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United Nations Institute for Training and Research

SUMMARY REPORT

Migration and Development Series 2009
PANEL ON
MIGRATION, BRAIN DRAIN, AND CAREGIVING

organized jointly with IOM, UNFPA and the MacArthur Foundation

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Dag Hammarskjold Library Auditorium
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BACKGROUND

The health care system is in crisis, a fact which continues to complicate progress toward the achievement of MDG 6, a commitment by the international community to combat HIV/AIDS, malaria and other major diseases. While HIV infections constitute a worldwide problem, the highest infection rates remain in countries of sub-Saharan Africa. According to recent reports published by UNAIDS, in some countries more than 20% of the total population are affected, compared to less than 4% globally[1].

Effective health care systems to counter this situation are needed, but progress towards their improvement hinges on the availability of adequately trained health care professionals. In this context, the exodus of qualified doctors, nurses, pharmacists, and laboratory technicians from developing countries, usually referred to as "brain drain" of health service providers, has become a global concern. At the same time, changing demographics in the, mostly developed, receiving countries result in an increased demand for health care professionals.

OBJECTIVES

The panel was designed to (i) examine brain drain and HIV/AIDS as contributing factors to the crisis of health care systems in sub-Saharan Africa; (ii) put special emphasis on the gender dimension: how HIV/AIDS, brain drain and the health care crisis impact men and women differently[2]; (iii) discuss how policy responses to HIV/AIDS and brain drain can be coordinated so as to ensure the right to health in developed and developing countries, including through the achievement of MDG 6.

Information on the seminar and the *Migration and Development Series* is available from info@unitarny.org or at http://www.unitarny.org/en/migdevseries.html

[1] UNAIDS: 2008 Report on the Global AIDS epidemic, Executive Summary, p.4;
UNAIDS: A global view of HIV infection - Estimated adult HIV prevalence for countries in 2007.

[2] The explicit emphasis put on the gender dimension was due to the context in which the panel took place, namely as a side event to the 53rd session of the Commission on the Status of Women (CSW) and its

SUMMARY OF DISCUSSIONS

In their discussion about the interlinkages between brain drain, HIV/AIDS, and caregiving, panelists conveyed three main points: First, a common conviction was expressed that one of the main obstacles in the achievement of MDG6 is the **global imbalance of available health care workers**. Both the number of professional caregivers and the amount of public spending on health care systems are lowest in those areas which showed the highest prevalence rates of HIV[3]. Consequently, a low density of health care workers and high mortality are clearly correlated.

A second point of consensus related to the **importance of the gender dimension** in the discussion, because of the relatively larger impacts of both HIV and caregiving on women. Indeed, caregiving professions tend to be dominated by women (the exception being some areas of physically more demanding intensive specialty nursing, which are largely filled by men). In addition, HIV infection rates are markedly higher among women then men.[4] Further, several speakers pointed out that policy discussions need to take into account the general feminization of migration which has been changing traditional migration patterns. Rather than following male migrant workers as spouses, today the majority of women migrate alone in search of employment.

The challenge to reconcile conflicting rights emerged as a third area of agreement among the panelists. One speaker emphasized that attempts to ensure the right to health in developed countries and the right to health in developing countries are bound to be opposing at times. Similarly, migrants' right to search for a better life abroad and states' desire to provide functioning health care systems bear a potential conflict of interest. The question arising from this conflict is how to reconcile these rights by implementing policies tailored to be beneficial for the countries of origin, destination, and migrants alike.

Factors to keep in mind

While presentations outlined **reasons for brain drain**, commonly divided into push and pull factors, they also introduced a new thread of thought by framing **HIV itself as an additional push factor** prompting health care workers to leave: As HIV is regarded as an occupational hazard in high prevalence areas, working in these areas becomes less desirable as the chance of infection is enhanced. Other push factors identified were insecurity in the work place, working conditions, low pay, lack of respect and recognition for work (esp. in the case of nurses), and overall political and economic instability. Notably, the amount of remuneration was presented as one push factor among many,

guiding theme of "The equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS".

[3] Particular concern was voiced over the situation in countries in sub-Saharan Africa: Those areas in which over 20% of the population is HIV positive receive less than 1% of world's total health care spending, and have only 3% of the global health care workforce at their disposal. Subsequently, life expectancy in Southern Africa has been dropping sharply since the 1990s, from over 60 years on average to less than 50 years, in accordance with the appearance of HIV/AIDS during that time.

[4] In sub-Saharan Africa, 60% of the infected are female, and in some countries, such as Swaziland, South Africa, and Zimbabwe, Central African Republic, female infection rates are more than three times as high as infection rates for men. A large percentage of women still lack access to reproductive health care in general, and, citing a UNAIDS study, less than 35% of HIV positive pregnant women worldwide receive antiretroviral prophylaxis.

but emphasis was placed on it not being the most important one. The major pull factors for health care migrants were identified as increased demand in developed countries for health care providers in ageing societies, higher salaries, and professional development opportunities.

Speakers also elaborated on **reasons for HIV infections**, stressing the need to address stigmatization of those infected with HIV. **Vulnerability to HIV and AIDS**, rather than being purely a question of individual risk behaviour, **is largely influenced by socio-economic conditions** and factors, including lack of education and awareness, poverty, a lack of decent work and living conditions (incl. domestic violence), gender inequality, as well as poor health access and services. All these factors increase overall physical vulnerability and create conditions conducive to higher infection risk.

Assessing the **impact of HIV and migration on each other**, experts noted that migrants usually find themselves at a higher infection risk than the rest of the population. Operating outside of their habitual normative system, migrants may engage in more risky behavior, such as unprotected sexual contacts; they lack social support networks, and face a higher risk to be exposed to and become victims of sexual violence. Further, migration can contribute to the spread of the disease across borders, for instance in the case of seasonal migrant workers who return home and infect their partners. Vice versa, HIV can impact the pattern of migratory flows, as health care workers move away from particularly high risk areas, or orphaned children move to their relatives in other cities or villages.

The discussion on the **impact of female health care worker migration on countries of origin** highlighted the fact that the effect of a mother migrating was rather different from a father migrating. Often female migration triggers so-called care chains, with the grandparent generation taking on care functions for their grandchildren, a likely overburdening task. Also, as women serve as primary caregivers in formal and informal settings, the impact of their migration is felt on the professional level as much as in families. The migration of women can put in question traditional gender roles, as women become important breadwinners.

Another recurring theme was the **need to change the gender blindness of labour migration policies**. Traditionally, labour migration policies tend to be tailored to male migration, as exemplified by a lack of reproductive health insurance provisions in many labour migration policies and cases of deportations of temporary migrant workers who become pregnant.

In contrast to popular perceptions of migration as a primarily South-North movement, the discussion repeatedly touched on the **intra-regional dimension of migration**. While the focus of the discussion was largely on brain drain from developing to developed countries, the panel also stressed the existence of substantial intra-regional migration flows especially within Africa, e.g. into South Africa. The African continent also serves as a transit point for migrants from Asia going through Africa on their way to Europe or the United States.

Experts also highlighted the need to tackle the phenomenon of **'brain waste'**, denominating cases in which migrants are not able to use their skills in the host country. In this context, they called for improving the recognition of skills in host countries, e.g. by enhancing the transferability of academic credentials. While brain waste is a problem pertaining to all professions, the health care sector is particularly prone to suffer from it: In addition to legal barriers, both language skills and cultural factors can hamper

migrants' access to caregiving jobs (more so than for example to agricultural work), as the provision of care is a contact and people based work.

On a more general note, **access to health care for migrants** was a further subject under discussion. Health care should not only be readily accessible for migrants, but also (culturally) acceptable. For instance, HIV prevention campaigns in developed countries are often framed as a homosexual issue, thus making migrants' use of HIV prevention services more unlikely[5].

Finally, the last recurring theme of the panel discussion related to the need for more data. The lack of data is a concern pertaining to nearly all areas of migration. With regards to the health care sector, **more data is needed** on the supply, distribution and specialization of physicians, but also other health workers, including pharmacists and lab technicians. The improvement of data collection, particularly in countries of origin, was highlighted as an elementary step towards the evidence-based formulation of policy responses to brain drain in the health care sector.

Policy responses to tackle the crisis of health care systems

First and foremost, the need for a **coherent approach** was highlighted, based on the principle of **shared responsibility** of all stakeholders, including governments of countries of origin and destination, the international community (UN family, IOs, NGOs), diaspora and migrant workers, employers and recruitment agencies, as well as civil society organizations at grassroots level. Cooperation between, and ethical behaviour towards other stakeholders was deemed to be crucial for effective policy making.

Second, efforts of all actors should be aimed at an **integrated response**, not only fighting one specific disease such as HIV or TB, but aiming to improve public health care systems. The double advantages of integrated clinics and **non-disease-specific funding** were explained to be higher immunization rates and a subsequent lower spread of diseases, as well as a greater health awareness and less fears of stigmatization (e.g. when entering a general clinic rather than a specialized HIV clinic). Further, the need for a **sustainable approach** resulting in the long-term development of the health care system was expressed repeatedly. More specifically, this relates to (i) building capacities of the public sector to provide health care, and (ii) using existing capacities more efficiently through task-shifting.

Experts named the sharing of knowledge among clinics and participation in professional conferences as factors increasing job performance (and satisfaction) of care providers. Another **capacity building** measure which was explored is the "Treat, Train and Retain" initiative of the Global Health Workforce Alliance (GHWA), established in 2006. It consists of three components, aiming to ensure improved access to HIV services for health care workers ("treat")[6], recruit more health care workers and provide specialized

[5] More general comments on health of migrants were made: Migrants' level of health is determined by a variety of factors, ranging from predisposition and culture to their mode of traveling and their legal status. While regular migrants usually chose safe manners of travel (planes, trains, etc.), and undergo thorough health assessment before they are granted entry to a destination country, they are subsequently in better health than the average population. In contrast, migrants in an irregular status are not subject to any health examination, and frequently are forced to use highly dangerous modes of travel (e.g. hidden in containers or trucks), putting their health and life at risk.

[6] Indeed, HIV caregivers are more at risk to be reluctant to use HIV services, because not only would they have to cope with the social stigma of being infected, but they would also be facing a higher probability to

HIV/AIDS relevant care training ("train"), and improve the work environment and offer financial incentives to reduce the push factors of migration ("retain").

Regarding the more effective use of existing capacities, one speaker shared the experience of her organization, Partners in Health, with **task-shifting** from one health care profession to another: from doctors to nurses (e.g. prescription of medication), and from nurses or midwives to community health workers (e.g. injections). While instances of "professional jealousy" (i.e. the fear that one group's reputation and status may be lowered) can pose a problem, task shifting has proved an effective way of enhancing access to health care.

As a fourth point, presenters explored the efforts of the international community to establish **ethical recruitment standards** through the formulation of different **Codes of Conduct**: The most encompassing initiative under discussion was the Code of Practice on the International Recruitment of Health Personnel[7], the drafting, negotiation, and implementation of which are led by the World Health Organization (WHO). First drafted in 2008, the Code's global approach aims to encourage the development of bilateral and multilateral agreements (both binding and voluntary) as well as national policies, for the ethical recruitment of health personnel. Criticized for its voluntary character, the Code was deemed in need of further strengthening. One way of doing so is to **include the private sector in ethical recruitment agreements**. So far, employment in the private sector has been used as a loophole to avoid ethical recruitment standards that apply to the public health care system, for example in the UK.

Addressing the **responsibilities of international NGOs**, a new NGO Code of Conduct for Health Systems Strengthening (www.ngocodeofconduct.org) aims to avoid competition with national health care systems for scarce human resources, and to increase the capacity of health care personnel in developing countries, e.g. by investing in pre-service education and training, particularly at university level. However, at 39, the number of NGOs that have adopted the Code is still low.

The responsibilities of governments in countries of origin were seen as touching on two areas: Firstly, in order to ensure a functioning health care system with equal access for everyone, the panel agreed that **more spending on public health** is needed. Governments should work to improve working conditions in the health sector in order to retain workers[8]. A first step in this direction is the 2001 Abuja Declaration, by which a number of African leaders have committed to increasing public health spending to 15% of their national budgets. These commitments have, however, not been met and must be pursued further.

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lose their job as a result of their HIV status. Consequently, they are not only at a higher risk of infection, but also less likely than the general population to be using HIV services.

[7] Additional codes of ethical behavior in the recruitment of health care workers are being developed or already in place, among them the UK Code of Practice, the Commonwealth Code of Practice, the Pacific Code of Practice, the EPSU – HOSPEEM Code of Conduct, and the Voluntary Code of Ethical Conduct for the Recruitment of Foreign Educated Nurses to the United States, to name a few.

[8] A study conducted in Uganda showed that 64% of health care workers responding to a survey indicated that the biggest problem with regards to their working condition was that their workload was not manageable, and about half of respondents named lacking access to electricity, supplies, and drugs as further constraints complicating their work.

Secondly, ministries of health should formulate and implement **policies to facilitate the return** of health care workers who have gone abroad. They could do so by directly **engaging members of the diaspora,** who should not only be perceived as potential providers of financial support, but also as a resource in terms of their skills and extensive networks. Following this rationale, IOM's MIDA programme facilitates temporary and permanent returns based on a matching of needs and skills between countries of origin and members of the diaspora.

The **responsibilities of governments of countries of destination** were also seen as twofold: If governments of receiving countries decide to promote circular migration, one way of fostering higher return rates to the countries of origin could be to issue **visas limited to temporary training programmes**. While this would build a legal barrier for migrants to settle permanently, it was also pointed out that the decision to return is more sustainable (and satisfactory to migrants) if it is based on a free decision rather than legal enforcement.

Also, the idea was voiced that destination countries could enter into **financial compensation agreements** that would benefit the health care systems of countries of origin. Such a system of compensation might be an additional incentive to adhere to the voluntary codes of ethical recruitment some governments have already put in place. Associated with such measures, though, is the danger of creating perverse incentives: rather than encouraging investments into the public health system and the retention of health care workers, they could lead to an enhanced interest in exporting labour, thereby further weakening health care systems.

Outlook: UN discussions on the global health care crisis

The observations and findings of this panel tie directly into UN discussions and meetings held in the context of the 2009 Annual Ministerial Review (AMR) of the Economic and Social Council (ECOSOC), which will focus on the topic of global public health. These include a recent AMR Regional Ministerial Meeting, held from 16 to 18 March 2009 in Colombo, Sri Lanka on the issue of domestic and external financing for health care, particularly in the context of the global financial crisis. Also, bearing in mind the topic of next year's AMR, gender equality and empowerment of women, it is clear that the questions addressed during this panel will remain on the UN agenda in the coming years.

UNITAR New York is responsible for the content of this report.