics rather than all aspects (Kennet, 2006).

3. Theoretical framework

Most people migrate from one country to another because they believe they will be better off. Each migrant has his or her own motive for migrating and has different experiences. Nevertheless, there are some common features and patterns, like the wish to escape poverty. These features are what this thesis is basing the theoretical framework upon, as the policies made to reduce the migration of nurses should be addressed reasons why they migrate in order to be successful and problem oriented. Sociologists have long analysed migration in terms of the “push-pull” model. This model differentiates between push factors that drive people to leave home, and pull factors that attract migrants to a new location. A second set of factors is stick and stay factors. Stick factors consist of reasons that keep people where they are in spite of compelling push and pull factors to migrate. Stay factors are those that prevent a person from returning to their country or place of origin after they have migrated (Dovlo et al. 2007). I will look into both push and pull factors and stick and stay factors in this thesis.

3.1 Push and pull factors

Push factors come in many forms and in one way or another they contribute to people leaving their country of origin. Some are left with no other choice than to leave their country, under circumstances such as natural disasters, war and political or religious persecution, while some choose to leave for reasons like better work opportunities or higher wages. According to the International Labour Organization, about half of the total population of current migrants have left home to find better jobs and lifestyle opportunities for their families. In some countries jobs simply do not exist for a grate deal of the population. In others, the gap between the rewards for labour in sending and receiving country are great enough to move (Globalization 101, 2012). Working conditions that reduce job satisfaction is a common reason for migration, such as poor management, lack of medicine and equipment and the accompanying inability to offer effective care to patients. There are also work-associated risks of being a health worker in southern Africa, particularly with the rise of HIV/ AIDS prevalence. Due to the high attrition from the health care profession, it leaves those who stay with an even heavier workload (Padarath et al. 2012). Poor

housing, general isolation from social networks and lack of quality education are also central push factors.

Whereas push factors drive migrants out of their countries of origin, pull factors generally decide where these travellers end up, depending on the positive aspects of some receiving countries who attract more migrants than others. As mentioned above, economics provide the biggest push and pull factors for potential migrants. People moving to more developed countries find it that the same work they were doing at home is rewarded with higher wages in another country. Pay levels are up to 24 times higher in receiving countries as they are in sending countries (Dovlo, 2005). Additionally, there will be a safety net for welfare benefits if they become unable to work.

3.2 Stick/stuck and stay factors

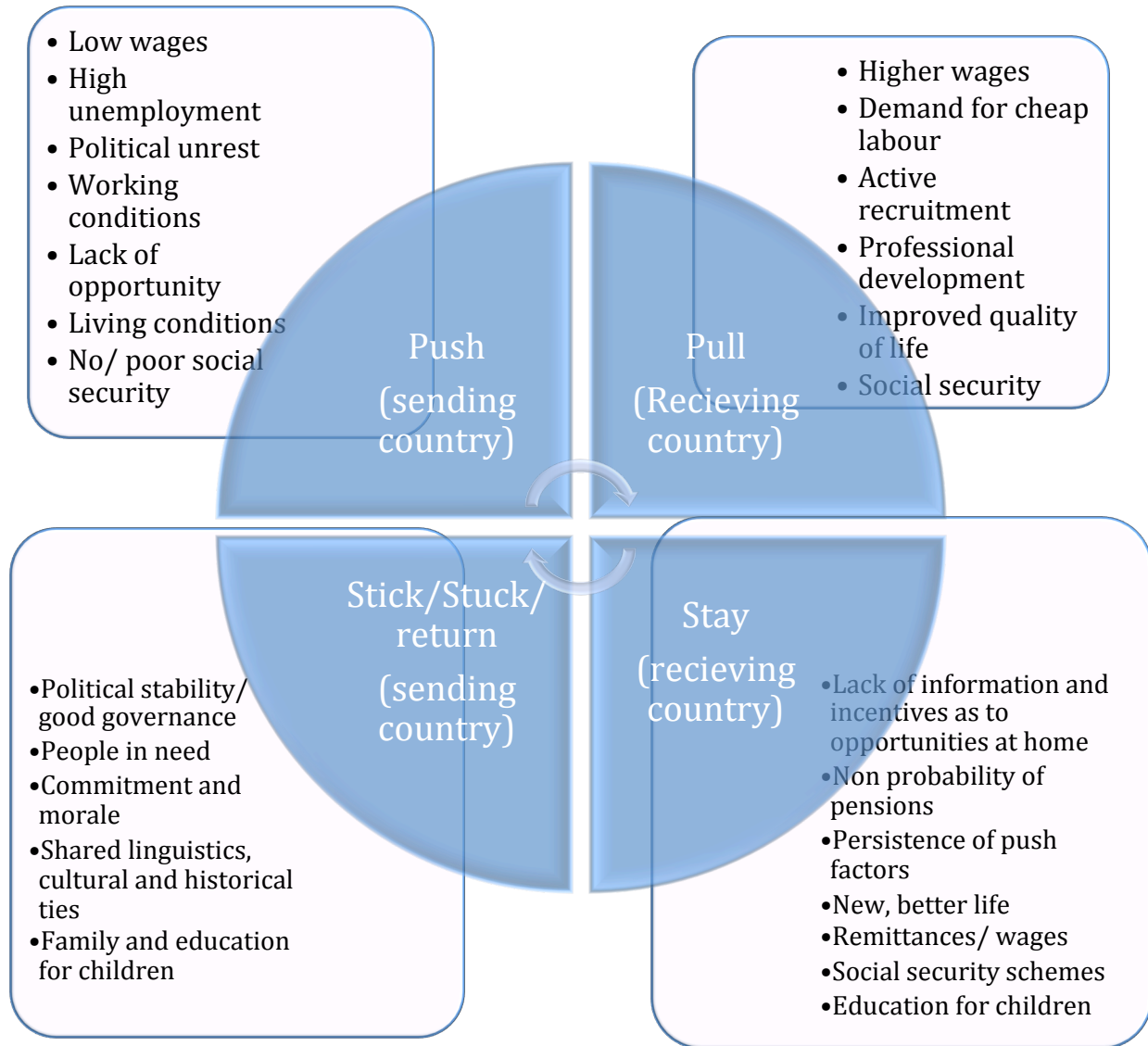
In order for the push and pull factors to actually lead a movement or migration they have to overcome various stick factors. It has been argued that there is a high level of morale among health workers, combined with their desire to deliver good quality care and being valued in the society. Other stick factors are rewards and incentives, making health workers prefer to stay home. Different barriers to migration, such as learning a language, cultural and religious differences also keep people from migrating (Padarath et al. 2003). Family, children and cultural ties are likely to be strong for some people and may keep them stuck in their country of origin. Loyalty towards the government and family, as well as the expense of relocation is also factors that may keep people from migrating or make it more difficult to do so. But also broad factors, such as quality of life, security, career paths and social values have a bearing on stick factors (ibid).

Once people have migrated to work abroad, they may choose not to return due to a variety of stay factors. These include the development of new social and cultural bonds, the risk of disruption in the education of the children, or a reluctance to disrupt new schooling and family patterns. Some are also unaware of job opportunities in the home country (ibid).

Additionally, there are also more ambiguous factors, called network factors that can either facilitate or deter migration. Network factors include cost of travel, the ease of communication and international business trends. These factors are not related to a specific country, but still have a profound effect on international migration (Globalization 101, 2012). Beneath is an overview of

all the factors mentioned previously, in order to give a more systematic picture of how the factors are interrelated and work.

Figure 1: Overview of migration theories



(Source: International Dialogue on Migration, 2011).

Part 2 – Results and analysis

Generally, there are different instruments for governments and organizations to affect the migration of health workers, such as multi-lateral agreements, codes of practice, bi-lateral agreements, regional agreements, position statement and strategies. Beneath I will look into several of these instruments (Pagett et al. 2007).

4. Policies in receiving country – Norway

4.1 The case of Norway

According to the Norwegian Foreign Ministry, Norway approved 13.375 work permits from developing countries in 2010, 9.921 in 2011 and 3.392 the first quarter of 2012.

According to the Department of Work in Norway, labour migrants has to be qualified as skilled workers in order to be granted an entry visa to Norway. Additionally, migrants must have a residence permit, as well as received a concrete offer of employment in Norway prior to entry into Norway. The current employer in Norway must receive a temporary confirmation for a residence permit and the application needs to be confirmed when the migrant reports to the police for an identity control within seven days of entering Norway. If the migrant does not have an offer of employment, he or she can apply for a six-month permit for skilled workers in Norway (gotonorway, 2012). Other rules apply for migrants from European Union or European Economic Area (EU/ EEA).

As the shortage of health workers in developing countries became more prominent and continued to increase, Norway was committed to pursue a policy that addressed to decrease the flow of qualified health workers from poor countries (UDI, 2008). In 2004, there were approximately 230.000 health workers employed in the Norwegian health care system, and in 2006 there were 12.000 foreign health workers working in Norway. According to the Norwegian Foreign Ministry (UDI), numbers show that the migration of health workers from developing countries to Norway is small compared to several other OECD countries, such as the UK. However, the aim is to study policies implemented in Norway to reduce factors that leads to migration of nurses from developing countries. This is interesting because in 2012, Norway received an international award from WHO: “Health worker migration Policy Council 2012 Innovation Award” for the

initiative on reducing active recruitment of health workers. This award was given the Norwegian government due to the work and initiative on following the WHO's guidelines, which stresses non-recruitment of health workers from countries who are in need themselves. The award is granted countries that have done a particular effort in the work of facilitating in a way that secures all countries worldwide sufficient access to health personnel (UDI, 2008).

4.2 Strategy/ Policy

4.2.1 The Norwegian Directory of Health, 2007.

A solidarity policy for the recruitment of health professionals

Table 3: A solidarity policy for the recruitment of health professionals

Agenda setting	The solidarity policy is based on the fact that Norway, as one of the richest countries in the world, holds a responsibility in contributing to a development that benefits the global health recourses in a solidary matter and opposes the flow of highly qualified workers from poor countries.
Policy formulation	<p>In 2007, the Ministry of Health (Helsedepartementet) gathered a broad group of people from 10 different institutions in the Norwegian government to best answer the task on reducing the immigration of highly skilled workers from poor countries. The task was given to the Directory of Health (Helsedirektoratet). The group found that challenges related to a solidary health personnel policy demands action in three dimensions.</p> <p><i>First</i>, own resources must as far as possible solve the national need for health workers.</p> <p><i>Second</i>, the Norwegian aid oriented towards capacity building and reductions of factors driving migration, such as push and pull factors.</p> <p><i>Third</i>, Norway wanted to take the lead in efforts to make responsible, ethical recruitment of health workers from poor countries. Not by denying people from poorer countries to migrate, but by creating a binding framework and regulations that safeguard the interests of poor countries and contribute to a recruitment that is conducted in a responsible and solidary matter.</p>
Implementation	The first step in being self- sufficient in health workers is to <i>exploit the potential</i> that is in the existing workforce.

1. Increase full time jobs	1. The plan for being successful with this measure is <i>to increase the proportion of full-time jobs in health care</i> . Part-time employees who have a desire to work more are considered underemployed and need additional employment.
2. Reduce attrition from health sector	2. The next step is <i>to reduce attrition from the sector</i> . In order to counteract dropout from the sector the policy aims to conduct a <i>thorough study of reasons why health workers leave the workforce or go on to other sectors</i> .
3. Better organization of health care services	3. <i>Better organization of health care services in Norway</i> is also addressed. It involves being efficient and allocating labour resources properly. An initiative to succeed is to implement job training for unskilled workers in the health care sector.
4. Educate more	4. The next aim is to <i>educate more health workers</i> in order to cover the present need and secure future challenges in health care resources.
5. Influence development in poor countries	5. The policy stresses that Norway, as one of the world's richest countries, has a responsibility <i>to influence the development of poor countries in a positive direction</i> . The Norwegian governments goal is therefore that <i>development aid is to be used efficient towards achieving the WHO development goals</i> . The development aid is an important role in the contribution on solving the health workforce crisis.
6. Help train more health workers in developing countries	6. Further, Norway should <i>specifically help train more health workers in developing countries</i> . Additionally, Norway should <i>contribute to reduce the push and pull factors</i> between low and high-income countries. Therefore, the development aid should be directed towards measures that support developing countries health care systems and the potential to increase the capacity of health workers. Another goal is to <i>strengthen the education capacity</i> in developing countries.
Reduce push/ pull factors	7. This policy aims to do so by strengthening and develop <i>exchange schemes</i> between Norway and developing countries by establishing cooperation with institutions and authority in developing countries.
Strengthen education capacity in developing countries	
7. Develop exchange schemes	

(Source: Helsedirektoratet, 2007).

4.3 Code of Practice

4.3.1 The WHO Global Code of Practice, Norway, 2011

The World Health Organization (WHO) Global CODE of Practice on the International Recruitment of Health Personnel

In 2011, the Norwegian government resolved to follow up the WHO Code of Practice nationally. The CODE is voluntary, and it is after this initiative Norway received the ‘Health worker migration Policy Council 2012 Innovation Award’ in 2012.

Table 4: The WHO Global Code of Practice

Agenda Setting	The WHO expresses a deep concern for the severe shortage of health workers, especially in poor health systems with very scarce resources that might not be able to reach the Millennium Development Goals.
Policy formulation	The World Health Assembly requested the WHO Director-General to develop a voluntary Code of Practice on the international recruitment of health personnel. Member States therefore agreed on 10 articles recommended as a basis for action.
Implementation <i>1. Codes and principles for ethical recruitment</i> <i>2. International cooperation</i> <i>3. Just and fair treatment of migrant health workers</i> <i>4. Technical and financial assistance</i> <i>5. Circular migration</i>	<p>The Code <i>promotes principles and practices for ethical international recruitment of health personnel</i>. It stresses <i>international cooperation</i> between governments. The Code was intended to be taken into account when Member States develop national health policies. Additionally, it stresses the importance of developed countries <i>technical and financial assistance</i> to strengthen health systems.</p> <p>The Code says that international recruitment of health personnel should be conducted in accordance with the principles of <i>transparency, fairness and promotion of sustainability of health systems in developing countries</i>. Law and legislations must be followed and Member States should <i>facilitate circular migration of health personnel</i> and the outstanding legal <i>responsibility for fair and just recruitment</i>. Both sending and receiving countries should benefit from the migration. All Member states should strengthen their educational institutions to scale up the training of health</p>

6. <i>Fair and just recruitment</i>	workers.
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(Source: World Health Assembly, 2010; Helsedirektoratet, 2010).

When adhering to the WHO Code of Practice the Member States were requested to (1) designate a National Reporting Authority. In Norway, the responsibility was given to the Directory of Health. In total, 81 Member States have followed the request as of September 2012. (2) It was also a request to report on the national implementation to WHO in Geneva within June 1st 2012. Norway reported within this date. Additionally, Norway has had two seminars (2011 and 2012) where the work on WHO's Code has been presented nationally. Nevertheless, Otto Christian Rø at the Norwegian Directorate of Health confirmed that the work had not yet been systematically evaluated, but is to be presented at the WHO in Geneva in 2013.

Therefore, the national work on the WHO Code has not yet been presented and has not been made official in its full context. In that respect, it is impossible to know the exact measures the Norwegian government has done in relation to the WHO guidelines. What can be said is that the guidelines are very much in accordance with the thorough policy implemented in Norway in 2007. The main guidance from WHO stresses (1) ethical international recruitment, (2) international cooperation, (3) just and fair treatment of migrant health workers, (4) technical and financial assistance, (5) Circular migration and (6) fair and just recruitment. These are all topics addressed when implementing 'A solidarity policy for the recruitment of health professionals' in 2007. Also, the Code constitutes a framework that governments should use when developing national policies in this area. This framework is very much consistent with the policy implemented in Norway in 2007.

I chose to present the above policies, as they are both essential turning points in Norwegian policymaking and directly address the problem area of the thesis. In 1998, the Norwegian Social and Health department launched a plan for health personnel called: 'Right person at the right place'. This plan encouraged the recruitment of nurses from both inside and outside the European Economic Area (EEA) (Sosial og Helsedepartementet, 1998). With this plan the government stressed that foreign workforce caused a labour reserve for Norway, and import of workforce were seen as the only solution to increase the number of nurses nationally (within a certain

timeframe). The government wanted to increase the recruitment of foreign health workers and evaluated different recruitment projects to pursue. In 2002, the government developed a new plan of action called ‘Recruitment for better quality’ (Ibid, 2002). Until there came a turning point in 2007, the Norwegian government actively recruited health personnel internationally through an employment service (Arbeidsmarkedsetaten, AETAT). The turning point, as mentioned, in 2007, came with the policy ‘A solidarity policy for the recruitment of health professionals’ followed by a new initiative in 2011; ‘The WHO Global CODE of Practice’ (Seeberg, 2012).

Norway has also established important cooperation platforms with developing countries. Exemplified, Norway has since 2004 cooperated with nursing schools in Malawi, which has contributed to a doubling of the capacity and a substantial improvement of the quality of the education in Malawi. Development aid directed toward the Malawian health sector is among the highest contributions to Malawi. Additionally, Norwegian NGO’s such as ‘Kirkens Nødhjelp’ has in cooperation with ‘Christian Health Organization of Malawi’ (CHAM) worked on educating more health workers and enhance the quality of the education. CHAM has educated about 80 per cent of the health workers in the country, as well as stands for 37 per cent of the health services in Malawi (Kirkens Nødhjelp, 2011).

5. Policies in receiving country – The United Kingdom

5.1 The case of the United Kingdom

The United Kingdom (UK) comprises of four countries – England, Northern Ireland, Scotland and Wales. In this thesis the main focus is on England, the largest of the UK countries. While there is health policy divergence in the four countries, all nurses are registered to practice at UK level, and most aspects of health resource policy are similar across the UK. In the UK, most health care is organized and delivered through the National Health Service (NHS).

The UK has been prominent in international nurse recruitment, both because it has explicitly used international recruitment as a policy response to national staff shortages and because it is the country that first introduced an “ethical” Code to underpin recruitment activity. This Code has been the main policy instrument in the UK on reducing the inflow of nurses and health workers from developing countries in need themselves.

Additionally, due to the UK's postcolonial legacy, the UK also has strong historical, educational and migratory connection to a range of English speaking countries worldwide (Buchan, 2007). The overseas recruitment was originally designed as a short-term measure to reduce shortages in the UK, but without it, the numbers in the UK nursing registry would supposedly not have been maintained since the late 1990's. The three countries supplying the largest number of nurses from overseas to the UK are the Philippines, India and South Africa (ibid, 2007).

In order to practice as a nurse in the UK as a non-EU/ EEA citizen, one has to register with the Nursing and Midwifery Council (NMC). A requirement is that the nurse has minimum one year of practice before applying, as well as pay the NMC charges to process the application and a registration fee (total amount of £302) (NMC, 2010). Additionally, the International English Language Testing System (IELTS) exam is a requirement before applying. This allows nurses to practice in the UK, but a valid work permit or visa is also required when entering the UK. To obtain a work permit nurses need to be sponsored by a hospital, private clinic or company, which is very likely to get due to the shortage of qualified personnel (UK Border Agency, 2012).

5.2 Codes of Practice

5.2.1 The Commonwealth

The basis for the formation of the Commonwealth was placed in the middle of the 1800s, when the British colonies in Australia, Canada, New Zealand and South Africa were given internal autonomy. These autonomous regions, as well as Ireland, were eventually called dominions. A law of 1931 confirmed the full sovereignty of the dominions and they united with Britain in common allegiance to the Crown (Store Norske Leksikon)

There are 54 member countries in the Commonwealth today. As the UK has a special role and participation in the Commonwealth, it challenges the UK as receiving country in terms of labour migration. The UK ancestry visa is for citizens of Commonwealth countries who have grandparents that were born in the UK and are still alive. Other requirements are that the migrants are able to support themselves without access to public funds, as well as apply for visa while still being in their home country or where they have legal residence (UK Visa Bureau, 2012).

Because the Commonwealth puts the UK in a unique position in relation to many developing countries and migration, there has been developed several strategies and cooperation platforms

between the UK and developing countries in order to better manage migration and brain drain to the UK. The Commonwealth take notion in the fact that uneven distribution of health workers deprives many groups of essential and life-saving health services. The Commonwealth also acknowledges that international migration of health workers to developed countries has aggravated shortages in many developing countries. This Code is particularly concerned with relations and cooperation between Commonwealth countries and will continue to work with governments to raise awareness of the Code and to deepen its implementation (The Commonwealth Secretariat, 2005).

5.2.2 The Commonwealth Code of Practice for International Recruitment of Health Workers, 2003

Table 5: The Commonwealth Code of Practice

Agenda setting	The Code was developed due to the global shortage of health workers, where some countries responded by recruiting health workers from developing countries. This was affecting developing countries and their capacity to provide quality health services to their population. The Commonwealth Ministers of Health agreed that a consensus approach dealing with the problem of international recruitment of health workers should be adopted.
Policy formulation	The Code of Practice provides a framework for how international recruitment of health workers from developing countries should take place. The Code is sensitive to the need of recipient countries and the migratory rights of individual health professionals, and in that way not hinder or limit the freedom of choice to move and work. The Code applies the principle of transparency, fairness and mutuality of benefits. The purpose of the Code is shortly to (1) provide guidelines for international recruitment of health workers, (2) discourage the targeted recruitment of health workers from countries which are themselves experiencing shortages and (3) safeguard the rights of recruits, and the condition relating to their profession in the recruiting countries.
Implementation	The Code is not legally binding, but it was hoped that governments would

<p><i>Supplement the Code with national guidance</i></p> <p><i>Seeks international organizations to promote the Code</i></p> <p><i>Scaling up production of health workers</i></p> <p><i>Return migration policies</i></p>	<p>subscribe to it. It suggests Commonwealth governments to <i>supplement the Code with additional guidance particular to their own national need and situation</i>. Commonwealth members are encouraged to take it into account in existing arrangements, treaties between countries and within regions in the application of the Code. Additionally, the Commonwealth seeks to <i>encourage the adoption of the Code by countries outside the commonwealth</i> by encouraging international organizations (such as WHO, ILO, ICN) to promote the Code to their non-Commonwealth members. The Commonwealth works on reducing brain drain and focuses on implementing the Commonwealth Code of Practice with regional workshops to inform groups about the code, engage professional associations and health regulation councils, make presentation on international forum, and engage partners to promote the codes implementation. They help to develop international policy instruments, such as the Global Code of Practice for International Recruitment of Health Workers, reporting on <i>scaling up the production of health workers</i> and supporting member states in these processes, through high-level dialogue and publications. On a smaller level the Commonwealth contribute to developing policies for the managed migration of health workers more suited to small states and also researching migration trends in the commonwealth, as well as <i>promoting policies for return migration</i>.</p>
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(Source: The Commonwealth, 2003)

5.2.3 The Code of Practice for National Health Service employers, 1999 and 2004

The Department of Health in England has attempted to limit the potential negative impact of active international recruitment on developing countries by introducing a Code of Practice for NHS employers. This was the first country level policy instrument that was designed to moderate international recruitment activity, as the department first established guidelines in 1999, which required NHS employers not to target South Africa and West Indies. Due to the first Codes' geographical restrictions and that it only addressed nurses, the NHS revised the Code and

extended the scope in 2004. The Code then covered recruitment agencies, temporary staff working in the NHS and private sector organizations (NHS, 2012).

Table 6: NHS Code of Practice

Agenda Setting	The UK’s National Health Service’s Code of Practice was driven by the thought that no country should prejudice the health care systems of developing countries. The UK therefore developed the Code, as the first nation to produce international recruitment guidance based on ethical principles, to reduce brain drain. It was developed in 1999 and revised and strengthened in 2004.
Policy formulation	There has been developed 7 benchmarks in the NHS Code: <ol style="list-style-type: none"> 1. International recruitment is a sound and legit contribution to the development of the healthcare workforce 2. Extensive opportunities exist for individuals in terms of training and education and the enhancement of clinical practice 3. Developing countries will not be targeted for recruitment, unless there is an explicit government to government agreement 4. International health care professionals will have a level of knowledge and proficiency comparable to that expected in the UK 5. Must speak an expectable English language 6. Health professionals are protected by UK employment law 7. Health professionals will have equitable support and access to further education and training
Implementation <i>No active recruitment from the countries on the list</i> <i>Not be charged fees</i> <i>Appropriate level of English</i>	There shall be <i>no active recruitment</i> of healthcare professionals from those <i>developing countries that are included in the department of health list</i> . All recruitment will follow <i>good recruitment practice</i> and demonstrate <i>ethical approach</i> . International healthcare professionals <i>will not be charged fees</i> in relation to gaining employment in the UK. Appropriate information will be given the health professional. They must have <i>appropriate level of English language</i> to meet requirements. All health professionals must be registered with the appropriate UK regulatory body. All international

<p><i>Supervised practice</i></p> <p><i>Valid work permit and no criminal record</i></p>	<p>healthcare professionals required to undertake <i>supervised practice</i> should be fully supported. All health care workers will undergo a normal health assessment prior to employment. All health care workers will be <i>checked for criminal records</i>. All health workers must have a <i>valid work permit visa</i> before entry to the UK.</p>
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(Source: National Health Service, 1999; National Health Service, 2004)

In 2012, the UK also adopted the WHO Code of Practice, as Norway did in 2011. Norway has now finished the first report after adhering, while the UK is still in the planning and commissioning phase with the WHO Code of Practice.

5.3 Bilateral agreements

5.3.1 Memorandum of Understanding, 2003

‘A memorandum of understanding between the Governments of South Africa and the United Kingdom of Great Britain and Northern Ireland on the reciprocal educational exchange of health care concepts and personnel’.

As the migration of professional health workers from South Africa to the UK increased it became a concern for the South African government. As a result of this, the two parties came together and discussed possible solutions to the growing problem. From this dialogue the South African and the UK department of Health agreed to formalize cooperation between the two countries and the Memorandum of Understanding (MoU) were developed, and signed in 2003. The MoU mainly focused on sharing expertise and information, as well as opportunities for time limited placements in each other’s countries. Health workers from the UK went to rural areas in South Africa and South African health workers went to the UK, associated to King’s College in London for two years, before returning to South Africa (UK Government, 2003).

The sharing of skills and expertise has led to development of many links, based on requests and identified needs. There has also been developed several twinning arrangements between institutions in the two countries. It has provided opportunities for personal development, as well as learning and sharing skills for both parties. South Africa has been one of the main sending countries to the UK. This memorandum of understanding is therefore relevant to the UK case and

to look into if this understanding between the governments has made a difference in the number of nurses that has migrated to the UK, as well as if the UK considers this understanding when recruiting nurses and health professionals.

5.3.2 Africa and EU strategic partnership, 2000

The UK is member of The European Union (EU), a treaty federation between democratic nations in Europe, having its origin in the aftermath of the Second World War. The EU now consists of 27 individual countries, which entitles all citizens to live, travel, work and retire in the country of their choice, without any problems in any EU country.

Increased migration into Europe is part of a global trend, both for skilled and unskilled workers from poorer countries to rich ones. Hence, for several reasons immigrants have become a subject of increasing political debate in many European countries. The EU's role is rather unclear and interesting at the same time, as it seems to be both the cause and a possible alleviator of migratory pressure. EU focuses on promoting policies, such as circular migration, by building cooperation platforms with African countries. As far as highly skilled workers are concerned, the EU is currently losing the global competition with Australia, Canada and the US in attracting skilled workers, which means that the highest amount of migrants into the EU seems to be unskilled workers.

The African Union has existed since 1999 when the Heads of State and Government of the Organization of African Unity issued a Declaration calling for the establishment of the African Union. The African Union was to play a rightful role in the global economy and establish cooperation both between African countries and other continents (European Council, 2011). Simultaneously, Africa is the continent that matters the most to EU policymakers regarding migration. It is said in a EU policy brief on migration that; “the member states can do precious little to manage the growing numbers of African migrants coming to Europe each year without help from African governments” (Brady, 2008, 5).

Therefore, in 2000 the EU launched a new dialogue with Africa to build a strategic partnership with the entire continent with the intention to strengthen existing measures. The EU needed African borders to strengthen border controls, take back illegal immigrants, increase local employment opportunities and help protect refugees. The partnership was formed to address several topics for cooperation, both within economy and health, migration being one of the

topics. As there is much focus on the downsides of migration, it was a need for policy makers in both continents to look deeper into the complete picture – together. So far the partnership is said to have created a forum for open exchanges in a sensitive and complex policy area, even though they stress that the immediate results are hard to measure. The debate has positively evolved over recent years, and several programs have been developed and implemented in Africa to better the effects of migration, such as African Remittances Institute (Africa - EU partnership, 2012).

As the European Union raises attention to migration issues and establishes cooperation with the African Union, it puts strings on the member states, among them the UK. Therefore, UK's membership with the European Union may have influenced the inflow of migrants as a result of EU legislation and partnership.

6. Policies in sending countries – the case of Ghana and Malawi

6.1 A Comparison of Ghana and Malawi

Malawi is one of the world's poorest countries with more than half of its population living in poverty, and as a result the health indicators in Malawi reflect the depth and severity of the poverty issue. Life expectancy has increased in Malawi during the last years. It hit a low in 2004 at 41 years old, but increased to 52.5 years by 2011 (indexmundi, 2012). The prevalence of HIV is relatively high and is estimated to be approximately 11 per cent for adults between 15-49 years old (ibid). There is still a concern for child health in Malawi, where 15.5 per cent of children under the age of 5 years are underweight.

The Ministry of Health (MoH) is the main supplier of health care in Malawi and accounts for 64 per cent of all formal health facilities, while the Christian Health Association of Malawi (CHAM) manages approximately 26 per cent of the facilities. CHAM operates on a non-profit basis and receives subsidy from the government. There is a relatively small formal private sector offering a limited range of health services as well.

The access to health facilities in Malawi is good by African standards, with 84 per cent of the urban population and 54 per cent of the rural population living within five kilometre of a health facility (Mangham, 2007). The government provides basic health care, defined as the Essential Health Package (EHP) to all citizens free of charge, even though the use of CHAM facilities incurs a small fee. Despite the “good” geographical coverage and absence of user charges in

government health facilities, access to health care is limited by an inadequacy of critical inputs. Front-line health services operate with extremely limited numbers of staff, equipment, drugs and other supplies. The overall supply of health workers depends on the number of new recruits and the retention of existing personnel. The number of newly qualified health workers entering the public services is currently insufficient to meet the human resource requirements. This is most likely a reflection of both the capacity of training institutions and the limited appeal of employment in the public (and in this case NGO) health sector. The increasing rate of attrition is a widely reported problem, and although mortality is reported to be the main cause, there also appear to be increasing numbers opting for voluntary attrition out of the health care sector in Malawi (Mangham, 2007; Ministry of Health Malawi, 2004).

Ghana, on the other hand, has experienced a strengthened economy recent years, due to relatively sound management, a competitive environment and sustained reduction in poverty levels. Ghana is also rich on natural resources and agriculture employs almost half of the workforce. Gold and cocoa production, as well as individual remittances is all major sources of foreign exchange. Since the mid 1980's, Ghana has had an impressive development and growth that has made the country one of the strongest performances in Africa. This resulted in Ghana attaining lower middle-income status in 2011.

Life expectancy at birth in Ghana is 61.5 years old, which is nine years more than Malawi, as mentioned above. The adult HIV/ AIDS prevalence in Ghana is 1.8 per cent among adults between 15-49 years old, compared to Malawi's prevalence at 11 per cent. Children under five mortality rates per 1.000 live births were 68.5 in 2009, and maternal mortality rates was in 2010 estimated to be 350 deaths per 100.000 live births (indexmundi, 2012). The WHO lists malaria and measles as the leading cause of premature death in Ghana. Nevertheless, infections compounded by malnutrition is the leading cause of death for children less than five years old, being responsible for approximately 70 per cent of the under five child mortality rates in Ghana (ibid).

The Ghanaian health services are provided both by central government, local institutions, Christian missions (private non-profit agencies), as well as a relatively small number of private for-profit practitioners. Norway was not the only country to receive the Health Worker Migration Policy Council 2012 Innovation Award; Ghana also received the award simultaneously as Norway, on May 25th 2012. The Ghanaian health minister, Alban S. K. Bagbin received the award for having reversed a negative trend. Before 2000, Ghana lost 68 per cent of their health workers who migrated for higher salaries. The Ghanaian health authorities saw what happened and started to offer attractive measures for health workers, which helped to turn the negative development around (Helsedirektoratet, 2012). Beneath is an overview of policies and programs that have been implemented in both Malawi and Ghana since the end of the 1990's.

Table 7: Overview of policies in sending countries: Malawi and Ghana

Malawi	Policy	Ghana	Policy
1999	National Human Resource Development Plan	1997	Human Resources for Health Policies and Principles document. Regularly been revised.
2001	Six Year Emergency Training Plan	1998(9)	Additional duty Hours Allowance (ADHA) (The Capacity Project)
2004-2010	A Joint Program of Work (PoW)	2003-2006	The Medium Term Human Resources Strategy and Plans for Ghana Health Service
2004-2009	Emergency Human Resource Program (EHRP)	2006	Incentive Package (The Capacity Project)
2006	The Capacity Project Malawi	2006-2011	Migration for Development in Africa (MIDA)
2007-2011	Human Resources for Health Strategic Plan	2007-2011	Human Resources for Health Policy and Plans
2008	The National Health Policy	2007	National Health Policy. Creating Wealth through Health
2008	The Human Resource Development Policy		

(Source: MWHO, 2010; GWHO, 2010).

Most of the human resources for health (HRH) programs in both Ghana and Malawi are initiated outside the Ministry of Health and organized by different international and domestic non-governmental agencies (NGO), with the support and cooperation of the Ministries. As well as

having a significant role in the development and implementation of different programs and strategies, the funding is also normally provided by the cooperating partners together with the governments (WHO, 2007).

In Ghana and Malawi the government has been operating without a written national health policy in place. To address the issue of migration, Ghana has developed a comprehensive, national migration management policy framework that was expected to be ready by August 2012, but has not yet been published by December 2012. Beneath is a short summary of the different policies and programs implemented in Malawi and Ghana, starting with Malawi.

In Malawi, Health Partners International (HPI) developed a comprehensive policy and statutory framework to help implement a reform. The draft National Health Policy indicates that the health system in Malawi continues to face a critical shortage of HRH. To address these problems the Human Resource for Health Strategic plan 2007 – 2011 was developed. The main goals of the strategic plan were to (1) attract, (2) develop and (3) retain adequate numbers of well-distributed health workers with skills and expertise in the health care system in Malawi (MWHO, 2010).

From 2004 to 2009 the Malawi Government implemented the Emergency Human Resource Program (EHRP) to manage the critical shortage of health workers. The government saw the need to expand training institutions and implement training programs nationally in order to educate and recruit more people to different health professions. The EHRP evaluation stresses that there has been a steady increase in the number of nurse graduates annually, partly due to the EHPR program and the Six Year Emergency Training Plan. The Six Year Emergency training Plan was developed by the government and development partners in 2001. The plan called for a substantial increase in training places at all institutions training health professionals. The Attrition of health workers also seemed to decrease during the EHRP. Additionally, the government implemented a series of remuneration mechanisms to reduce the shortage of health workers, such as giving health workers monthly salary payments based on the individual's job grade. The government also started to pay risk allowance if there were increased risk factors associated to the work place (ibid, 2010).

Malawi used a mix of salary enhancement and non-financial incentives to retain and motivate health workers, such as job security, generous retirement packages, countrywide job opportunities and so on. Through the EHRP in 2004, the government used funds and donor support to offer a specially designed 52 per cent salary top-up for public health workers, along with other non-financial incentives, such as improved professional opportunities and free meals while on duty. The Human Resources for Health Strategic Plan addresses the broader HR requirements of the public health sector and adopts a global perspective of HRH. The strategic objectives include (1) building capacity for HRH training and development to ensure constant supply of adequate, relevant, proper mix and competent workforce (2) attaining the right HRH numbers and skills mix to populate the health sector taking into account the available resources (3) creating, maintaining and using strong knowledge and evidence (4) managing HRH efficiently and effectively (5) developing capacities for HRH policy and (6) building sustainable partnership and cooperation among HRH stakeholders (ibid, 2010).

In Ghana in 1998, the Additional Duty Hours Allowance (ADHA) was implemented, primarily to negotiate settlement of strikes among doctors in public sector for long hours and low pay. The scheme rapidly expanded across all workers in the health sector, and within a few years it had effectively increased the take-home pay of health workers between 75 and 150 per cent. Therefore, the government put together an Incentive Package for health workers in 2006, called the Capacity Project. The aim of the project was to (1) attract, (2) motivate and (3) retain health workers (GHWO, 2011).

The ministry of health in Ghana runs different training programs in the country to prepare personnel for the provision of quality health care to the people living in Ghana. During the last decade the Ministry of Health expanded all existing health-training institutions, and from 2001-2006 they set up 21 new training institutions, including five general nursing schools in Ghana. The MOH policy to increase the number of graduates together with strengthening capacities has resulted in most training institutions having a 50 per cent increase in admission into health training institutions since 2001. The health sector in Ghana has faced serious problems with high attrition among health workers due to migration, and the health sector is severely understaffed. In 2006, the government sharply increased the salaries of health workers yet again. There are

indicators that the migration of health workers out of the country has reduced considerably following the salary increases. Nevertheless, the increase in salaries has resulted in a strain on the health sector budget. Currently over 90 per cent of the sectors recurrent budget goes into salaries and other staff emoluments (ibid).

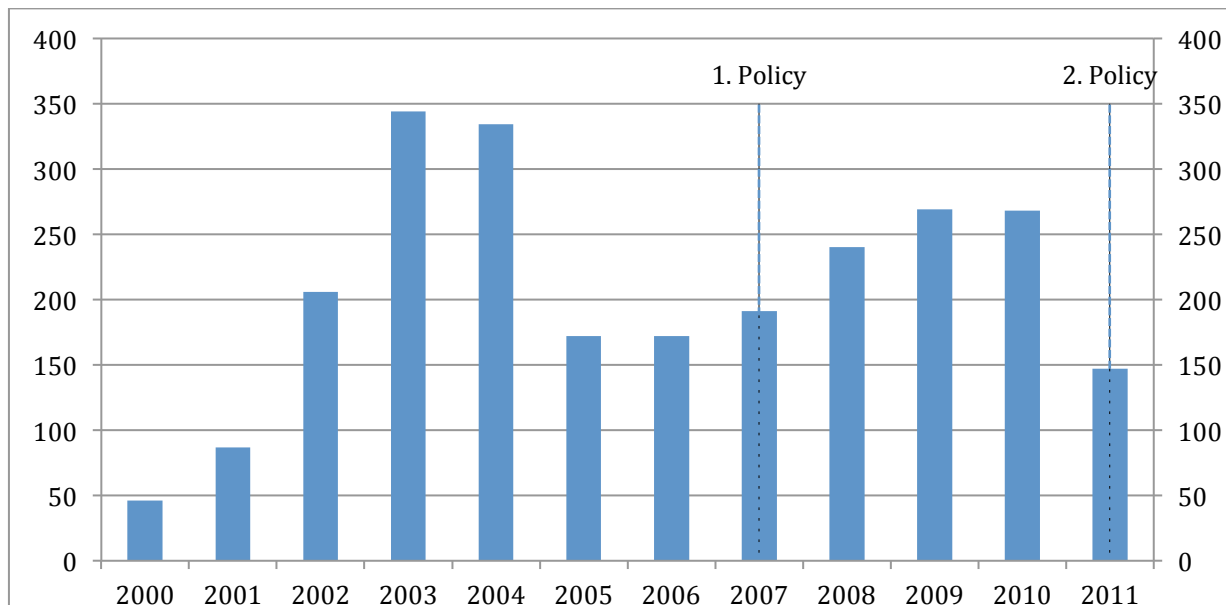
7. Analysis of policy outcomes: Norway, UK, Ghana and Malawi

In order to look into the possible outcomes of the policies addressed at reducing brain drain from developing countries, I have searched for statistics and numbers on annual inflow/ outflow of nurses from the different countries in mind. It is difficult to assess the correct number of nurses annually, due to several variables that may affect the total number. Nevertheless, I believe the numbers will give an indication of the flow and trends in a country, and may also give an indication of how the different policies implemented in a specific time period has affected the migration.

7.1 Statistics and analysis Norway

When searching for information regarding the flow of nurse migrants to Norway, most of the data were obtained from annual reports presented by The Norwegian Authority for Health Personnel (Statens Autorisasjonskontor for Helsepersonell, SAFH). The numbers from 2008 and 2009 was sent to me by Jens Erik Østenby at SAFH. Included in these figures are also Norwegians who studied abroad, which may cause deviation to the actual number. Therefore, countries within the OECD were excluded, as well as popular study destinations for Norwegians. Hence, it is not assumed that a significant amount of Norwegian students complete their study program in developing countries. It is therefore likely to believe that these numbers do not bias the indicator of the migration flow of nurses from developing countries to Norway. Beneath is a graphical overview of the trend of nurses migrating to Norway from developing countries. The ‘policy’ markings in the graph represent the year the relevant policies were implemented.

Figure 2: Annual number of foreign nurses who received authorization in Norway



(Source: Statens Autorisasjonskontor for Helsepersonell, SAFH, 2005, 2007, 2011, 2012).

1. Policy: A solidarity policy for the recruitment of health professionals, 2007.
2. Policy: The WHO Global Code of practice, 2011.

The graph provides an indicator of how the migration trend to Norway has been from 2000-2011. It shows an increase in the number of authorizations from 2000 up until 2003, where it stagnates at its highest year, and starts a decrease from 2004 to 2005-2006. Further there is an increase from 2007-2009, where it again stagnates to 2010. From 2010-2011 there is a decrease in the number of foreign nurse registrations to Norway.

The main policies regarding health worker immigration to Norway were implemented in 2007 and 2011. The increase in the number from 2000 to 2003-2004 may be because the Norwegian government and AETAT committed active recruitment up until 2004. The Norwegian government at first opened for recruitment, but revised and changed policies when the magnitude and consequences of brain drain fully appeared.

Norway is presumably not the most attractive country for nurses to immigrate to, in spite of high salaries and much better working conditions. This may be much due to linguistics and the persuasion of recruitment agencies, as English-speaking countries may be a priority to individuals who have English as their first language. The need for health workers in developing countries has

made it a market for competition between developed countries, and Norway might have come to short with bigger countries, such as the UK. Nevertheless, there is no indication in this graph after 2007, when the first policy was implemented, that shows a decrease in the trend of nurses immigrating from developing countries. The increase in the number of migrants to Norway between 2007-2010 might be a result of the global financial crisis. Overall, the numbers are small, but Norway did not experience the impact of the financial crisis to the extent as many other OECD countries did. Therefore, Norway may have been a better and easier target for international migrants. This may also have prevented a positive effect of the first policy implemented in 2007. The overall migration of nurses to Norway has decreased the recent years, and are now at its lowest since 2002.

7.2.1 Addressing the theories of migration

One of the aims of this study is to look at how different governments make policies that respond to the theories of migration. It is obvious that the different theories interact, and that there is “No single solution, No single actor” as Klokkerud states in her thesis (Klokkerud, 2007, 40).

The contrasts between rich and poor countries in it self creates push and pull effects on people in poor countries. The first policy developed in Norway in 2007, says, “[...] Norway will contribute to reducing push and pull factors” (A solidarity policy for the recruitment of health professionals, 2007, 21). One of the most influencing push and pull factors are salaries. Undoubtedly, the differences in salaries between countries will remain and salaries in (for instance) Ghana and Malawi will not be able to compete with Norwegian and UK salary levels. But the Norwegian government contributes with financial development aid targeted at specific areas in the receiving countries, which again contributes to reducing push and pull factors between high and low income countries. Financial development aid targeted at the health care sector, drugs, equipment, education and so on betters the circumstances in a country. As an example, apart from development aid, of reducing pull factors is the cooperation Norway has had with Malawi, where as mentioned above, basic health care reaches more people and improved several health indicators. Additionally, Norway has since 2004 supported cooperation between nursing schools in Norway and Malawi - resulting in a doubling of the capacity and quality of the education in Malawi.

Remittances are of course both an important and significant stay factor for a migrant. Therefore, higher wages in sending countries will most likely contribute to reducing stay factors in receiving countries, as the need for remittances will no longer be that prominent. Norway has showed responsibility and engagement in the work of reducing pull factors and facilitated better organization in developing countries, as well as changed domestic policies and followed the international guidelines in order to prevent brain drain and worsening the situation in sending countries.

In order to control the demand for cheap labour in Norway, the government has focused on how to make use of own resources. The solidarity policy (2007) demonstrates how Norway can be self sufficient by exploiting the potential that is in the existing workforce, how to reduce department from the health sector, better organizations of the health care services, as well as educate more health workers, with concrete, realistic and manageable goals. The policy stresses Norway's responsibility on influencing the development of poor countries in a positive direction and giving development aid towards achieving WHO's development goals. The active recruitment from developing countries has decreased significantly in Norway, and the ethical guidelines are followed. People who want to migrate are of course not being refused. To target professional development, Norway has, as mentioned above, several cooperation's within education and exchange schemes, so that the sending country do not suffer losses. The exchange schemes may also have a positive effect on stay factors, as the plan is to return to the home country and therefore the source country do not loose nurses to developed countries.

A pull factor often mentioned by health workers migrating is improved quality of life. This is subjective to all individuals, but it includes the overall push and pull factors, meaning that each factor has to be targeted in order to reduce the overall desire to migrate. Neither is there any doubt that social security schemes are better in Norway, and not comparable to the ones in many developing countries, though there has been implemented several incentives for health workers in developing countries.

Norway apparently leads a clear policy and has worked at the intersection of departments in the government in order to develop the best policies and strategies to reduce brain drain.

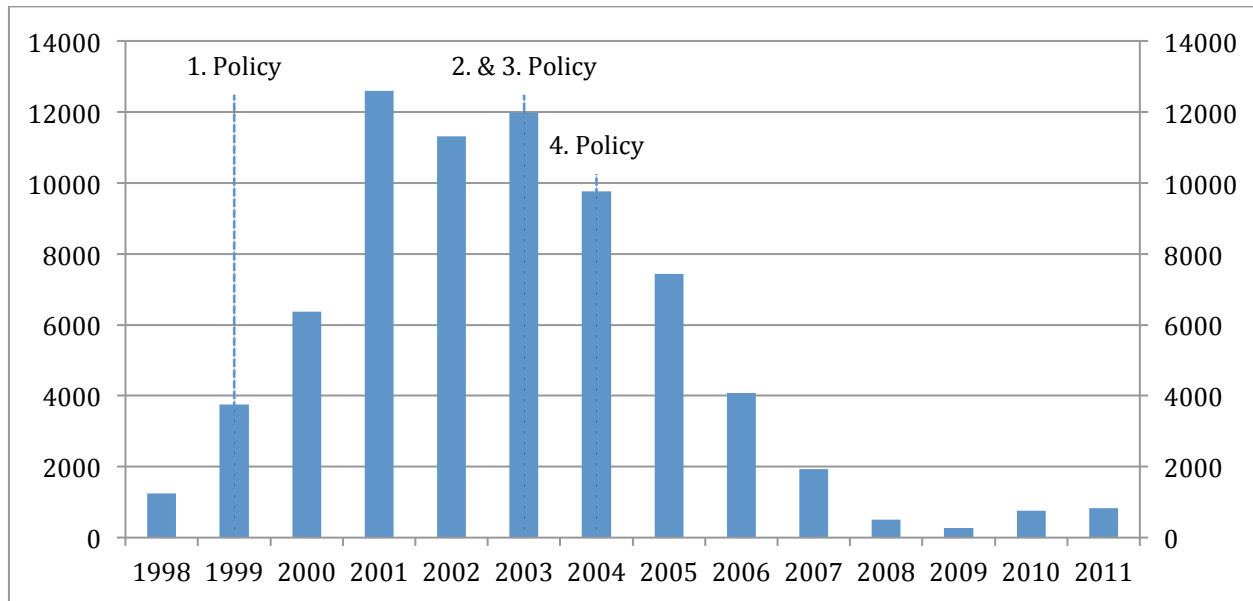
Norway has strengthened national policies to reduce pull and stay factors, as well as looked into ways to contribute to reduce push factors in sending countries. Additionally, the solidarity policy (2007) stresses that Norway should specifically help to train more health workers in developing countries, with a specific aim at reducing push and pull factors between low and high income countries, by strengthening education in developing countries, as well as establishing cooperation and exchange schemes between governments.

Norway has within a short period of time taken the WHO Code of practice into consideration and developed national policies built on these guidelines, where they assure ethical recruitment. The WHO presented the Code in order to manage brain drain and recruit health workers in an ethical matter, with the aim at cooperation between governments. It also stresses technical and financial assistance to strengthen health systems in developing countries, and that both countries should benefit from the migration. It has not been possible to obtain the Norwegian WHO report that are to be presented in Geneva in 2013, but I expect much of the guidelines to be in thread with the ones made in 2007, as the policy were thorough and already addresses many of the guidelines that WHO suggested in 2010.

7.2 Statistics and analysis United Kingdom

Katherine Szentgyorgyi at the Nursing and Midwifery Council (NMC) in London provided me with numbers of initial registrations in the UK, broken down by country of training and nationality from 2002 to 2012. There was not significant deviation between country of training and nationality, but I chose to use numbers from country of training. This because I do not believe a significant number of nursing students from the UK carry out their entire study program in developing countries. Hence, I used the same procedure as described with Norway, adding the number of registrations from countries outside the OECD, and excluding countries within the OECD. Szentgyorgyi at the NMC was not able to provide me with numbers previous to 2002, which is important as one of the policies in mind were implemented in this time period. I therefore conducted these numbers provided by Bach at the International Labour Office, given to him by the NMC at the time (Bach, 2003, 7). Here as well, I excluded countries within the OECD. Additionally, registration numbers for midwives was included in the numbers received from NMC, which was excluded from the total number, only focusing on nurses from countries outside the OECD, as done with Norway. The annual data from NMC represents the period from April 1st to March 31st the following year.

Figure 3: Annual numbers of foreign nurses who received authorization in the UK



(Source: Nurse and Midwifery Council, 2012; Bach, 2003).

1. Policy: National Health Service Code of practice, 1999
2. Policy: Commonwealth Code of Practice, 2003
3. Policy: Memorandum of Understanding, 2003
4. Policy: National Health Service Code of Practice, revised, 2004

When studying the numbers from both Norway and UK, it is obvious that the Norwegian numbers are generally low in comparison to UK. In 2001, the UK experienced the highest amount of nurses immigrating, approximately 46 times as many as in 2009, which is the year with the lowest number of nurse immigrants to the UK. Compared to Norway, who at the most had 7.5 times as many nurse immigrants between the highest and the lowest year, 2003 and 2000. The general trend in inflow of nurses to the UK from overseas increased rapidly from 1998, with a peak at the beginning of 2001. Thereafter, the data shows some decline in numbers of registrations, before it again increased from 2002-2003. From 2003 there is a significant, rapid and lasting change in the registration of overseas nurses in the UK the next years. It hits an absolute low in 2009, until it slightly increases in 2010 and stays rather stable until March 2011.

The number of foreign nurses kept increasing until 2001-2002, when the first decrease sets in. The NHS Code of Practice was implemented in 1999 and was not mandatory. Therefore, the private recruitment agencies were free to continue their recruitment as usual. Another explanation

is that this was the first Code developed; the magnitude of brain drain from poor countries was not yet shed light on and was therefore not taken seriously by governments and institutions in the West. In the case of Norway as well, the government encouraged recruitment from other countries as a measure to solve national staff shortages – the “free” resources was highly appreciated and needed. Another factor that may have affected the first decrease between 2001 and 2002 is the terror attacks on the United States on September 11th 2001. According to the OECD this led to a reduction in new foreign labour migration, as well as strengthening of own immigration policies in most countries, hence it probably affected the UK as well (OECD Outlook, 2011).

The NHS Code of Practice that was developed and released in 1999 was a Code on ethical recruitment, and how recruitment within the National Health Service should take place. It covered employees’ rights and the responsibility of employers when recruiting personnel. Therefore, the Code primarily looked into what should be done when recruiting personnel, in order to make better conditions for the immigrant workers and stay within legal frameworks. The NHS Code was not mandatory, and the private recruitment agencies could, and often maybe would, choose to oversee it.

In 2000, the African Union (AU) and the European Union (EU) established a strategic partnership. The UK are members of the EU, hence when EU increased the focus on addressing migration between Africa and Europe, the UK were obliged to adhere to the partnership. Further, the EU reckoned that the most effective way to start would be to establish a dialogue with the African Union. By this time the notion and magnitude of the brain drain were starting to show consequences, and a reason for the decline in overseas registrant from 2001 and onward may be the increased knowledge and pressure from other bodies, such as the EU, WHO and foreign governments. Nevertheless, there is an increase from 2003 to 2004 of 687 nurses from overseas, outside the OECD.

From 2003 the number of registrations starts to decline, and in 2003 the Commonwealth Code of Practice was developed and presented. This put further strings on the government, but the private recruitment agencies were still not obliged to adhere, as with the NHS Code of Practice.

Additionally, the UK develops a Memorandum of Understanding with South Africa, which has been one of the main sending countries of health workers to the UK. The MoU puts more responsibility on the UK, as well as mutuality between the two countries. The UK now agreed on exchanging health workers and implementing measures that would also benefit, in this case, South Africa. This again led to more responsibility for the UK, where UK health workers gained more knowledge, although it did not help the health workforce to grow in the UK.

In 2004, the NHS Code of practice was strengthened and revised. The Code states that developing countries should not be targeted when recruiting healthcare professionals. In order to secure this, the department of health worked with the department of international development to produce a list of 154 developing countries that should not be recruited from. This list may make this policy the most powerful of the ones existing, as it is possible to identify when it is broken. Further, the NHS keeps a list of recruitment agencies that have adopted the guidelines, and employers organized by the NHS can only use these agencies in the recruitment of foreign health workers. Due to this list of recruitment agencies approved by the NHS, it also gives a certain ability to follow up and filter out those agencies that does not follow guidelines. As the graph shows, there is no doubt that UK policies implemented within this time period may have caused a significant difference and at the same time been effective in the reduction of the recruitment of health workers from developing countries.

In 2005, London suffered a terror attack that strengthened the immigration policies by the Home Office, as the Al Qaida undertook responsibility, without that ever being proved. It is natural to assume that this may have had an effect on the number of work migrants to the UK, and therefore enhanced further decrease.

One can then ask what the general trend in labour migration to the UK from non-EEA countries has been. This question arises due to the curiosity whether the general trends in labour migration has been the same as nurse migration trends to the UK. In that case, it would be more logical to assume that general migration policy and other alternative explanations have had the same impact on nurse migration. The Migration Observatory states that non-EEA labour migration has increased over the 1990's and early 2000, but has declined since a peak from 2004-2006. This means that the general decline stated by the Migration Observatory began later than the decrease

in the number of nurse immigrants, which again substantiate that the Codes of Practices implemented in the UK, as well as bilateral agreements may have had a positive effect on the migration and started the decreasing trend.

The drastic decrease from 2008-2010 may be explained by changes in managed migration in the UK. The Ministers stressed that continuing pressure on borders underlined the need to impose strict limits on non-EU citizens applying to live and work in the UK. Thereafter, a new point-based immigration system was introduced and the scheme was phased between 2008 and 2010. In June 2010, Britain brought in a temporary cap on immigration of those entering the UK from outside the EU in order to stop an expected rush of applicant before a permanent cap was imposed in April 2011.

The absolute low of nurse immigrants according to the NHS were in 2009. It can neither be ruled out that the strike of the global financial crises had an impact. Khalid Koser at the IOM states, “there is no question that the current global financial crisis is impacting migration patterns and processes around the world” (IOM; Koser, 2009, 5). Koser also states, "a reduction in migration flows has been reported [..]" as a result of the financial crisis (ibid, 2009, 5). Additionally, figures show that there has been a slowdown in the rate of increase of remittances on a global level, with regional variations.

7.3.1 Addressing the theories of migration

Active recruitment has been one of the most prominent pull factors in the UK. In order to reduce the active recruitment and stop recruiting from countries in severe shortages themselves, the UK has made several measures. First and foremost there has been developed a list of countries that shall not be subjected to recruitment. The problem has been private recruitment agencies, but since 2004, the National Health Service would not use recruitment agencies that do not adhere to the list. Therefore, the UK has made more strict immigration and recruitment policies, which seemingly has been complied and had a positive effect on the recruitment. In addition, the UK government has established cooperation with South Africa, the Memorandum of Understanding. The MoU stresses to reduce the recruitment and focuses on exchange of health workers between the two countries. This type of governmental cooperation creates a responsibility for both countries and reduces stay factors, as well as gives a better opportunity to monitor the migration. It also furthers the fact that both countries benefit from the migration. Professional development

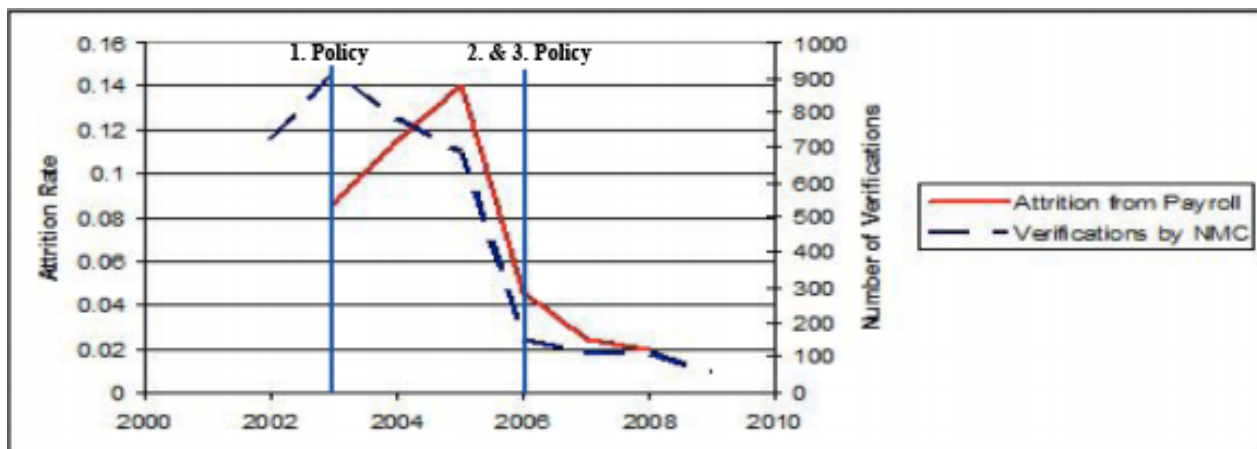
is also an important pull factor that may be reduced due to exchange schemes, and both countries will most likely benefit from the shared knowledge. The demand for labour does not increase in the UK, and there have been some discussions to raise salaries in the UK to attract more people to the nursing profession, but there does not seem to be any concrete, well-developed measures as to how the UK plans on coping with the domestic shortage.

7.3 Statistics and analysis Ghana and Malawi

A discovery made while doing this study is the lack of data and statistics from both Ghana and Malawi. It was somewhat expected, but I was unable to conduct data from the Ministry of Health in both of the countries, as well as nursing councils and other agencies that could be helpful. I also repeatedly contacted country representatives from WHO, but was unable to get replies. Neither does the OECD keep statistics on the number of nurses immigrating to countries within the OECD from different non-OECD countries. Nevertheless, I was able to find reliable statistics that will be used as an indicator on the trend of migration from both Ghana and Malawi.

Beneath is an overview of the migration and attrition of nurses from Ghana. This figure shows that the migration trend of nurses from Ghana has slowed considerably recent years, from having its peak around 2003. From there on it shows a steady decline to approximately 2005, where the numbers of migrants drops significantly to 2006 and levels off at a reduced rate.

Figure 4: Migration and attrition of nurses from Ghana



(Source: Atwi et al. 2011).

1. Policy: Medium Term Human Resource Strategy

2. Policy: Incentive Package, 2006
3. Policy: Migration for Development in Africa, 2006

In Ghana, the migration of health workers got government attention around 1997, when the 'Human Resources for Health Policies and Principles' document first were introduced. In 1998-1999, the Additional Duty Hours Allowance (ADHA) was introduced; nevertheless, the emigration of nurses from Ghana continued to increase for three more years.

In 2003, a new project planned to last for three years 'the Medium term Human Resource Strategy and Plans for Ghana Health Service' were put forward. Together with other stakeholders, the Ministry of Health clarified its priority policy objectives that were captured in these strategies and plans. This was a plan to better governance of the countries health system and the vision was supported by three pillars: (1) good governance, (2) promotion of the private sector and (3) human capital development. As the graph shows in 2003-2004 the emigration of nurses also starts a steady decline towards 2006. This indicates that this scheme might have been successful and started a decrease.

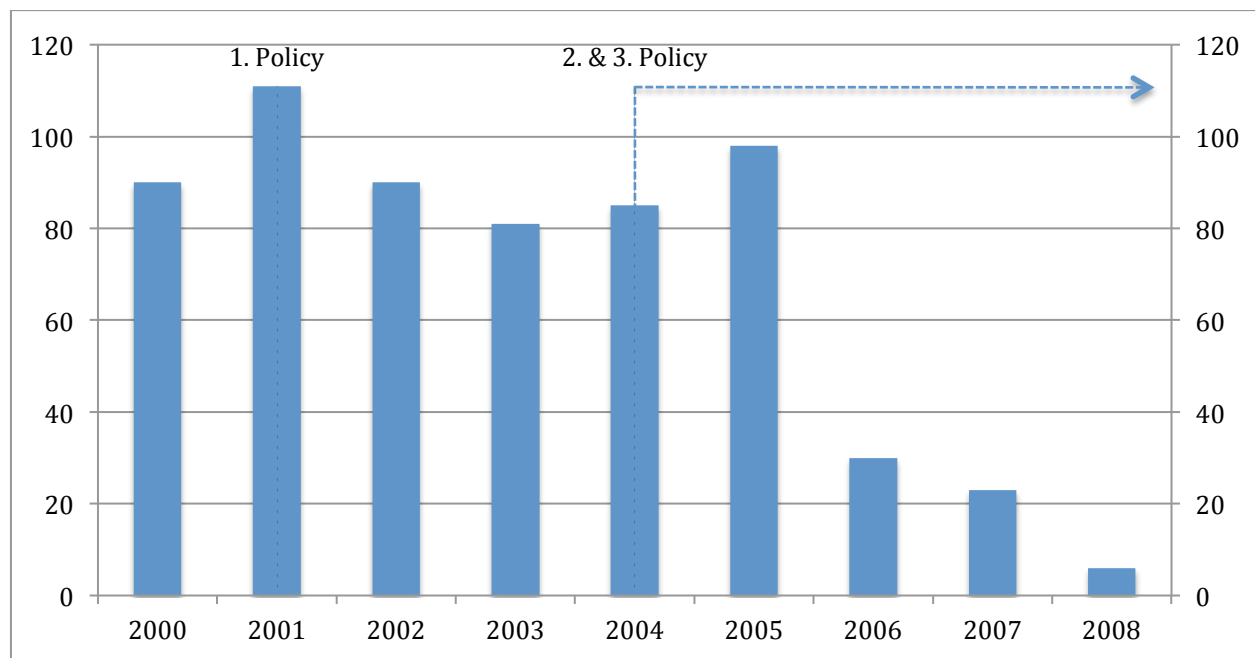
As mentioned above, the numbers again drop drastically from approximately 2005 to 2006. There is not implemented any new policies or schemes in Ghana during this time period, but in 2006 an 'Incentive Package' was introduced in Ghana. Additionally, in 2006 the 'Migration for Development in Africa' (MIDA) scheme was implemented and planned finished in 2011. In 2007(-2011), the 'Human Resources for Health Policy and Plans' was implemented, as well as the 'National Health Policy'. These policies may have led the numbers to level off at a reduced rate after 2006. The ADHA scheme, focusing on raising salaries in Ghana, has been documented to have some effect on health worker migration. The scheme was implemented in 1998-1999, nevertheless the graph presented above does not show a decline in the emigration of nurses after this time period, as the trend increases till its peak in 2002. A sudden increase in salaries could most likely also cause a sudden policy effect that would show in the graph.

Ghanaian migrants often leave for English-speaking, high income countries, and indications show that 71 per cent of nurses leaving Ghana from 2002-2005 went to the UK, with the most remaining leaving for the US. Therefore, it is more than likely that the migration between the sending and receiving country interact and affect each other. In 2003, around the time the decline

starts in Ghana, the Commonwealth Code of Practice is implemented in the UK, which affects sending countries within the Commonwealth. Both Ghana and Malawi are members of the Commonwealth, as mentioned earlier. Additionally, in 2004, the NHS Code of practice were revised and implemented once again in the UK, which may have contributed to the decrease of nurse migration from Ghana.

From 2000-2008, 614 nurses registered to leave Malawi, although registering for migration does not mean to actually do it. Beneath is a figure of nurses who have migrated to other countries from Malawi, and gives an indicator of the trend in nurse and midwife migration from Malawi. These numbers does include midwives, which I have chosen to exclude earlier. Nevertheless, this was the data found on Malawi and the numbers of midwives migrating are small compared to the numbers of nurses, even though it may create a deviation in some of the numbers and therefore effect the liability.

Figure 5: Nurses and midwives who migrated to other countries from Malawi



(Source: Gorman, Global Health Report, 2008).

1. Policy: Six Year Emergency Human Resource Plan, 2001.
2. Policy: A Joint Program of Work, 2004- 2010
3. Policy: Emergency Human Resource Program, 2004- 2009.

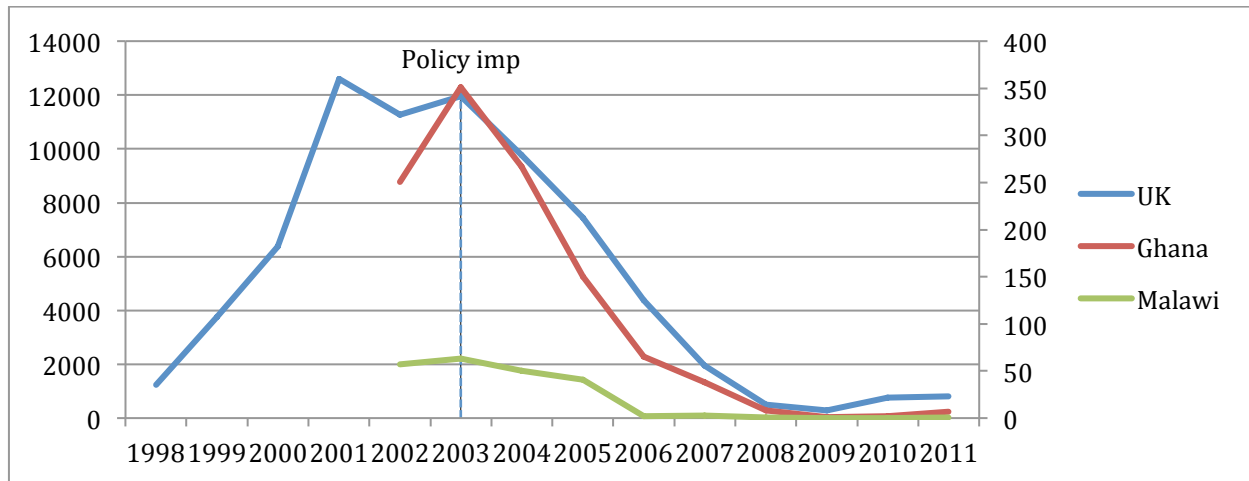
A generally lower number of nurses and midwives emigrate from Malawi than Ghana annually, even though the impact on the workforce creates the same challenges due to the fact that the total number of nurses practicing in Malawi is much lower and therefore have a smaller density of nurses.

In 1999, the Malawian Government implemented the first ‘National Human Resource Development Plan’. The number of nurses migrating yet increases from 2000 to 2001, where it peaks. Thereafter, from 2001 to 2003 there is a decrease in the number of nurse and midwife migrants. In 2001, when the decrease starts, the Six Year Emergency Training Plan is implemented in Malawi, which may have had a positive effect on the nurse migration. Again, the numbers increased in 2004 and 2005, where it suddenly had a significant drop from 2005-2006. In 2004, ‘A joint Program of Work’ (PoW) was implemented, which was a six-year program. Additionally, in 2004 the ‘Emergency Human Resource Program’ (EHRP) was implemented, and ended in 2009. During this period the annual numbers of nurses and midwives emigrating decreased significantly, which indicates that one, or both of these programs have had a positive effect on the decrease of nurse and midwife emigration. From 2006-2008 Malawi experiences a steady decrease, with 2008 being the lowest so far. In 2008 ‘The National Health Policy’ was implemented, as well as the ‘Human Resource Development Policy’.

The UK is the main receiving country for both Ghana and Malawi’s nurse and midwife migrants. When comparing the trends of immigrants to the UK from Ghana and Malawi together in one figure, as done beneath, the migration trends have a clear interaction. Here as well, the annual data from NMC represents the period from April 1st to March 31st the following year.

Figure 6: Trends in the UK: Ghana and Malawi

(Right hand side: UK, left hand side: Ghana and Malawi)



(Source: Nurse and Midwifery Council, 2012; Bach, 2003)

1. Policy: The Commonwealth Code of Practice, 2003.

Both Ghana and Malawi has followed the same trends as the general nurse immigration trend to the UK. The absolute turning point is in 2003, when the Commonwealth Code of Practice is implemented in the UK, followed by the revised version of the NHS Code of practice in 2004. Malawi had a policy implementation in 2001 with the ‘Six Year Human Emergency Resource Plan’, and then again in 2004 with the PoW and EHRP, which may have further contributed to the decreasing trend. Ghana had ‘The Medium Term Human Resources Strategy and Plans for Ghana Health Service’ in 2003, as mentioned above. In this particular time period there does not seem to be any clear alternative factors, other than the policies implemented that most likely has had an effect in the migration between these countries. Both Ghana and Malawi show the same trends as in the UK, and the similarity with UK’s trend initiates that there is a strong correlation between countries, and that policies implemented in one country, in this context, may have just as strong impact in another country.

7.3.1 Addressing the theories of migration in Ghana and Malawi

For sending countries, the goal is to reduce push factors, as well as strengthen stick/stuck and return factors, often called retention policies. Both Ghana and Malawi have implemented schemes that focus on incentives, which both reduce the need and desire to migrate, as well as

make it more attractive to return to the sending country. Both Ghana and Malawi has increased salaries, Ghana with the ADHA program in 1998 and 2006 and Malawi with the EHRP in 2004. Higher salaries surely has the potential to reduce push factors, as well as increase the stick and return factors for potential migrants, being one of the most prominent push and pull factor between countries. Numbers in policy evaluations indicate that this has had some positive effect and at least reduced push factors to some extent in both Ghana and Malawi.

The high attrition rate from the health care sector in Malawi has been much due to fear at the work place, for violence and contradicting HIV/ AIDS. The government therefore started to pay risk allowance when there was increased risk associated with the work place. Malawi has also introduced non-financial incentives, such as job security, retirement packages (social security), job opportunities, free meals while on duty and improved professional opportunities. This targets the stay factors for nurses and it may reduce the push/ pulls factors between countries. Additionally, it may contribute to strengthen return factors to the health care sector.

The lack of opportunity is also a push factor for many nurses. There has been developed bilateral agreements and cooperation between countries, for example Norway and Malawi, the UK and South Africa, as mentioned earlier, with exchange schemes so that health workers can come to Norway and the UK to work and learn, and visa versa. Hence, both countries benefit from the migration and the push/ pull and stay/stuck/ return factors are addressed.

In Malawi there has also been political unrest due to the country's governance, poor economic governance, lack of respect for human rights and not complying with scheduled local elections. Several Western donor countries, among them Norway, the EU commission and the World Bank, have stopped or reduced budgetary support. This again increases push/ pull factors, and can only be solved by resuming good governance, which is too wide to grasp in this context. Political unrest, as the example with Malawi, also worsens working conditions, as medical supplies empties and wages are not paid. Good governance ultimately seems essential in order to reduce the factors that cause nurses to emigrate from their country of origin.

8. Conclusion and recommendations

The background for this thesis is my experiences while practicing as a nurse, both in Ghana and Norway. There were of course substantial differences, but in both countries I witnessed understaffing of nurses due to shortage of personnel. I believe one of the most important measures worldwide is to educate more nurses to improve the quality of health care, and make working conditions easier on those already working.

There is still a global shortage of nurses, and those in most need are the ones suffering the most. The primary aim of the policies examined in this thesis is therefore to promote a more justified allocation of nurses (and health workers) globally. The results in this thesis show a clear decreasing trend in the migration of nurses from low to high-income countries. Norway, as well as the UK- one of the biggest receiving countries in the world, shows a marked decline in nurse immigrants. Additionally, both sending countries, Ghana and Malawi, show a decrease in the number of nurses who emigrated the previous years. Hence, the outcome of the policies presented in this thesis indicates a clear progress and that much of the goals now have been reached. Future challenges will therefore be to comply this decreasing trend, and develop measures and strategies on how to keep the trend persistent. Nevertheless, it may be difficult to only assess the effect of the policies implemented, as there can be alternative explanations contributing to the decrease, as mentioned previously.

It is also obvious that the theories of migration are many and complex, and good governance seem to be the most underlying and preventive measure against push and pull factors, as well as it strengthens the return and retention factors in a country. There are clear interactions between the theories of migration, and it may even be as simple as if one person leaves, more follow, resulting in a ‘snowball effect’, which makes it difficult to assess the main cause of migration.

As well as good governance, a further recommendation is increased cooperation between governments in different countries. It seems essential as the statistics show a clear interaction between countries and across borders. Policies implemented in one country can, in this case, affect other countries.

More exchange schemes between countries can also have a good effect on cooperation, managing factors that contribute to migration and fosters increased knowledge and understanding between countries. Also, the term brain drain can change towards brain circulation and brain gain. Many do not return to the country of origin, which is often caused from lack of information and incentives about opportunities at home. Exchange schemes may better this and keep people more up to date on situations and opportunities in the home country.

Now that the migration trends between these countries seem to be decreasing, the future goal must be to educate more nurses in all countries, but particularly in the countries in most need of nurses. Therefore, cooperation between countries seems essential here as well, as Western countries has a responsibility to help these countries, not only because they are responsible for much of the brain drain, but also due to moral issues and obligations. The interaction between the countries are clear, and the trends may primarily have been changed due to policies implemented in receiving countries, but at the same time, both Ghana and Malawi has made national measures to better the situation for their health workers.

We are aware that there is a significant need for health workers globally, and successful measures have been made, both on national and international level to best manage brain drain. Finally, Florence Nightingale, the founder of modern nursing, made a statement I believe is for thought in this specific case:

“Were there none who were discontented with what they have, the world would never reach anything better” – Florence Nightingale.

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