



Mobility of Health Professionals to and from the EU: Perspective from Six African Countries

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- Shortages, maldistribution especially in rural, public sector facilities (Kenya, Angola, Ghana)
- South Africa – fair numbers, but maldistribution between public and private, and between rural and urban areas.
- Egypt – good numbers, maldistribution between urban and rural areas; much focus on Middle Eastern countries
- Morocco – Increased training capacity with more doctors trained internally; no public sector employment for those trained in private institutions, provides a pool for migrants



The Six countries

Country	Gross National Income Per Capita (PPP\$)	Per Capita Expenditure on Health (Int. PPP\$)	Life expectancy	Maternal mortality ratio	Physician Density (per 10,000 inhabitants)	Nurse + midwife density
Angola	3890	71	41	1400	<1.0	19
Ghana	1240	100	57	560	2	9
Kenya	1470	105	53	560	1	12
South Africa	8900	869	51	400	8	41
Egypt	4940	316	68	130	24	34
Morocco	3860	273	72	240	5	8.0



- **Angola – mainly to Portugal, due to language and recognition of training standards; significant history of insecurity and civil strife; lack of information systems and cooperation from authorities for access to available information;**
- **Kenya – UK is a favourite destination, especially for nurses; physicians migrate in search of higher training opportunities**
- **Ghana – Anglophone countries, especially UK, USA and Canada; declining trends since 2005/6**



- **South Africa:** receiving, transit and source country; but six times as many emigrate as immigrate; nurse migration to the UK tends to be temporary; declining.
- **Egypt:** mainly to Middle East countries (Saudi Arabia), not as pronounced to EU countries tends to be temporary or circular; those that move to EU countries tend to return for cultural reasons (to raise children in Islamic environment); main professionals involved are doctors, nurses hardly emigrate.
- **Morocco:** international migration is not seen as a problem; definite patterns of movement to France, Spain and Italy, and Eastern Europe



- **Poor public service conditions and obligations imposed, such as work in remote areas which often have no infrastructure (Morocco, South Africa).**
- **Low pay, benefits, lack of incentives (all)**
- **Corruption, political instability/civil strife (Angola, Morocco)**
- **Desire for further education/training – All, especially Morocco and Ghana**
- **Political changes: South African exodus following fall of apartheid and fear of the new system; Angola at independence and during the civil war**
- **Economic conditions: Ghana, Kenya – late 1980s to early 2000s – IMF/WB structural adjustment regimes with low social sector investments**



Stick factors

- **Morocco and Angola: Urbanization and growth leads to increased demand for secondary healthcare services and therefore increased opportunities for private practice.**
- **High quality of life, in a stable political environment with relatively high levels of freedom; positive economic outlook (Ghana, Morocco, Angola).**
- **Morocco: Lax regulatory environment and nepotism encourages investments and high returns in private health care facilities, encourages select wealthy graduates to stay in Morocco or return from Europe.**



Stick factors

- **Morocco:** opened up more training schools, allowed private practice
- **Angola:** economic boom, end of civil war and return of peace
- **Egypt:** Cultural considerations: need for children to grow up in Islamic environment
- **Kenya:** General improvements in workplace environment, higher pay.
- **South Africa:** various attraction and retention strategies



- **South Africa: Rural allowances, scarce skills allowances, community service; continuing professional development; salary enhancement through the Occupation Specific Dispensation (OSD) scheme**
- **Ghana: multi-pronged approach through – opportunities for post-graduate training (Ghana College of Physicians and Surgeons), incentive package with deprived area allowance, vehicle ownership scheme, and longer internship period**



Common Stay factors

- High demand for health professionals in the EU countries, prepared to pay highly for health professional migrant services.
- Level of freedom and integrity in the workplace and everyday life makes it hard to leave.
- Job stability and fear of starting all over again in home country
- Lack of return incentives or knowledge of job opportunities in home country.
- Persistence of factors that initially “pushed” the health professionals out.



Policy Environment

- As a destination country – South Africa adopted a policy of not actively recruiting from other African countries, and presently does not recruit from African countries except on government-to-government arrangements (Tunisia)
- Morocco public sector does not employ those trained in private schools → pool of migrant health workers
- Economic programme and conditions that limit employment of health professionals: unemployed nurses in Kenya, potential pool of migrants.
- Work permit issues: restrictive in the EU, reduce mobility (Egypt); advent of the EU Blue Card – ?increased mobility (Morocco)



- **Deliberate retention/attraction strategies – South Africa, Ghana: reduce outflows, improve local distribution**
- **Increased local training opportunities – undergraduate in Morocco, post-graduate in Ghana – reduce student movement, increase pool within country**
- **Morocco allowed private practice, attracted those in the diaspora**
- **Kenya: emergency hiring plan and managed migration thru government-to-government programmes with Namibia, Lesotho.**



Policy recommendations

- Evidence-based support for local initiatives that build capacity for training higher numbers, and that contribute to attraction and retention of health professionals
- Preference for bilateral arrangements between African countries and EU countries, that will be mutually beneficial for all
- International commitments, e.g. The proposed WHO Code should be embraced as an opportunity for collective action



Ahead.....

- **Micro-phase to explore :**
 - **Suggestions for retention strategies, and how the EU could assist African countries in their implementation**
 - **How to turn the brain drain into a brain gain: support from the EU for engagement of those in the diaspora**
 - **Strengthening national HRH Observatories to keep a close eye on the trends of health professional migration**
 - **Interrogate the role of “middle-men”, recruitment agencies in health professional migration from African states, and what impact their regulation may have**
 - **Explore the impact of health professional migration on source countries.**

