



## **Public Services International**

International Migration and Women Health and Social  
Care Workers Programme

**“Quality healthcare and workers on the move”**

## **South Africa National Report**

By Dr Jane Pillinger  
*September 2011*





Public Services International is a global trade union federation representing 20 million working women and men who deliver vital public services in 150 countries. PSI champions human rights, advocates for social justice and promotes universal access to quality public services. PSI works with the United Nations system and in partnership with labour, civil society and other organisations.

PSI runs a global Programme on International Migration and Women Health Workers. The programme is run with the generous support of FNV Mondiaal, Abvakabo/FNV, IMPACT and ILO ACTRAV. The Programme Coordinator is Genevieve Gencianos. Contact: [Genevieve.Gencianos@world-psi.org](mailto:Genevieve.Gencianos@world-psi.org)

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# Preface

Public Services International is proud to present the South Africa National Report. It presents the results of a comprehensive literature review, and first-hand on-the-ground research on the health and social care sectors in South Africa.

The research is one of the activities conducted within PSI's International Migration and Women Health and Social Care Workers Programme. The programme involves countries of origin and destination across all regions of the world. It includes three countries in Africa – Ghana, Kenya and South Africa. Its main objective is to build the capacity of public sector trade unions in addressing the causes and impact of migration in the health and social care sectors.

In South Africa, a National Working Group representing affiliated public sector unions has been established to implement the programme. The participatory research was carried out by members of the National Working Group. The overall research programme and training were coordinated and written up by the Research Consultant, Dr. Jane Pillinger.

The South Africa national report is one of several research projects in key origin and destination countries. These will be consolidated into a Global Report on Migration in the Health and Social Care Sectors for presentation to the PSI World Congress in November 2012. Through the research, we aim to build a strong evidence base from which we can develop tools and strategies to strengthen the health workforce and address migration issues.

As the world recovers from the economic crisis, quality public services such as health and social care are crucial to ensure people's welfare and achieve greater equality. Quality health services depend on a strong and sustainable workforce. It is hoped that the findings and recommendations of this report will contribute to strengthening the health workforce, reducing migration pressures, and ensuring that if and when migration occurs, it will be a beneficial experience for all.

PSI wishes to thank the members of the National Working Group for their willingness and commitment

to carrying out the training as peer-researchers, and for their work in conducting interviews and focus groups in every province in South Africa. The PSI would also like to thank Thembi Mngomezulu, PSI's Sub-Regional Secretary for South Africa, who has coordinated the research in South Africa.



**Peter Waldorff**

General Secretary  
Public Services International

# Section 1: Introduction and context

## 1.1 Introduction

This report documents innovative participatory research carried out in South Africa by PSI affiliated trade unions under the PSI's Programme on Women and International Migration in the Health and Social Care Sectors. The following eight unions affiliated to the PSI participated in the research.

- Democratic Nursing Organisation of South Africa (DENOSA, 70,174 members)
- National Education, Health and Allied Workers Union (NEHAWU, 180,516 members)
- National Public Service Workers Union (NPSWU, 7,142 members)
- National Union of Public Service and Allied Workers (NUPSAW, 24,999 members)
- Police and Prison Civil Rights Union (POPCRU, 104,969 members);
- Health and other service Personnel Trade Union of South Africa HOSPERSA (46,171 members)
- South African Municipal Workers Union (SAMWU, 135,679 members)
- South African Democratic Nurses Union (SADNU, 9,000 members)

The research gives voice to the experiences and needs of health and social care workers. It provides first-hand evidence to support trade union advocacy on behalf of health and social care workers. This report on the situation in South Africa is part of a global research project being carried out by PSI affiliates in South Africa, Kenya, Ghana and the Philippines, and in other origin and destination countries around the world.

The migration of health and social care workers from South Africa must be considered in the broader context of the human right to health and decent work, ethical migration and recruitment processes, global human resources for health (HRH) and the health related Millennium Development Goals (MDGs) established by the United Nations. The research suggests ways in which trade unions, employers and the government can work together

to ensure that South Africa manages migration so that it benefits from a 'brain gain.' Equally important, the report points to how informed migration choices, and better investment in healthcare, can help retain valuable health workers, create high quality healthcare services and improve working conditions. This is particularly important, as South Africa is a country of significant outward and inward migration. South African health and social care workers have migrated to more than 44 countries across the world.

Global inequalities in economic and social development and a high rate of international migration have left the healthcare system in South Africa stripped of staff and resources. The economic and social costs of losing trained staff to international migration are enormous. This broader context must be addressed if South Africa is to retain its health workers, many of whom migrate to have decent pay and working conditions. While migration is a human right and a choice for many health and social care workers, it is essential that workers who migrate do so within a positive migration policy framework, with information and support, decent working conditions, opportunities to gain skills and knowledge, and to re-integrate back into the workplace when they return to South Africa.

Our research shows that the majority of health and social care workers want to live in and contribute to the health, well-being and development of their own country. A working environment that is rewarding, where workers are valued, that is safe and stress free, and that provides satisfying work and opportunities for career development will avoid putting workers in a position where they feel they have little choice but to migrate.

The healthcare system in South Africa faces a human resources crisis, resulting from a significant 'brain drain', staffing shortages and an under-funded healthcare system. There are not enough healthcare workers to meet the needs of the population, particularly in rural and disadvantaged areas. At the same time, developed countries have an increasing demand for health and social care staff resulting from the care needs of an ageing population. Healthcare workers in South Africa experience very poor and difficult working environments, poverty

level wages, inadequate recognition of their value and poor career development. (WHO 2006) Understaffing, underemployment, a lack of skilled staff and lack of job satisfaction also contribute to poor working conditions and stress at work.

## 1.2 The global economic crisis

It is difficult at this stage to predict the full impact of the global economic crisis on migration and the pressure on workers to return to their countries of origin. Public deficits and public expenditure cuts in many countries of destination have led to cuts in healthcare funding, reductions in staffing levels and in nurse recruitment. Although these pressures are significant, there is a corresponding increase in demand for health and social care workers in many of these countries. There is a growing concern that the expansion of the private care market has led to the recruitment of skilled nurses to provide less qualified care. It is in this sector that there are concerns of exploitation, poor working conditions and downgrading of skills.

Many countries of destination have imposed new restrictions to limit migration. Migrant workers, who often work in a temporary capacity, are the first to be affected by job cuts. Associated with this is a worrying rise in anti-immigrant and discriminatory attitudes towards migrant workers. The IOM (2009) predicts that the impact of the global economic crisis will lead to an increase in migrants returning to their countries of origin, as well as rising unemployment amongst migrant workers, an increase in racism and xenophobia against migrant workers, a greater potential for worker exploitation and reduced salaries. Compounding the impact of these challenging trends, foreign aid and remittances to developing countries have been reduced. Data from the World Bank shows that officially recorded remittance flows to developing countries fell by 5.5% (USD \$307 billion) in 2009. (World Development Indicators 2010)

## 1.3 The globalisation and feminisation of migration

Women account for 94.5 million migrants or nearly half of all migrants. (UNFPA 2006) However, the feminization of international migration has declined slightly in recent years from 49.4% in 2000 to 49% in 2009. (United Nations 2009) Many women migrate alone. A growing number are primary breadwinners, many of whom are parenting transnationally. Globally women remitted at least half of the US\$ 328 billion sent through official channels in 2008. The majority of the global nursing and social care workforce are women. In South Africa, 92% of the nursing and midwifery workforce are women, and a similar proportion of those who seek verification to work abroad are women.

At face value, migration appears not to be gender specific. However, women experience different patterns of migration, family responsibilities and access to economic and social resources. A gender-based analysis of migration legal frameworks and measures to ensure equality of treatment and recognition of the value of women's care work is crucial in the light of the globalization of care relationships. Raising the political, economic and social value of care as "the basis of citizenship, of solidarity and of justice" (Williams 2010), is essential if there are to be lasting and sustainable outcomes for economic and social development, reductions in poverty, reduction of inequalities in health, and greater gender equality.



## 1.4 The role of the social dialogue in the health sector in South Africa

Trade union rights are guaranteed in the Constitution of South Africa. Workers' rights are enshrined in the 1995 Labour Relations Act. Trade unions in the health sector have established effective forms of social dialogue with the government and employers, and have been influential in shaping national policy on employment, wages and working conditions.

A national social dialogue structure under the National Economic Development and Labour Council (NEDLAC) exists as an umbrella body to discuss issues of common interest. This also provides an opportunity for trade unions to have an input into government policy. In the health sector there are two social dialogue bodies, the most important of which is the Public Service Coordination Bargaining Council.

The Public Service Coordinating Bargaining Council (PSCBC), created under section 35 of the Labour Relations Act, is the umbrella body for collective bargaining on wages and salaries in the public services. Provincial Coordinating Chambers of the Council exist in all provinces. The PSCBC is made up of four Sectoral Bargaining Councils, one of which covers workers in national and provincial health and social development departments, namely the Public Health & Social Development Sectoral Bargaining Council (PHSDSBC). The other Sectoral Bargaining Councils cover Educators, Safety and Security Services and General sectors. The PHSDSBC has a role to conclude, monitor and enforce collective agreements on pay and conditions of service, and to prevent and resolve labour disputes. The mission of the PHSDSBC is "to contribute towards quality service delivery and quality work in the sector, by way of constructive collective bargaining, prompt dispute prevention and resolution." Trade unions are required to have a membership threshold of 50,000 members to join the PSCBC. Smaller unions collaborate with the larger unions to ensure that they are represented. An example of this collaboration is the alliance between the larger nurses' union and the smaller medical practitioners union. A membership threshold of 20,000 members is required for a seat on the PHSDSBC.

A major breakthrough for trade unions was the 2007 Agreement for the Occupational Specific

Dispensation (OSD) for Nurses, agreed through the PHSDSBC, to improve the salaries, career progression and working conditions of nurses. The agreement was a direct response to the need to retain nurses in the workforce and stem the loss of nurses to international migration.

A social dialogue structure has also been created under the Health & Welfare Sector Education & Training Authority (HWSETA). HWSETA is responsible for skills development in the sector, and includes public and private sector employers, trade unions and other stakeholders. HWSETA was established under the 1998 Skills Development Act to facilitate skills development in the health and social development sector – to ensure that skills needs are identified and addressed. An important recent development has been the production of a Sector Skills Plan for the Health Sector in South Africa (HWSETA 2011). This has resulted in a strategy for enhancing skills in the sector in order to meet changing health needs.

Since 2005 workplaces have been required to draw up Workplace Skills Plans and Implementation Reports, which are carried out and agreed in partnership with trade unions at the workplace level. Completion of the reports and payment of a Skills Development Levy to HWSETA entitles workplaces to mandatory training grants from HWSETA and participation in skills development programmes. The healthcare unions in South Africa have welcomed this as a positive development. They indicate that the commitment and funding to close the skills gap is having a positive impact on skills development in the health sector. In particular, there has been an emphasis on the development of scarce and critical skills in nursing and social care through the implementation of skills development projects, and the promotion of internships and work experience projects for unemployed graduates where skills shortages have been identified. This has been a very important development given the skills and capacity shortages facing human resources for health (HRH) in South Africa and the impact of migration of skilled health professionals on skills shortages in the sector (HWSETA 2011).

## Section 2: Overview of health, policy and migration in South Africa

### 2.1 The health of the population in South Africa

South Africa has experienced an increase in the demand for healthcare services at a time of a corresponding global shortage of health workers. International migration has led to the loss of valuable skills and has had an adverse effect on local health services.

#### Healthcare needs and the burden of disease

South Africa has a disease burden that is four times that of developed countries and two times that of other developing countries.

South Africa faces a quadruple burden of diseases consisting of HIV and AIDS; communicable diseases; non-communicable diseases; and violence and injuries. The consequence of this is high levels of mortality and morbidity.

*Dr Motsoaledi, Minister of Health, Forward to the National Department of Health Strategic Plan 2010/11-2012/13*

South Africa has a population of just under 50 million. In 2010, life expectancy at birth was 54 years (53.5 years for males and 57.2 years for females), compared to 63 years in 1990.

In 2010, 5.4 million people (11% of the population) are HIV positive, of whom 19% are of working age. AIDS-related deaths were estimated at 2.6 million. The country's TB epidemic is amongst the most serious in the world, with an estimated annual incidence rate of 940 per 100,000 population. About 10% of the population in South Africa live in malaria-risk areas. Malaria is at very high levels in Limpopo, Mpumalanga and north-eastern KwaZulu-Natal. (Day and Gray, 2008)

In 2010, the mortality rate among children under five rose to 104 per 1,000 live births, from 59 in 1998. The infant mortality rate was 69 per 1,000 in 2010, compared to 54 in 2001. The maternal mortality rate grew from 150 per 100,000 population in 1998 to

400-625 in 2010. This is well below the MDG target of 38 by 2015. (Statistics South Africa, 2010) The health related MDGs include reducing child mortality rates by two-thirds, maternal mortality ratios by three-quarters and halting and reversing the spread of HIV, tuberculosis and malaria by 2015. In South Africa these goals are unlikely to be met by 2015. (WHO 2008, UNDP 2010)

#### Inequalities in the public-private healthcare mix

Inequalities in access to healthcare result from the public-private healthcare mix. More than 41 million people rely on the public healthcare system, while only 7.9 million people are covered by medical insurance. In 2009, the per capita expenditure on healthcare in the public sector was around R2,058; in the private sector this was six times higher. In 2010 more than 53% of healthcare spending was in the private sector. The situation is very stark given that much higher numbers of health professionals work in the private sector compared to the public sector. In 2010, an estimated 460,000 people were employed in the health sector, of whom 39% were employed in the private sector and 61% in the public sector. Almost half, 47%, of employees in the private sector are employed as professionals, compared to 28% in the public sector. The ratio of nurses to patients is almost twice as high in the private sector as it is in the public sector.





It is widely recognised that care levels, outcomes and management of the public health system are under strain partly because of significant staff shortages, a maldistribution of skills between urban and rural areas, and an inadequate skills base. Management of the health system is under strain at almost all levels. Widespread inefficiencies result in services that are unresponsive to health and patient needs, and a lack of accountability exists on a large scale. *Health and Welfare Sector Education and Training Authority (2011) Sector Skills Plan for the Health Sector in South Africa, p xiii*

## 2.2 Healthcare policy

The National Health Act, 2003 has the objective to provide equitable healthcare services in South Africa through a national health system comprising the public and private sectors. It lays down the rights and duties of healthcare providers, health workers, establishments and users. The national Department of Health (DoH) regulates the healthcare system and the nine provincial departments of health, who are responsible for planning, managing and developing human resources. Public spending on health declined in real terms between 1996 and 2005. By 2011 it is anticipated that spending will be double that of 2005. Public funding of health is 3.7% of GDP and represents 13% of the government's budget.

Government policy on healthcare has emphasized a shift from hospital-based care to primary healthcare. Today nearly half of public health resources are allocated to district health services, which include primary healthcare clinics, community health centres and district hospitals. Policy priorities established under the DoH's Health Sector Strategic Framework 2009-2014, include the expansion of primary care and community-based health services in order to provide for significantly increased levels of HIV, AIDS and TB treatment, services to improve maternal and child health, better management and governance of the health system and more effective human resources planning. In addition, a key priority is to establish a national health insurance (NHI) system, the objective of which is to provide universal coverage and free health services to all South Africans by 2014. The National Department of Health Strategic Plan 2010-2013 has established a priority to improve health outcomes and engage in inter-sectoral action in areas such as education,

water and sanitation, and to meet the vision of creating "an accessible, caring and high quality healthcare system". (DoH 2010: 10)

However, this health policy context continues to fail to enable the South African health system to meet the MDGs. As a result, the Minister of Health announced in May 2011 new policy guidelines, which include new HRH priorities, new management structures and an overhaul of the healthcare system.

**The Health Sector Strategic Framework: The 10 Point Plan 2009-2014, sets out the objectives of healthcare, including:**

- Re-focusing of healthcare resources on primary healthcare and community-based health services
- The implementation of a National Health Insurance (NHI) scheme
- Accelerated implementation of tuberculosis controls and HIV and AIDS policies (including expanded prevention strategies and access to ART)
- Greater focus on improving maternal, prenatal and child health
- Health promotion and the prevention of lifestyle diseases and better nutrition
- Strategic leadership, improved management and governance of the health system
- Improvements in human resources planning and development, including the recruitment and retention of professionals and the training of nurses, primary healthcare personnel and mid-level health workers

All of these priorities have significant resource, training and staffing implications, which will be difficult to achieve in the light of the significant burden of disease and the endemic shortages of staff throughout the public healthcare system.



## 2.3 Healthcare staffing and skills shortages

The loss of skilled healthcare workers remains a major challenge in the health sector. This is a problem arising from both internal migration within South Africa and external migration of healthcare workers. Outward migration and internal migration within South Africa has resulted in 'brain drain' of skilled workers from disadvantaged urban areas and some rural areas. The employment of doctors and nurses in the public sector continues to fall short of international WHO minimum guidelines required to attain the MDGs. With just 209 doctors, professional nurses and staff nurses per 100,000 population, South Africa falls short of the WHO standard of 230 doctors and nurses required to meet the MDGs.

Significant staffing shortages exist in the public health sector. Staffing shortages are affected by a growth in demand for healthcare services, difficulties in retaining staff and the migration of healthcare workers. In 2010, there were approximately 281,000 employees in the public health sector. This is well below the estimated need for 315,087 healthcare staff by 2008 to meet the needs associated with population growth and the expanding disease burden. There is currently a vacancy rate of up to 60% in some professional health groups in the public sector, compared to just 2.3% in the private sector (HWSETA 2010, DBSA 2008). It is anticipated that the Occupational Specific Dispensation (OSD) for Nurses (discussed below), negotiated with trade unions to provide salary increases and career progression pathways will go some way to resolving the problems associated with the 'brain drain' and loss of skills in the sector.



## 2.4 Human Resources for Health

Human Resources for Health (HRH) are the foundation of effective healthcare systems. In South Africa problems arise from shortages of staff in key areas of the health sector, an inequitable distribution of available health personnel and the significant attrition of trained staff. Push factors are low pay, risks at work associated with HIV/AIDS and TB, inadequate human resources planning, unrealistic work loads, poor infrastructure, poor conditions of work, lack of career development opportunities and inadequate structures for supervision and support. (EQUINET 2007)

South Africa lacks an effective human resources strategy to ensure that the public sector is sufficiently resourced to provide an adequate supply of health professionals. (DBSA 2008, DoH 2011) Inefficiencies in the healthcare system, a lack of accountability and inadequate skills training and organizational development have been highlighted as critical human resource issues by the government, trade unions and leading bodies in South Africa. (DBSA 2008, HWSETA, 2011)

To date the South African government has put in place a number of strategies to address the uneven geographic distribution of health workers and the imbalance between public and private sector employment. This includes the redistribution of healthcare professionals to the public sector and to rural and disadvantaged areas through compulsory community service, improvements in salaries and increases in the number of health facilities. The following key policy strategies in the area of HRH have been initiated to avert the HRH crisis:

### **Agreement for the Occupational Specific Dispensation (OSD) for Nurses**

The Agreement for the Occupational Specific Dispensation (OSD) for Nurses concluded in the PHSDSBC in 2007 was a major achievement for trade unions in negotiating improved pay and career progression for nurses. The agreement was a direct response to the exodus of nurses in search of better pay and working conditions. The OSD has the objective to improve the salaries, career progression and other conditions of service in order to attract and retain nursing professionals to and in the public health sector. The agreement also led to

the introduction of differentiated salary scales for identified categories of nursing professionals and the incorporation of the existing Scarce Skills Allowance for specialist nurses as part of their salaries. All five trade unions in the PHSDSBC namely, DENOSA, NEHAWU, PSA, HOSPERSA and NUPSAW, were parties to the agreement. The agreement will benefit all 100,000 nurses and midwives employed by the government. The OSD is being implemented in two phases. Phase one saw the salaries of staff nurses increase by 20% and the salaries of entry-level Nursing Assistants and Professional Nurses in general nursing by 24%. Phase two is to be based on salary increases based on the number of years of relevant experience of nurses. This is likely to represent an additional 7.5% general salary adjustment. Agreement for this was reached following negotiations at the end of the public service strike in 2007. Healthcare unions are continuing to fight for the full implementation of the OSD and for improved salaries under the agreement.

### **Human Resources for Health: A Strategic Plan, 2006**

The 2006 DoH plan, Human Resources for Health: A Strategic Plan, established targets for the training of healthcare professionals by education and training institutions to primarily address the needs of the public sector. At the time the DoH acknowledged that the targets should have been influenced by actual healthcare needs identified in provincial health service plans. Targets for the training of professional nurses were set to increase from 1,900 to 3,000 per year and enrolled staff nurses had to increase from 5,000 to 8,000 per year. However, there was no clear plan to implement the targets.

### **Human Resources Strategy for South Africa, 2011**

The urgency of the HRH crisis has led the National DoH to engage in a consultation process for the development of new *Human Resources Strategy for South Africa* to be fully implemented by 2030 (DoH 2011). Although still at a consultation stage the strategy will signal the strategic priorities and interventions that are required to address equity, shortages in skills and staff and maldistribution of staff across South Africa. It will signal the required level of staffing, skill mix and training to meet the vision for improved access to healthcare for all by 2030. As well as employing new staff the strategy

signals the need for increased workforce flexibility, and ways to improve productivity and improve retention.

### **HWSETA Skills strategy, 2011**

The need for skills development programmes has been signaled as a priority in the HWSETA sector skills plan for the health sector, developed in partnership with trade unions (2011). These new skills are anticipated in the light of new HIV testing programmes and the planned increase in the number of patients on anti-retroviral treatment (ART), and programmes to fight TB and improve the health of mothers, children and women. Nurse education and training in South Africa has also been revised under the National Qualifications Framework Act, 2008, and the Nursing Act, 2005.

### **Department of Health, Nursing Strategy for South Africa, 2008**

The *Nursing Strategy for South Africa* was developed as a response to the chronic shortage of nurses. It aims to implement an adequate supply and distribution of nursing professionals, as well as professional standards and quality in nursing practice, in order to meet the needs of South African people. The key areas contained in the strategy are nurse education and training, nurse leadership, nursing regulation, social positioning of nursing and resources for nursing. Trade unions represented through the PHSDSBC have been involved in discussions with the DoH on the implementation of the strategy at the provincial level.

“Regardless of the push and pull factors, migration of healthcare workers from developing countries to developed ones, has done more harm than good on the healthcare deliveries in the developing countries... The strength of any nation depends to a large extent on its productivity, which in turn depends on the well-being of the population. Emigration of healthcare professionals has both short and long-term consequences on the sustenance of the originating countries.”  
*Misau Y, Al-Sadat N, BakariGerei A (2010) Brain-drain and healthcare delivery in developing countries. Journal of Public Health in Africa, Volume 1:e6*

## 2.5 Managing migration to reduce the 'brain drain' from South Africa

Strategies to address the 'brain drain' include projects to engage with the South African diaspora to encourage return migration and skills-sharing. The Migration Dialogue for Southern Africa (MIDSA) has recommended the removal of barriers to mobility between Southern Africa Development Community (SADC) countries, policies for accessible and affordable healthcare, and human resource development to attract and retain, and encourage the return, of healthcare professionals.

The government has put in place a number of strategies to manage migration in South Africa and enhance the potential for a 'brain gain'. One example is the Memorandum of Understanding on the Reciprocal Exchange of Health Concepts and Personnel between the South African and UK Governments, which promotes exchange programmes, strategies to attract returning emigrants, study visits, exchanges of information, advice and expertise in areas such as workforce planning and post-graduate training. Bilateral agreements have also been signed with countries of destination to encourage the retention of health workers in their country of origin and their return. Ethical recruitment practices have been put in place by a number of countries of destination. The best-known example is the UK National Health Service Code of Practice on Ethical Recruitment of Healthcare Professionals, which has restricted recruitment into the UK from developing countries. However, research on the recruitment of South African nurses through recruitment companies has found little or no evidence of nurses being exploited by recruitment agencies in South Africa. (Oosthuizen et al, 2005)

## 2.6 Recruitment and employment of foreign health professionals

The employment of foreign health workers is subject to the provisions of the Public Service Act, 1994, the Public Service Regulations, 2001, and the Immigration Act, 2002. Current national policy is to limit recruitment of foreign trained health professionals on three-year renewable contracts under government-to-government agreements. These country-to-country agreements with other African countries are designed to restrict the recruitment of health professionals in an attempt to reduce the 'brain drain' experienced by poorer countries.

The Department of Health has developed a policy to promote high standards of practice in the recruitment and employment of health professionals in the health sector in South Africa. The National Health Council approved a policy on Employment of Foreign Health Professionals in the South African Health Sector, on 5 February 2010. The policy draws on international recruitment codes of practice from the World Health Organisation (WHO) and bilateral and multi-lateral agreements in the South African Development Community (SADC) and the African Union (AU). The policy discourages the active recruitment of health professionals from developing countries unless there are government-to-government agreements for this in place. The policy specifies that foreign health professionals "shall enjoy the service benefits and comply with all the conditions of service" on the same basis as their South African counterparts, including "support for their professional development to enhance their clinical skills". The policy states that recruitment shall be limited to health facilities in designated underserved or rural areas.



## Section 3: The nursing and midwifery workforce and outward migration

This section gives an overview of the nursing and midwifery workforce and data on verifications for outward migration provided by the South African Nursing Council.

### 3.1 Gaps in health coverage and shortages of nursing staff

There are significant gaps in health coverage and shortages of staff in rural and disadvantaged areas and across South Africa's nine provinces. Table 1 shows the ratio of nurses and midwives to the population and reveals significant differences across the nine provinces. The lowest nurse-population ratio is found in Mpumalanga province, where there is one nurse/midwife to every 309 persons in the region. This is compared to the highest nurse-population ratio in Western Cape where there is one nurse/midwife to 184 persons in the population.

**Table 1:** Nurse-population ratios by province (population per qualified Nurse)

Province	Registered Nurses and Midwives	Enrolled Nurses and Midwives	Enrolled Nursing Auxiliaries	Total
Limpopo	603:1	1304:1	653:1	253:1
North West	412:1	1256:1	676:1	213:1
Mpumalanga	633:1	1589:1	969:1	309:1
Gauteng	372:1	861:1	671:1	187:1
Free State	374:1	1530:1	957:1	229:1
KwaZulu Natal	437:1	563:1	927:1	194:1
Northern Cape	514:1	2395:1	842:1	282:1
Western Cape	357:1	933:1	642:1	184:1
Eastern Cape	482:1	1891:1	1101:1	285:1
<b>TOTAL</b>	<b>434:1</b>	<b>955:1</b>	<b>788:1</b>	<b>216:1</b>

**Source:** Population Figures, Statistics South Africa

Like many countries, South Africa has an ageing nursing and midwifery workforce. Over half of the nursing and midwifery workforce in South Africa are over the age of 40 years. The age profile of nurses and midwives can be found in Table 2. The ageing

workforce also has implications for nursing ratios. It is exacerbated by the fact that those who migrate to work overseas are in a younger age cohort.

**Table 2:** Age profile of nurses and midwives, 2010

Age	Registered Nurses and Midwives (%)	Enrolled Nurses and Midwives (%)	Enrolled Nursing Auxiliaries (%)
Under 30	4	15	16
30-39	19	33	34
40-49	31	28	24
50-59	29	18	18
60-69	13	5	7
Over 69	3	1	0
Not reported	1	0	1

**Source:** South African Nurses Council

### 3.2 Migration of nurses and midwives

Data from the South African Nursing Council (SANC) shows the verifications to work overseas. The data on verifications reflects the number of nurses and midwives that have requested verifications of qualifications and training. However, nurses and midwives are not required to notify the Council if they do migrate to work abroad, and as a result the data



– while indicative – may not reflect the true picture of the numbers that actually migrated and took up nursing and midwifery positions in other countries.

Table 3 shows that between 2006 and 2010 there were 3,491 verifications to work overseas. Australia was the highest country of destination, followed by the UK, New Zealand, the USA and Canada. Verifications peaked in 2008 at 1 180, and since then there has been a decline to 819 verifications in 2009 and 500 in 2010. It is not clear why there has been a decline since 2008, although factors pointing to this relate to the reduced levels of migration to the UK owing to the implementation of the NHS Code of Practice, while the economic crisis hitting a number of developed countries had led to restrictions on new appointments in the health sector. Another factor is new investment for the training of larger numbers of nurses and midwives and improved salaries and career progression for nurses and midwives resulting from the Agreement for the Occupational Specific Dispensation (OSD) for Nurses.

**Table 3:** Verifications from the South African Nursing Council

Country	2006	2008	2009	2010	Total
Australia	470	664	451	99	1684
Canada	16	61	53	25	155
Ireland	20	34	14	6	74
Namibia	84	12	13	9	118
New Zealand	1	214	91	70	376
United Kingdom	218	109	85	54	466
USA	83	50	16	27	176
Abu Dhabi	0	0	0	100	100
Other countries	100	36	96	110	342
<b>Total</b>	<b>992</b>	<b>1180</b>	<b>819</b>	<b>500</b>	<b>3491</b>

One of the findings from our research is that understaffing and pressures at work are push factors leading to an exodus from the country. Increasing the supply of trained nurses and midwives has been crucial to addressing these shortages. As Table 4, shows there has been a significant increase in the numbers of registered and enrolled nurses and midwives and enrolled nursing auxiliaries. Between 2001 and 2010 there was a 34% increase in the numbers of nurses on the register of SANC, from 172,338 in 2001 to 231,086 in 2010. Registered nurses on the register grew by 22% during this time. This includes Enrolled Nurses who completed a

bridging programme and became Registered Nurses. There has been a 63% increase in Enrolled Nurses on the register and a 69% increase in Enrolled Nursing Auxiliaries.

**Table 4:** Growth of nursing register: South African Nursing Council

	Registered Nurses and Midwives	Enrolled Nurses and Midwives	Enrolled Nursing Auxiliaries	Total
2001	95,552	32,120	45,666	173,338
2002	94,948	32,495	45,426	172,869
2003	96,715	33,575	47,431	177,721
2004	98,490	35,226	50,703	184,419
2005	99,534	37,085	54,650	191,269
2006	101,295	39,305	56,314	196,914
2007	103,792	40,582	59,574	203,948
2008	107,978	43,686	61,142	212,806
2009	111,299	48,078	62,440	221,817
2010	115,244	52,370	63,472	231,086

Table 5 shows persons entering the nursing profession for the first time. The number of Student Registered Nurses and Pupil Enrolled Nurses has grown steadily since 2001. The lower level of Pupil Nursing Auxiliaries has remained fairly stable. However, 2010 marked a year of significant growth of students/pupils in training, an increase of 9,353 on 2009. Prior to 2001 there had been a significantly lower number of trained nurses in all categories, and by the end of 2002 the numbers had returned to the pre-1998 levels.



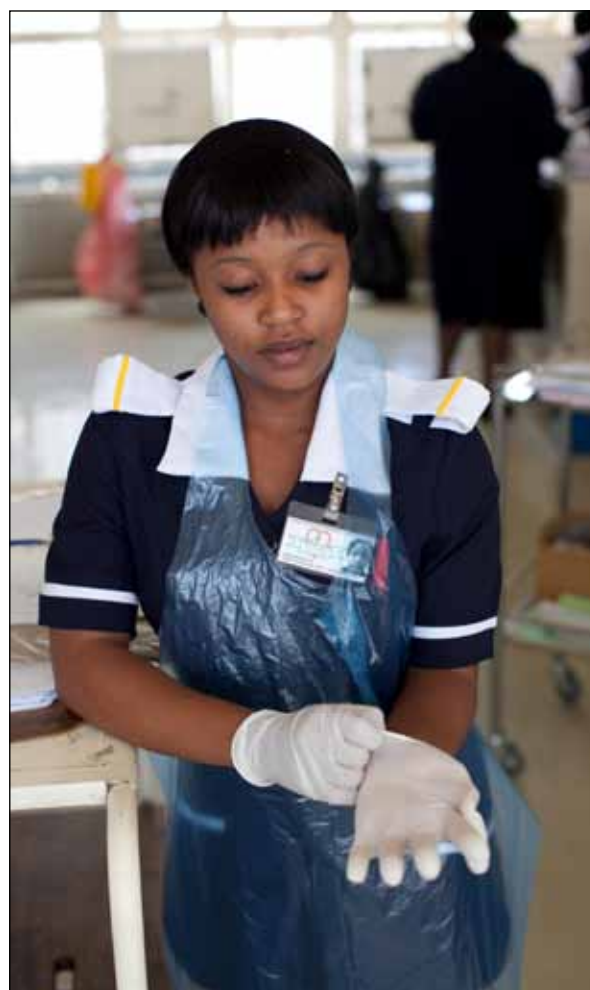


**Table 5:** Growth in student numbers

	Student Registered Nurses and Midwives	Pupil Enrolled Nurses	Pupil Nursing Auxiliaries	Total
2001	9,527	4,933	3,651	18,111
2002	10,338	6,081	4,685	21,104
2003	11,478	7,245	4,938	23,661
2004	12,280	8,300	6,577	27,157
2005	13,096	8,096	6,289	27,481
2006	13,272	8,483	6,169	27,924
2007	15,258	9,528	4,812	29,598
2008	16,457	11,179	5,058	32,694
2009	17,167	13,052	3,753	33,972
2010	19,778	16,836	6,711	43,325

SANC is of the view that there is still a shortage of qualified nurses in South Africa. However, they point out that the growth in nurses on the register has exceeded the growth in the population of South Africa. Between 2001 and 2010 the population increased by 12.8%.

The next section presents the findings from the participatory research carried out by the PSI.



# Section 4: PSI participatory research in South Africa on the international migration of health and social care workers

## 4.1 Introduction and methodology

Participatory peer-led research was carried out by PSI affiliates in South Africa. All affiliates are represented on the National Working Group in South Africa.

### The objectives of the research were to:

- Collect first-hand evidence and data on the impact of migration on health and social care in South Africa.
- Identify potential future trends.
- Identify key actions for trade unions and the government.

### The methodology included:

- Face-to-face interviews with 300 health and social care workers in all nine provinces in South Africa, conducted in Spring 2011.
- Three focus group discussions with health and social care workers were held in May 2011. One group consisted of migrant nurses and midwives who have considered or who are currently considering migrating, one of social workers and one of nurses and midwives that had migrated to work in South Africa.

The research methodology was designed to empower and train a group of peer-researchers to carry out interviews and focus groups. The benefits of this method in a trade union context are two-fold. First, health workers were empowered and trained in the research skills needed to identify the needs of a wider number of health workers. This method is particularly valuable as health workers are more likely to be open and trusting in discussing their needs and experiences with their peers. This also builds the research and data gathering capacity of trade unionists. Second, because the research

was carried out by trade union members, unions were able to disseminate the project's Pre-Decision Kits and Passport to Workers' Rights, and to talk to participants about the work of trade unions in improving information and discussing policies on migration for health and social care workers.

Fifteen peer-researchers, who were members of the National Working Group, were trained in a workshop held in Johannesburg in November 2010. The unions worked jointly to carry out the participatory research, overseen by the PSI's Sub-Regional Secretary for Southern Africa, who coordinates the National Working Group. The PSI provided travel and other expenses to facilitate the data gathering. As well as developing a plan for the research, the training covered research methodology and ethics, interview skills, piloting of the questionnaire, and the holding of and reporting on focus groups. In addition, the Research Consultant reviewed South Africa legislation governing health, migration and employment, and interviewed key informants in the South Africa government and the trade unions.

By the end of the training the peer-researchers had developed the skills and confidence to carry out the interviews and focus groups. The peer-researchers were hugely committed and motivated to carry out the research. They reported a high level of interest in the research by participants in interviews and focus group discussions. The participants in the research hoped that the evidence collected would lead to improved pay, working conditions, career progression opportunities, and more informed decision-making on migration. The feedback consistently emphasized that the majority of healthcare workers want to contribute to the healthcare of people in their own country and want migration to be a genuine choice that can result in a 'brain gain' for South Africa.

Feedback from peer-researchers on the research training workshop and the value of the research, held in Johannesburg in November 2010



## Feedback on the research training

"I now have a better understanding of participatory research."

"I am very much empowered and the training will be useful in the future."

"I have a better understanding of research and the difference between qualitative and quantitative research; very informative and empowering."

"Glad someone is doing this research and that someone is me!"

"I have the opportunity to be a researcher and this is a positive challenge."

### Feedback on the value of the research

"I am very enthusiastic and very positive about the research."

"The research will enable people to make informed decisions."

"I am optimistic that at the end of the research we are empowered to do something."

"I can be part of the solution – the issue needs to be in collective bargaining."



## 4.2 Findings from the research

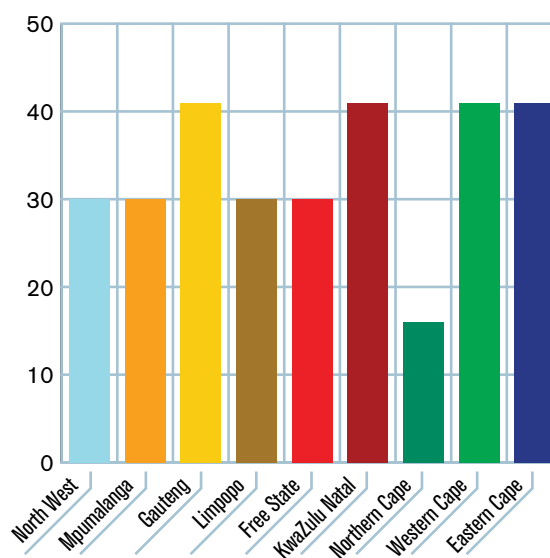
### a) Number, geographic location and age of interviewees

A total of 300 face-to-face interviews were held with health and social care workers, including:

- 150 interviews with health and social care workers who had not migrated.
- 100 interviews with health and social care workers who had migrated to work overseas and returned to South Africa.
- 50 interviews with health and social care workers who had migrated from other countries to work in South Africa.

The interviews were held in all nine provinces of South Africa. Chart 1 shows the distribution of the 300 interviews across each of the nine provinces.

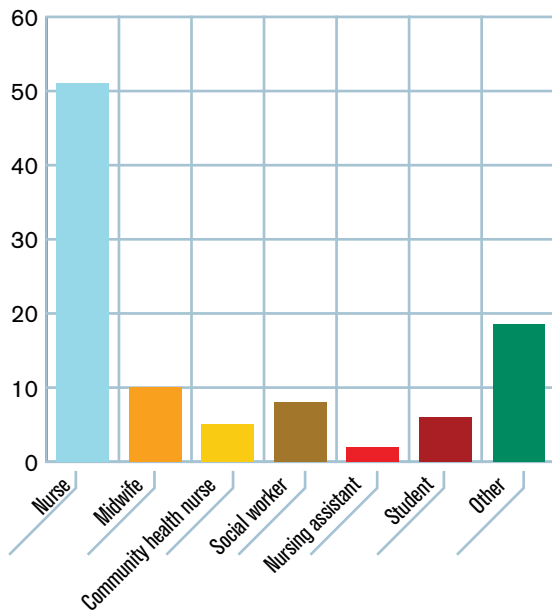
**Chart 1: Interviews by Province**



The highest proportion of those interviewed were in the 26-35 year age group, representing 37% of the participants. This was followed by 36% in the 36-45 year age group, 14% in the 46-55 year age group, 10% in the 55-65 year age group, and 11% in the 18-25 year age group. Overall, 68% of those interviewed were women and 32% were men.

Chart 2 shows the occupational background of those interviewed. The majority were nurses, followed by midwives, social workers, students and community health nurses.

**Chart 2: Occupation groups of interviewees**

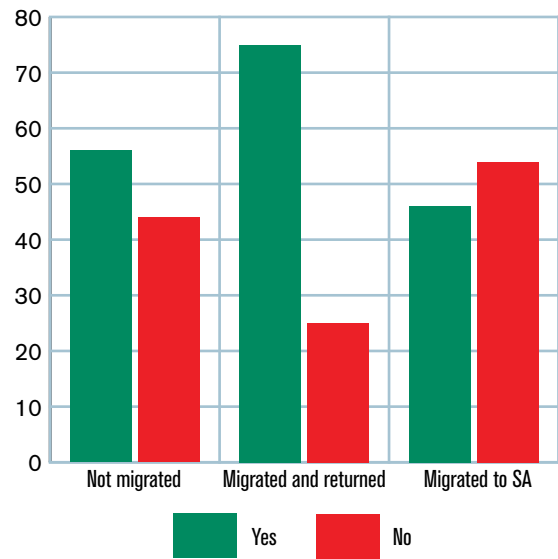


**b) Trade union membership and awareness of the PSI Project and Pre-Decision Kit**

As well as contributing to an evidence base for the project, a secondary objective of the participatory research was to enable unions in South Africa to have in-depth conversations with healthcare workers, inform them of the activities of the migration programme, and disseminate the Pre-Decision Kit and the Passport to Workers' Rights that were prepared by the National Working Group in 2009.

Chart 3 shows the trade union membership of those interviewed in the three sample groups: those that had not migrated, those that had migrated and returned to South Africa and those that had migrated from overseas to work in South Africa. More than half, 59%, of those interviewed were trade union members. They belonged to the following unions: NEHAWU, HOSPERSA, DENOSA, POPCRU, NPSWU and SAMWU. The highest rate of trade union membership, 75%, was amongst the interviewees that had migrated and returned to South Africa. The lowest rate, 46%, was of health and social care workers that migrated from overseas to work in South Africa.

**Chart 3: Trade union membership of interviewees**



The fact that such a large proportion of those interviewed, 41%, were not trade union members does suggest the need for unions to engage in more effective information dissemination and contact with healthcare workers about the role of trade unions in the health sector. This has particular implications for newly arrived migrant workers and those who are returning from working overseas.

The research was also an opportunity to identify how many of those interviewed were aware of the PSI's programme on international migration and of the Pre-Decision Kit. The Pre-Decision Kit, published in 2009, is a tool to inform and prepare health workers who are considering migration, with advice about overseas recruitment, trade unions and contacts in countries of destination. The Kit has been widely disseminated to health and social care workers in South Africa and the unions are planning further distribution.

The research found that, to date, there is a low level of awareness amongst union members of the PSI's migration programme and the Pre-Decision Kit. As Chart 4 shows, only 22% of those interviewed were aware of the PSI's programme on migration; a significant 78% were not aware of the programme.

**Chart 4: Awareness of the PSI's migration programme**

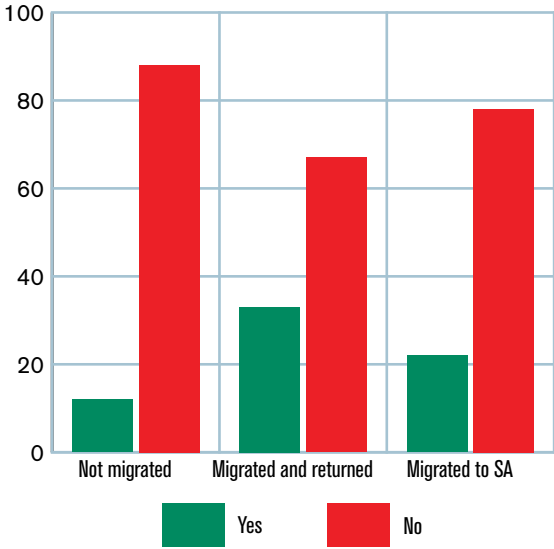
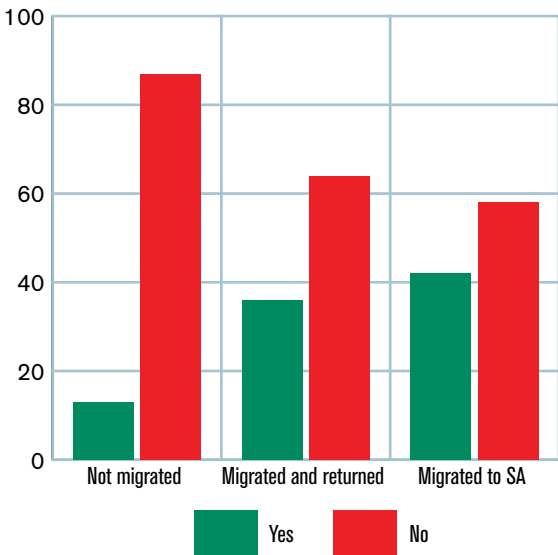


Chart 5 shows that of those interviewees that were aware of the PSI's migration programme 70% were not aware of the Pre-Decision Kit. This has important implications for unions in South Africa, suggesting the need for a strategy to renew efforts to raise awareness of both the migration programme and the Pre-Decision Kit and to disseminate it across the country.

**Chart 5: Awareness of the Pre-Decision Kit**



### c) Migration decisions

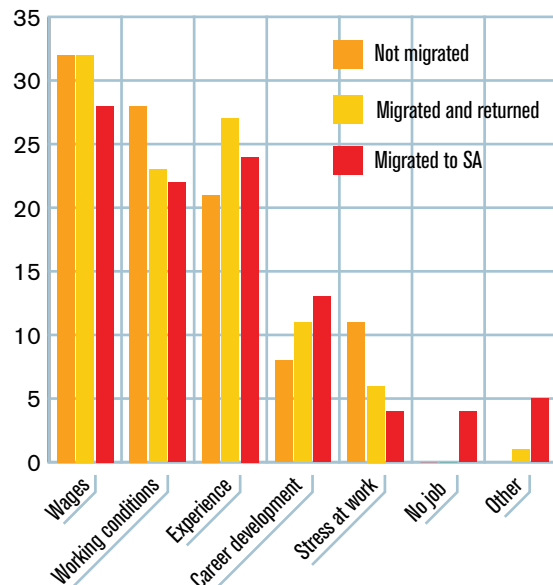
Health and social care workers in South Africa migrate for a large number of reasons. Research shows that migration decisions are largely affected by economic factors, opportunities for improved working conditions and for career development. The 'push' factors include high rates of unemployment, low rates of pay, poor quality health services, low

job satisfaction, long working hours, deteriorating working conditions, and limited opportunities for professional development and training. Migration has significant economic and social costs for the country, while investments in education and training of health workers may fail to be recouped for the benefit of healthcare services in South Africa.

Our research shows that migration can be a positive and empowering experience for female health and social care workers, enabling them to gain autonomy and independence in their lives, experience and career opportunities, and, to move towards gender equality. However, our research also shows that women migrants can experience gender, ethnic and racial discrimination – in both their workplaces and their daily lives – in the countries they migrate to.

There is a wide range of factors that impact on decisions to migrate. Chart 6 shows the factors influencing decisions to migrate from the three sample groups: those who had not migrated, those that had migrated and returned to South Africa and those that had migrated to work in South Africa. It shows that wanting to earn a decent wage, having decent working conditions and opportunities to gain experience from working abroad were overwhelmingly the most important considerations for the health and social care workers interviewed.

**Chart 6: Factors influencing decisions to migrate**



Of the three sample groups:

- *Health and social care workers that have not migrated:* Nearly three-quarters (75%) had at some times in the working lives considered migrating. 32% said that they wanted to earn a decent wage, 28% wanted better working conditions and 21% wanted to experience working abroad.
- *Health and social care workers that had migrated to work overseas and had returned to South Africa.* 32% said that they migrated to earn a decent wage, 27% migrated to experience working abroad and 23% wanted to have better working conditions.
- *Health and social care workers that had migrated to South Africa from overseas:* 28% said that they migrated to South Africa to earn a decent wage, 24% migrated to experience working abroad and 22% to have better working conditions.



## Factors influencing decisions to migrate: Focus group discussion with health and social care workers who are considering migrating

The main factors highlighted by focus group participants were related to low wages and the problems in the healthcare system, arising from a lack of funding and significant demands on staff. Some participants were concerned about the risks to patients and the impact of negative reporting in the media that undermined the role and professionalism of nurses and midwives.

### Experience and the opportunity to travel

“I want to gain experience abroad and ‘see the world’.”

“The adventure and opportunity to travel and gain experience abroad.”

“I want to see how other people live in different parts of the world.”

### Wages and working conditions

“My reason is to make more money, earning in a strong foreign currency.”

“I am looking for better working conditions, facilities that are better staffed and adequate equipment to work with.”

“Improve the quality of personal life by earning better wages than what we earn at home.”

### Under-staffing

“There are frustrations with the system here at home – with more work and less staff available. Patients are more dependent and require a lot of care, and there is negative reporting by the media and sensationalizing negative incidents in our system.”

“There are a lot of us and more of them – that is sick patients to manage – and we feel concerned that we are unable to do a good job which predisposes us to ‘unsafe practices’. We fear making mistakes and being charged with malpractice by the professional councils.”

#### d) Factors influencing decisions not to migrate

Despite the high numbers of health and social care workers who have considered migrating, there are multiple and complex barriers that influence final decisions. These range from anecdotal stories of bad experiences working abroad to lack of information and support from the government, and the complex and costly processes involved in migrating.

The most significant factor influencing decisions not to migrate, according to 27% of interviewees, was that there was no practical support from their government. This was followed by 20% who said that their decision was influenced by difficulties in leaving their children and families. Finding out that the cost of living was too high in the new country was a prohibitive factor for 20% of interviewees. A further 19% said that their decision not to migrate was influenced by uncertainty about the recruitment process and 2% said it was too expensive to register and travel to work overseas. A further 13% stated that there were other reasons. As one interviewee from KwaZulu Natal stated: "The recruitment process was not practical." Another said that she had decided not to migrate because she had "heard of colleagues' negative experiences of working overseas."

Low levels of staffing and difficulties in recruiting and retaining nurses and midwives in rural areas also affected migration decisions. One interviewee from Eastern Cape said, "I would like to migrate but I can't because no one wants to serve this rural community. If I migrate no one else will serve this community." Another interviewee also from Eastern Cape said that it is "very difficult to recruit and retain health workers in this rural community."

The role of trade unions in assisting people in making decisions about migration

The research found that trade unions have a key role to play in providing information and assisting people in making informed decisions about the migration process. 87% of the health and social care workers who had considered migrating or that had migrated and returned to South Africa stated that their unions had not provided them with any assistance or information to help them make a decision about whether to migrate or not. However, the majority had not thought about contacting their union, were not aware that their union would be of any assistance, and until now had not seen the relevance of contacting their unions in this regard. This is an

important finding for the trade unions in South Africa and suggests that trade unions can play a much greater role in informing their membership about migration issues.

#### Where unions had been helpful interviewees stated:

"They provided the information I needed."

"Gave me all necessary information."

"The union supported my right to choose to migrate."

"Migration was openly discussed in the union."

#### e) Working conditions, staffing levels, pay, working environment and job satisfaction of health and social care workers in South Africa

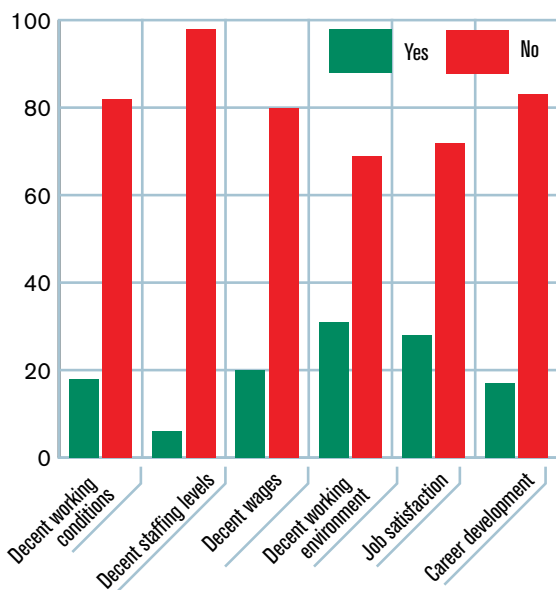
The majority of the health and social care workers interviewed believed that retaining staff will require significant additional resources to improve the quality of healthcare, pay and working conditions in South Africa. Many health and social care workers stated in the interviews and focus groups that they wanted opportunities for professional development, skills training and further education. Having the opportunity to migrate overseas to gain experience, and then return home, was seen as something the government could encourage, in order to benefit from a 'brain gain' for the country.

The survey asked respondents to comment on their experience of working in the health sector in South Africa with regards to working conditions, staffing levels, wages, and job satisfaction. They were also asked what needed to be done to improve the healthcare system, and to ensure that health and social care workers are able to make informed decisions about migrating. Improved pay, better working conditions and higher staffing levels, as well as better recognition of work carried out, were key factors identified in the interviews and focus groups.

As Chart 7 illustrates, an overwhelming 98% stated that there was inadequate staffing to provide quality care. 83% stated that they did not have opportunities for career development. 82% said that they did not have decent working conditions. 80% stated that they did not have decent pay. 72% stated that they did not have job satisfaction in their work. A further 69% did not have a decent working environment.

There were some differences across the nine provinces, with decent staffing levels being the primary factor in all but one province. In the Limpopo province job satisfaction was ranked the most important, while in other provinces it was ranked third or fourth most important. In the North West decent staffing levels and decent working conditions were ranked equally as being the most important. Decent working conditions were ranked as the second most important factor in Mpumalanga, Free State, KwaZulu Natal, Northern Cape, Western Cape and Eastern Cape. Career development was seen to be a particularly important factor, ranking third, in both the Western Cape and Eastern Cape.

**Chart 7: Experience of working in the health sector in South Africa**



### f) Migrants who have returned to South Africa

There is significant anecdotal and research evidence from trade unions in countries of origin and destination that some migrant health and social care workers experience exploitation and abuse of fundamental rights to decent work. Complaints and information supplied to the PSI and to trade unions in South Africa include deception by recruitment agencies, employment contracts not being honoured, exploitative pay levels and employment of nurses in social care positions that do not recognise their qualifications.

The interviews and focus groups captured some of these experiences, both positive and negative. PSI's research in a wide range of countries across the world has found that nurses and midwives perceived



discrimination in career progression, which resulted in alienation, demoralisation and disengagement from their work. Returning health and social care workers face many challenges. As a result, there is a need to make return more attractive, with policies to ensure that returning healthcare workers are fairly and fully reintegrated to the workforce.

One hundred of the 300 interviews were carried out with migrant health and social care workers who had returned to South Africa after a period of work overseas. The findings from this sample group are that:

- The main countries of destination were the UK, Australia, Saudi Arabia, USA, Canada, and Ireland.
- The length of working abroad was largely of a short duration. The majority of interviewees, 71%, worked abroad for between one and five years. 18% worked abroad for less than a year, 11% for between five and ten years, and 1% for more than ten years.
- The majority, 87%, had migrated alone, 7% had migrated with their partner, 3% had migrated with their partner and children, and 3% had migrated with a friend.
- A large number of interviewees, 77%, stated that the job that they held overseas was at the skills

and pay level that they expected. This was not the case for 23% of interviewees.

- Everyone interviewed sent remittances home. Of these, 36% of interviewees sent remittances home for their children's livelihoods and education and 44% sent remittances home to support other family members. A further 16% sent remittances home for investments in housing or for setting up a new business.

### **The role of trade unions in countries of origin and destination**

Trade unions in both countries of origin and destination have a potentially important role to play in the future in both helping migrants to integrate in a new country and in providing information prior to migration. This is particularly relevant as 17% of interviewees said that their union had been of some help to them before they migrated, while this was not the case for 83% of interviewees.

Only 23% of interviewees joined a trade union in the country that they migrated to, while 77% did not. Of those that did join a trade union, 74% said that the trade union had been helpful to them, while 26% said that the union had not given them any help. In some cases this was because they had not asked for any help or assistance.

### **Help and assistance from governments in countries of origin and destination**

Regarding the level of help and assistance in the country health and social care workers migrated to, 86% of interviewees stated that they received no help or assistance from the government, while 14% did receive some help and assistance.

### **Experiences of working abroad**

Regarding the experience of migrating and working abroad, the majority of interviewees, 81%, had a positive experience working abroad. 12% stated that they had a negative experience and 7% had neither a positive nor a negative experience.

Overall, the experience was positive. As one nurse said: "I achieved my goals, I gained experience and I saved money." Another said that it was "Challenging but enriching." For others having better pay and the chance to send remittances home was a positive factor, and as one said: "I needed money and made the sacrifice." Gaining experience was very valuable for a large number of nurses and midwives. As one

interviewee stated: "I studied whilst abroad and used the experience in my own practice back home." Another said: "I gained experience and additional qualifications whilst abroad and I'm happy I had such an experience."

Negative experiences included the challenge of settling into a new country and working in an unfamiliar environment, missing family and home and racism. One nurse, interviewed in Gauteng, said there was, "No respect for foreigners." Coming to terms with social, religious and cultural differences also presented a challenge for some interviewees. As one interviewee who had migrated to Saudi Arabia stated: "The way of life was different from South Africa. I had to adjust to the restrictions, which were not a problem in the long run. I respected their social and religious beliefs. Crime was low. I felt free to walk without fear especially in the malls. It was a real eye opener about how other people live out there."

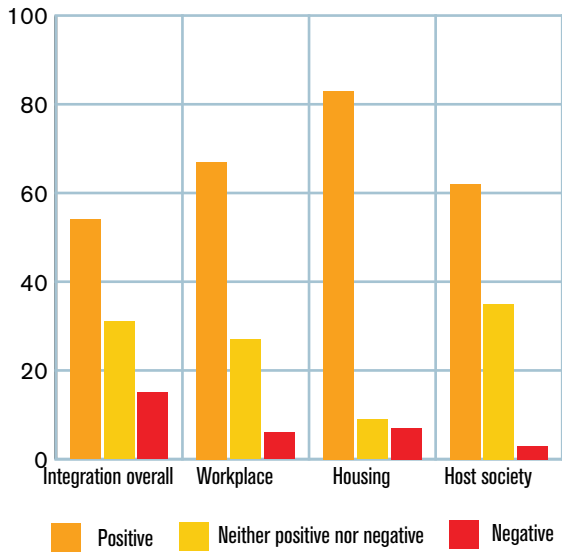
### **Example of a nurse who migrated to the work in the UK**

One interviewee had a negative experience of migration. She worked as a Chief Staff Nurse in South Africa and decided to migrate in order to earn a better salary to help her children with their university fees. She also felt that she was not valued in her work in South Africa. She was recruited by a UK based recruitment agency to work in a private residential home for older people, where she worked for eight years. She received payment of £1 an hour, which is well below the national minimum wage, and worked 47 hours a week. Since she returned to South Africa she has found it difficult to get a job. She believes that the government should utilise her skills more effectively as she would like to contribute to the health of the people in South Africa.

### **Integrating into a new country**

Integrating into a new country is of great importance for migrant health and social care workers. As Chart 8 shows health and social care workers who migrated had mixed experiences of integration into a new country. These experiences were largely positive: 54% had a positive experience of integrating into the country that they migrated to, 15% a negative experience and 31% had neither a positive nor a negative experience.

**Chart 8: Integration of workers who migrated abroad**



Based on these experiences of working abroad, 78% of interviewees said that they would work abroad again, while 22% stated that they would not. Several interviewees stated that they would not work abroad again because the experience was very challenging. Migrating abroad had led to marital and family problems arising from separation for some interviewees. Others experienced loneliness and not being able to settle because of personal problems; while for others there was a lack of support from colleagues and the host society. As one nurse working in Western Cape said: “I do not recommend migration.”

**Integration: workplace, housing and the host community**

Integration into a new workplace in a new country is a very important factor impacting on whether the experience is positive or negative. 67% had a positive experience of the workplace in which they worked, 27% stated that the experience in the workplace was neither positive nor negative, and 6% had a negative experience. Positive experiences included earning decent pay, gaining clinical and professional experience, opportunities to work with modern medical equipment and gain new skills, good working conditions, a positive working environment, access to technology, and a less stressful working environment.

This was summarized by one nurse interviewed in Gauteng as: “Better salaries career opportunities, better equipment in working order, better working conditions, a less stressful working environment and better staffing.” Another interviewee from Western Cape said that: “If I could take my family with me I

would work abroad because they value you as if you are the single most important asset in that country. You are respected and cared for when you have a crisis. The pay is good.”

Some of the other advantages were having access to free healthcare, good levels of holiday leave and other beneficial conditions of service. For others the reasons to migrate related to the value given to the role of the healthcare professional. As one nurse said: “In South Africa, nurses are not appreciated. They are taken for granted. Nobody cares about the nurses’ welfare as compared to other countries.” Overwhelmingly, it was the opportunity for better pay and working conditions. As one nurse said: “I would easily work abroad again if my working conditions and salary do not get better in the near future.”

Some health and social care workers had difficulties integrating into the workplace. One interviewee from Mpumalanga province stated: “Other staff members made you feel like a real outsider in the workplace. Migrating is not as positive as it sounds. You have to search for the greener pastures. You feel like an outsider and other staff members frustrate you.” However, a large number of those who migrated to work in the UK, particularly London, found the support of other South African nurses very valuable. A nurse interviewed in the North West summed this up: “The support by SA Nurses network was critical support for me.”

Housing is another major factor that impacts on the integration of migrants. 62% of interviewees had a positive experience of the housing that they lived in, 9% had neither a positive nor negative experience and 7% had a bad experience in relation to housing. Many of those with a positive experience spoke about the benefits to them of having housing provided on arrival, and of better housing conditions than existed at home. Acceptance by the host community is another important factor influencing the integration process. 62% had a positive experience of this, 35% had neither a positive nor a negative experience, while for 3% the experience was negative.

**Recruitment of migrant health and social care workers**

Recruitment procedures are a major factor in creating a positive or negative experience of migration. 65% of interviewees were recruited through an agency. Of these, 64% were recruited through a South African run agency, 25% from an agency run by another country and 10% did not



know whether the agency was South African or not. When asked how they came in contact with the agency, 51% had seen an advertisement in the newspaper or a nursing journal, 42% heard about the agency by word-of-mouth, 6% heard about the agency in their workplace, and a further 2% did not know. 94% stated that the agency carried out ethical recruitment. Only 6% of interviewees believed that the recruitment had been unethical.

Those who were recruited through recruitment agencies and through UK-South Africa government exchange programmes were interviewed, usually by tele-conference, in South Africa. In most cases the recruitment companies were very helpful and supportive. They assisted with verification of qualifications with the relevant Nurses Council and with registration and visa applications in the new country. They provided assistance on arrival, for example, by meeting the person at the airport, providing temporary accommodation, cash loans, help in opening bank accounts and food. In some cases the recruitment companies stayed in touch with the migrant worker.

Most interviewees said that they had not experienced any problems, and that all agreements and contractual arrangements were honoured. As one nurse interviewed in Limpopo province said: "I was given respect and all the promises were kept." However, in some cases recruitment companies provided little help and support. Another nurse interviewed in Limpopo said, "They gave us less information about the place, wages and everything."

"I paid a South African agency which helped me organize my visa, cell phone and other support. They helped with visa applications, job placement, accommodation and directions, and they supplied the uniform. They assisted with verification and registration of qualifications."  
(Nurse recruited to work in the UK, now working in KwaZulu Natal)

"The interview was done through video conference and they paid for the ticket. On arrival in Australia they arranged for transport and I was welcomed by the staff and manager."  
(Nurse recruited to work in Australia, now working in the Western Cape).

In one case a nurse who had worked abroad and returned to work in the Western Cape stated that the "process was fast and efficient. Interviews were set up with overseas companies. The paper work was

done by agency, including tickets accommodation and welcome." Another said: "They were very professional, helpful and informative. They provided information regarding housing, work environment and the country customs. They organized a workshop where staff of the hospital met new recruits." Settling into accommodation and arranging schooling for children was particularly important. As one nurse interviewed in Gauteng province said: "My housing was sorted out quickly and my children were welcomed in school. I was very happy with this."

Several participants spoke about their frustrations about the length of time it took to have verifications and registration documents completed. As one nurse interviewed in the Free State province said: "It took very long to register with their Nursing Council."

Those who had participated in the two-year exchange programme between the governments of South Africa and UK and the British Council's study programme had a very positive experience of the recruitment process and of the help given to settle into the new country. One participant in the programme stated that: "I was assisted with the whole process and the visa application to the new country." Another said, "Opportunities to study in UK were provided by the British Council to graduates in South Africa."



### Returning to South Africa

The main reasons for returning to South Africa were that the interviewees missed their home, children and families (50%) or because their contracts ended (32%). 9% returned because they found the country they worked in to be very expensive, and 8% because the job was not what they expected.

Typical comments in interviews included: "I came back home because my contract ended and I did not want to renew it," and "because I missed my family so much." In some cases expectations had not been fully met, as in the case of one nurse interviewed in Western Cape: "The working conditions were not what I expected. But it was a nice experience to work overseas to see what other countries are doing and how they live and to experience their climate." Some interviewees had experienced difficulties in the registration process and not being able to find a suitable job. As one interviewee said: "I returned because of difficulties with registration of qualifications in UK." Another said: "I returned because I could not find a suitable job." One interviewee was forced to return home after she arrived in the UK to take up a new nursing job, only to be refused the job because her medical records showed that she had TB as a child.

### Integrating back into work

Integrating back into work is not always easy. 96% of interviewees found a job when they returned to South Africa. 75% stated that the job was at a skill level that they had expected and that took account of their experience of working overseas. This was not the case for 25% of interviewees.

Although most interviewees found jobs when they returned, some were dissatisfied with the lack of recognition of the skills and experience gained abroad. This led one interviewee in Limpopo to suggest: "The government should take into consideration that people who work abroad gain more experience than those working locally so that experience should be recognised and given better salary." Some nurses and midwives reported on negative views of colleagues, in one case: "On return back to the public sector the nurses were envious. The nurses felt threatened because of my qualifications and experience that placed me in a higher salary bracket due to the OSD." In particular, a large number of returning health and social care workers highlighted the importance of the 'brain gain' for South Africa, resulting from experience of working in other healthcare systems.

"I studied whilst abroad, but upon return I could not find any positions accepting me. People with lower qualifications were appointed above me. It was frustrating and I had to moonlight and do temporary jobs."

(Interviewee in Gauteng province)

"When I returned to South Africa it was very difficult to secure a job in the government sector. I ended up working for an NGO for a period of 3 months as a social worker. Although I had 12 years' experience, it took too long to be called for an interview with the government. I came back in March 2007 and only started working for the government in May 2008. The recruitment process and filling of posts within the government needs to improve."

(Interviewee from Gauteng province)

### g) Health and social care workers who have migrated to work in South Africa

Fifty health and social care workers who had migrated to work in South Africa were interviewed as part of the research.

- The countries of origin of the 50 interviewees are: Nigeria (8), Malawi (6), India (6), Ghana (6), Zambia (5), Zimbabwe (5), Congo (3), Swaziland (3), UK (3), Lesotho (2), Botswana (1), DRC (1) and Saudi Arabia (1).



- Just over half of those who had migrated to work in South Africa were in the 26-35 year age group and a further 27% were in the 36-45 year age group.
- The majority (61%) took up a job in nursing and 9% in midwifery. 11% had migrated to train to be student nurses or midwives, 2% as community health nurses, 2% as social workers, and 11% to other nursing and health related occupations.
- 91% stated that the job they took up in South Africa was at the level and skills that they expected. 87% stated that this was at the same skill level as the job they had left in their home country, 11% stated that the job was at a lower skill level, and 3% at a higher skill level.
- 63% migrated alone, 24% with a spouse/partner and their children, and 12% with their spouse/partner.
- All fifty interviewees sent remittances home. 6% were for their children, 86% were for other family members, and 9% were for investments in housing or for setting up businesses when they returned.
- 31% were recruited through an agency, which was South African. 89% stated that the agency carried out ethical recruitment, while 11% stated that the practices were unethical. Knowledge of the agency was gained through word-of-mouth for 44% of interviewees, from an advertisement for 39%, and through their workplace for 17%.

### **Reasons for migrating**

The main reason for migrating was to earn a decent wage, with 28% of interviewees stating that they migrated to earn a decent wage. However, it is of interest to note that 57% of this sample group that had migrated to work in South Africa stated that they did not earn a decent wage in South Africa. 22% stated that they migrated to enjoy better working conditions than existed in their home country. However, in the interviews 59% stated that they did not have decent working conditions in the job they took up in South Africa. 24% stated that they had migrated to South Africa because they wanted to gain experience from working abroad. 13% wanted access to career progression. 4% stated that they wanted less stress in their work, and a further 4% migrated because they did not have a job in their country of origin. Of the interviewees that

had migrated to South Africa the most important improvements were to have better resources for equipment and medicines, followed by improved staffing levels and wages.

“To work in South Africa is very nice but the environment is very hectic. The challenge is shortage of medical equipment and shortage of staff.”

(Nurse who migrated from India to South Africa, Gauteng province)

The majority had plans to work in South Africa for a relatively short period of time, in most cases for five years, which is conditional on work permits and contracts. In the case of some nurses and midwives the lack of jobs in their home countries was an important factor. In other cases the political or economic situation at home was prohibitive. As one nurse from Zimbabwe stated: “Should the political situation stabilise I will return to Zimbabwe. I am waiting for political stability in Zimbabwe.” Nurses from other African countries saw the benefits of gaining experience in South Africa and the positive approach to development. As one nurse working in KwaZulu Natal said “There are many development opportunities in this country.” Several migrant nurses working in KwaZulu Natal were happy with the quality of life and experience of working in a rural community: “I love working in a rural community in South Africa.”

### **Trade union membership**

Just under half of interviewees, 46%, had joined a trade union in South Africa. It is interesting to note that only 16% had been a member of a trade union in their home country. Of these workers who were trade union members, 20% stated that their trade union had been helpful to them prior to migrating. Nearly half, 45%, had received help and information from the union they joined in South Africa when they arrived and a further 14% had received some help and information.

A relatively high number, representing 78% of interviewees in this sample group were not aware of the PSI's project on migration. Of the 22% of interviewees aware of the project, 22% knew about the Pre-Decision Kit prepared by the National Working Group.

### Assistance and help from governments in countries of origin and destination

45% had received help from their government prior to migrating, and a further 14% received some help. 58% had received no help from the government in South Africa when they arrived, while 42% had received some help and assistance from the government.

#### Experiences of integration and working in South Africa

A large number, representing 98% of interviewees had a positive experience of working in South Africa, and only 2% had a negative experience. Compared to their own countries, South Africa provided greater opportunities and better resources for healthcare.

“There is no shortage of medical equipment. No shortage of staff. No problems of salaries. The cost of living is low. The money that we were earning we send it home.”  
(Nigerian nurse working in Gauteng province)

Chart 9 shows that there has been a largely positive experience of integration. Overall, 76% of interviewees had a positive experience of integration, for 22% this was neither positive nor negative, and 2% the experience was negative.

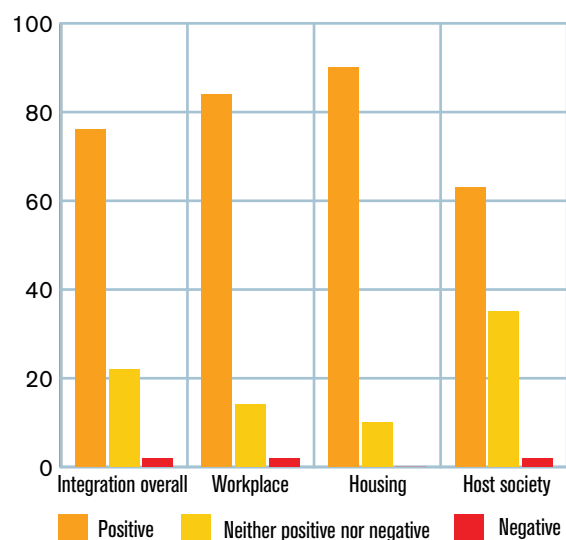
In relation to the experience of integrating into the workplace, 84% stated that this had been a positive experience, for 14% it was neither positive nor negative, and for 2% it was negative. In relation to housing, 92% had a positive experience in relation



to their housing, and for 8% this was neither positive nor negative. Regarding the experience of acceptance of the host society, this was a positive experience for 63% of interviewees, 35% stated this was neither positive nor negative, and 2% had a negative experience of the host society.

Having contact with and support from other migrant workers also helped with settling in and working abroad. Interviewees from Nigeria working in KwaZulu Natal stated that integration was made easier because there was a supportive group of other Nigerians. A similar experience was given by Indian nurses working in Durban, who had established a close network of support.

**Chart 9:** Integration of workers who migrated to South Africa



Of those planning to return home, 33% of interviewees are currently planning to return to their country of origin, 67% are not. The main reason, affecting 47% of interviewees, is that their contract has ended, while 35% stated that they would be returning home because they missed their home and family. Of those not currently planning to return home, 27% plan to stay in South Africa for between one and two years, 25% for between two and four years, 11% for between five and ten years, 34% indefinitely, and 2% had not decided.

**Focus group: health and social care workers who have migrated to South Africa**

“Planning and preparing for migration is important – migrant workers should explore the labour market systems in the destination country to ensure that expectations are realistic in terms of job opportunities and pay levels.”

“It is not enough to rely on the information provided by recruitment agencies. People may be disappointed.”

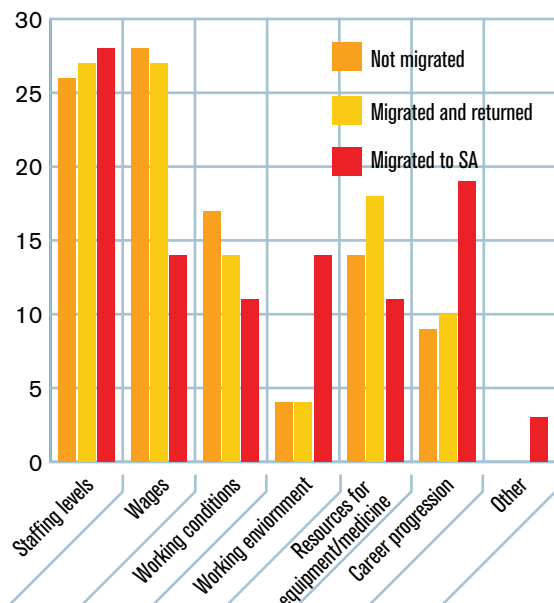
“Information on the costs of basic commodities should be made available.”

“Cultural diversities – coming into South Africa from Africa one expected that it would be very easy as we are all Africans. However, experiences were different and there was a need to adapt and understand the culture of the community.”

**h) Improvements needed to reduce the outward migration of health and social care workers**

Chart 10 shows the improvements that interviewees proposed to reduce the outward migration of health and social care workers. The most important priority identified is improved staffing levels, followed by pay, more resources for equipment and medicine, better working conditions, opportunities for career progression, and a less stressful working environment.

**Chart 10:** Improvements needed to reduce outward migration



Recruiting and retaining more nurses is essential if South Africa is to build a better healthcare system. While these are factors that have resource implications, they also speak to the need for improvements in the organisation and delivery of healthcare and more systematic approaches to HRH management and planning.

A number of interviewees were critical of the government's lack of investment in the health sector and in improving the wages of skilled workers. Typical responses from interviewees were: “The government must pay us more so that we do not migrate for greener pastures,” and, “We need better conditions and better wages.”

The reintegration of health and social care workers into the workforce when they return from a period of work overseas, was highlighted as a key concern by many interviewees and focus group participants. This particularly related to the need to ensure that experience and qualifications gained overseas are recognised and valued, that jobs were kept open for people migrating, and that migrants who return after a longer period of time working overseas have assistance in integrating back into the workforce.

“I would advise most health officials to migrate to other countries for development, to gain more skills and knowledge of equipment that are not used in South Africa and to accumulate more information that can be shared in our country through education.”  
(Interviewee from Limpopo)

This is particularly important as our study shows that many health and social care workers migrate or plan to migrate for relatively short periods of time. The fear of not being able to find a job on return to South Africa is a disincentive for migrant nurses who want to return home. This is a crucial factor in facilitating return migration that creates a ‘brain gain’ by enabling migrant healthcare workers to use their experience for promotion and career development when they return. That said, many migrants do emphasize the importance of improving conditions of work, pay levels and opportunities for career development at home.

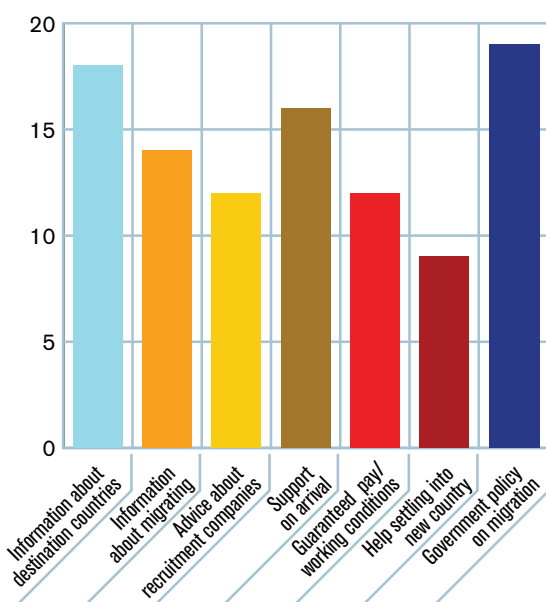
## i) Improving the experience of migration: the role for the government

“The government and/or trade unions should have a programme to support and assist those who have been out of the country on their return so that they are integrated back into the country.”  
(Interviewee from Mpumalanga)

A key element of the research was to identify – from the perspective of the 300 health and social care workers, and from the three focus groups – what can be done to improve the migration experience. The interviews focussed specifically on what the government and trade unions could do to provide information, advice and support prior to and during the migration process.

Chart 11 illustrates how respondents ranked the main actions the government should take to improve the migration experience.

**Chart 11: Actions proposed for the government**



Overall, the need for a clear government policy on migration, with information about permits, rights and how migration can result in ‘brain gain’ was ranked the highest. As one interviewee from Limpopo said: “There is no government support and policies on migration are not clear.”

The provision of information about countries of destination was ranked as the second most important action for the government. This includes information about living expenses and housing, as these appear to be key factors that have led to difficulties for migrants.

Third in the ranking is the provision of support for health and social care workers when they arrive in a new country to work. This relates to both the South Africa government and governments the countries of destination. Of particular concern was the lack of recourse to overseas missions and embassies if unethical recruitment takes place or if workers are exploited.

Fourth in the ranking is the need to provide more information about the requirements for registration and applying for jobs overseas. This issue was particularly relevant to nurses who had migrated to another country prior to receiving a job offer and verification from the South Africa Nursing Council.

Given equal support at fifth in the ranking are the need for advice about recruitment companies, and for guaranteed pay and decent working conditions in the new countries. The survey found significant mistrust of recruitment companies, and negative experiences resulting from unethical recruitment practices. Knowing which agencies to trust was identified as a key factor. Many health workers are unaware of and are not following recruitment procedures, including the verification of their qualifications with the South African Nursing Council prior to migrating.

This is followed by the need for the South African government and governments in countries of destination to ensure that migrants are guaranteed levels of pay and decent working conditions in the jobs that they migrate to. A smaller number of respondents stated that they needed help settling into a new country.

### Suggestions for government action to improve working conditions: focus groups and interviewees

“The state as the employer must set a good example of being the ‘employer of choice’ to be in a position to attract and retain skilled workers.”

“The image of caring professions should be improved to attract new recruits of good calibre. There are many options in the market and school leavers are no longer attracted to health and social care services.”

“Contact details of the South African embassy overseas should be available in case the nurse runs into problems.”

“Major exchange programmes and study opportunities, the British Council no longer provides these which were very helpful in the past.”

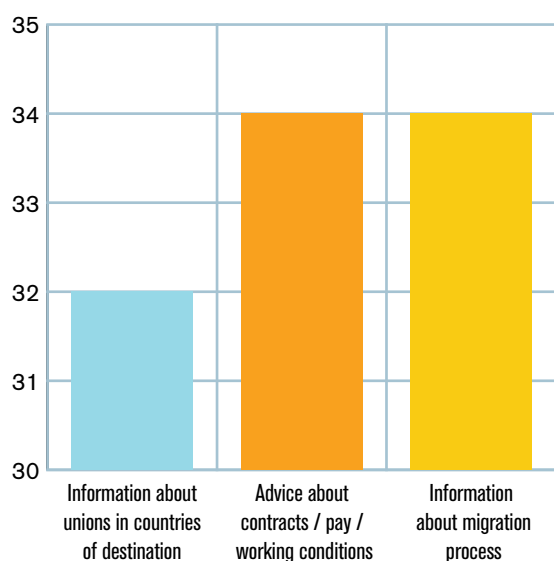
“Workers should be helped back into the workplace when they have returned from working overseas, to assist them so they are integrated.”

### j) Improving the experience of migration: the role of trade unions

The role of the National Working Group has been hugely important in building capacity and awareness of international migration. As mentioned above, the PSI’s project has led to the development of key resources, including the Pre-Decision Kit and the Passport to Workers’ Rights.

Chart 12 shows that interviewees ranked advice about contracts and working conditions, and information about the migration process, as being the most important roles that unions can play. Information about unions in countries of destination was ranked third.

**Chart 12:** Action for trade unions



Issues highlighted in the interviews included the role that unions can play in improving conditions of work, which would reduce the number of workers migrating to earn higher wages and improve working conditions. Trade unions could also provide support by partnering with unions in countries of destination and follow-up with migrants to ensure they have decent working conditions.

### Suggestions for action by trade unions: focus groups and interviewees

The focus group discussions stressed the need for good and clear information, bi-lateral contacts with unions in countries of destination, for unions to continue to advocate for better healthcare resources, and to address migration in collective bargaining.

“Provide as much information as possible about the country of destination and unions in the sector that may support us on arrival.”

“Continue to negotiate to improve conditions of service in this land to alleviate frustrations.”

“To provide adequate information to allow us to make informed decisions – we think the PSI is really fulfilling a big need.”

“Unionisation should not be a threat but be used by both unions and government to improve the quality of healthcare and nurses’ lives.”

“Communication channels should be there. South African unions should have affiliation with overseas unions so that members are well represented. Support systems should be in the data base of the new country.”

Suggestions from health and social care workers who have migrated to South Africa:

“Migrant workers should organize themselves into support groups and trade unions have an opportunity to organize these workers and protect their interests.”

“An information point should be created where migrant workers can access information in the destination country.”

“Support groups should be managed so that they do not perpetrate segregation of workers.”



## Summary of the findings from the participatory research

### a) Interview profile

- 300 face-to-face interviews were held across all provinces in South Africa. Three focus groups were held.
- The majority of interviewees were in the age ranges of 26-35 years and 35-45 years.
- 68% of those interviewed were women and 32% were men.
- 59% of those interviewed were trade union members.
- 22% were aware of the PSI's programme on migration and 30% were aware of the Pre-Decision Kit.

### b) Working conditions, staffing levels, pay, working environment and job satisfaction

- 98% stated that there was inadequate staffing to provide quality care.
- 83% did not have opportunities for career development.
- 82% did not have decent working conditions.
- 80% did not have decent pay.
- 72% did not have job satisfaction in their work.
- 69% did not have a decent working environment.

### c) Health and social care workers who had not migrated

- 150 interviews were carried out with health and social care workers who had not migrated.
- 75% of interviewees had considered migrating at some stage in their working lives.
- Wages, followed by wanting to gain experience and to have decent work conditions were the most important push factors to migrate.

#### Factors influencing decisions not to migrate

- 27% said there was a lack of practical support from the government.
- 20% said it was too difficult to leave their children and families.
- 20% stated that the cost of living was too high to work abroad.

- 19% cited uncertainty about the recruitment process.
- 2% said that the costs involved in migrating and registering were too high.

### d) Migrants who have returned to South Africa

- 100 interviews were held with migrant nurses who had returned to South Africa. The majority worked abroad for between one and five years. The main countries of destination were the UK, Australia, Saudi Arabia, USA, Canada and Ireland.
- 87% had migrated alone. All interviewees sent remittances home for children and family members, or for investments and housing.
- 87% had received no help or assistance from their union prior to migrating. 23% joined a trade union in the country they migrated to.
- 88% received no help from the government in the country that they migrated to.
- 65% were recruited through an agency; of these 94% stated that the agency carried out ethical recruitment.

#### Experiences of working abroad and integration: migrants who have returned to South Africa

- 81% had a positive experience of working abroad, 7% had neither a positive nor negative experience, and 12% had a negative experience.
- 78% said that based on these experiences they would work abroad again.
- 54% had a positive experience of integration in the country they migrated to; 64% had a positive experience integrating into the workplace; 62% had a positive experience in relation to their housing; and 62% had a positive experience of acceptance by the host community.

#### Returning to South Africa and integrating back into work

- 50% came home because they missed their children and families; 32% because their contracts ended; 9% because the country they migrated to was very expensive; and 8% because the job was not what they expected.



- 96% found a job when they returned to South Africa. 75% said that this was at a skill level that they had expected and that it took account of their overseas work experience.

### e) Foreign health and social care workers who have migrated to South Africa

- 50 interviews were held with foreign health and social care workers who migrated to work in South Africa. The most common countries of origin were Nigeria, Malawi, Ghana, India, Zambia and Zimbabwe.
- Just over half were in the 26-35 year age group.
- The majority took up nursing and midwifery positions, and 11% to carry out training in nursing and midwifery.
- 63% migrated alone. All interviewees sent remittances home for children and family members, or for investments and housing.
- 31% were interviewed through a South African recruitment agency. 89% stated that the agency carried out ethical recruitment.
- 46% had joined a trade union in South Africa; of these 45% had received help from the union they joined.
- 45% had received help from their government prior to migrating; 42% received some help from the South African government when they arrived.

#### Experiences of working in South Africa

- 98% had a positive experience of working in South Africa.
- 76% had a positive experience of integrating in South Africa; 84% had a positive experience of integration in the workplace; 92% had a positive experience in relation to their housing; and 63% had a positive experience of acceptance by the host society.
- At the time of the interview 33% were planning to return home, primarily because of the ending of their contract. 27% planned to stay for a further one or two years.

### f) Improvements suggested by interviewees to reduce outward migration

- Improvements in staffing levels were ranked the highest, followed by wages, working conditions, resources for equipment and medicine, better working conditions, opportunities for career progression and a less stressful working environment.

### g) Recommendations for the government

- A government policy on migration was ranked the most important action for the South African government. This was followed by the provision of information about countries of destination, support on arrival in a new country, information on migration, guaranteed pay and working conditions, information about recruitment companies, and help settling into a new country.
- Specific recommendations made in interviews and focus groups included ensuring that there are programmes to reintegrate returning migrants into the labour market and that there are measures in place to attract and retain health workers. Other recommendations included providing support to overseas migrants through embassies and the implementation of exchange programmes and overseas study opportunities.

### h) Recommendations for trade unions

- Ranked equally important was the role that trade unions can play in providing advice about pay and working conditions, and in providing information about the migration process. Trade unions were also seen to have a role to play in providing information about trade unions in countries of destination.
- Specific recommendations made in interviews and focus groups included the role that trade union can play in developing clear information, bi-lateral contacts with unions in countries of destination and trade union collective bargaining to improve pay and conditions of employment in South Africa.
- Health and social care workers who had migrated to South Africa recommended that unions could assist in the setting up of support groups for migrant workers and the provision of information for newly arrived migrants.

## Section 5: Conclusions and recommendations

South Africa is unique in the region as it is both a source and destination country of migrant workers. South Africa has experienced a substantial drain of skilled labour– the rate of emigration has exceeded the rate of immigration by a factor of four (IOM 2007). The overwhelming shortage of nurses and midwives and the under-staffing of public healthcare facilities, coupled with the country's burden of disease, has led to a healthcare crisis in South Africa.

This research, the first of its kind carried out in South Africa, documents the critical situation that faces the healthcare system in South Africa. This arises from a significant disease burden, under-funded and under-staffed public health facilities and the continuing outward migration of health and social care workers. The inequalities arising from the public-private mix mean that a disproportionate share of resources and staff are working in the private sector. The public sector continues to suffer from inadequate staffing levels that fail to meet the healthcare needs of the population, particularly in disadvantaged and rural areas. Our research shows that under-staffing, low pay and poor working conditions are underlying conditions that push health and social care workers to migrate. The absence of a coherent approach to HRH planning and difficulties in implementing strategic health priorities further exacerbate the difficulties faced by healthcare workers.

Globalization has had a major impact on patterns of migration. Our study shows that migration presents challenges and opportunities for health and social care workers. It is characterized by complex and changing realities related to the quality, funding and availability of healthcare, and the desire of healthcare workers to gain experience and better working conditions and pay in developed countries. Underlying this is that managing migration of health and social care workers could enable the return migration of health and social care workers to contribute to strengthened healthcare services in their countries of origin.

This review of policy and data, coupled with the results of the participatory research, demonstrates an urgent need for fundamental changes in HRH

policies and investment to address the chronic under-funding and under-staffing of the public healthcare system. Despite recent improvements in the training and recruitment of nurses and midwives and enhancements in salaries and career development pathways arising from the Occupation Specific Dispensation (OSD) for nurses, these measures are still insufficient to address the critical problems facing healthcare delivery in South Africa. Most important is the need for a strategic and planned approach to human resources, skills training and for the resourcing of healthcare in the most disadvantaged and rural areas that have the highest burden of disease and unmet needs.

The participatory research, based on 300 interviews and three focus groups with health and social care workers, gives voice to the concerns and issues facing South Africa's healthcare workforce. As a trade union study it provides an evidence base for the further development of trade union advocacy, information and campaign work, and underscores the key role that the social dialogue can play in advocating for ethical and coordinated migration policies, decent working conditions and the right to health. The trade unions bring key resources, knowledge and perspectives that can enhance the search for solutions to these critical issues and support the long-term economic and social development of South Africa. As part of a global research project, the findings from South Africa will also link strategically into the PSI's global advocacy work with international organisations. Through the National Working Group in South Africa, the trade unions have put in place a broad and holistic approach to addressing the causes of international migration, the underlying concerns of poverty, inequality, and the need for quality healthcare services.

Health and social care workers in South Africa want to contribute to the health and well-being of the population of South Africa. They have strong loyalties and pride in their country, and would prefer not to migrate if conditions were improved at home. They would like the choice to migrate to be a free choice

and informed, not one that is forced upon them by the economic, professional and work constraints that they face.

The research recommends government and trade union action to provide a coherent and ethical migration policy framework, linked to the provision of quality healthcare services capable of meeting the needs of the population. This will require increased expenditure on health service provision, including planning and human resource development, improvements in staffing levels, pay, specialist training and deployment of staff, and improved working lives. These investments will pay dividends for the economic and social development of South Africa, reduce inequalities in health, improve access to healthcare, and help meet the health related MDGs. They are essential to creating the optimum conditions whereby South Africa can benefit from a future 'brain gain'. Migration can become a tool for acquiring the knowledge and skills to build a more effective healthcare system in South Africa. This will require the government to take steps to ensure the successful integration into the healthcare workforce of new migrants who have come to work in South Africa and returning migrants. Returning migrants bring knowledge and skills from working abroad, which can be used to benefit a 'brain gain' for the country.

### Strengthening the social dialogue in South Africa

The social dialogue is a central to driving future development. Trade unions in South Africa are well organised and they participate in national and provincial collective bargaining structures in the health sector. They are well placed to strategically take the recommendations of this report into their collective bargaining structures and to disseminate them to their membership. Measures to strengthen and enhance the role and outcomes of the social dialogue underpin the recommendations to trade unions and the government set out below.

Through the social dialogue and collective bargaining, trade unions have a key role to play in advocating for and creating the economic and social conditions needed to retain trained and valued healthcare staff, promote gender equality and decent work, and contribute to the overall economic and social development of the country. Strengthening and further developing the social dialogue in the health sector is one of the most important ways to establish a systematic and ongoing approach to addressing

policy on migration, funding and development of the health sector, HRH policies, and measures to retain healthcare workers.

### Recommendations for trade unions

- Trade unions are in a strong position to further build the capacity of their membership to advocate for quality public healthcare services, a coherent migration policy framework, and measures to address the underlying causes of migration.
- Trade unions should urge relevant ministries to actively participate in a social dialogue framework to address the key issues identified in this study. With regards to the workplace, this includes improved staffing levels, working conditions and wages to retain nurses and midwives. With regards to migration, this includes advocating for improved procedures and protections for those planning to migrate, programmes for the reintegration of returning migrants, support structures for newly arrived migrants migrating to South Africa, simplified procedures for nurses seeking registration to work overseas, and ethical recruitment practices.
- The PSI's programme of activities on ethical recruitment, distribution of the Pre-Decision Kit and Passport to Workers' Rights, and the findings from the research can be used strategically as tools for organising and recruiting workers in the health sector. A strategy for this should be developed through the National Working Group as a basis for trade union coordination in this area.
- Trade unions have a key role to play in supporting workers who are considering migration. This should be coordinated with the government and employers. Trade unions can use their national and international networks to support migrant healthcare workers to help them make informed decisions about migration, to assist them when they migrate, to ensure that they have decent working conditions and dignity at work, have contact with trade unions and support in integration in countries of destination, and the ability to reintegrate into the workplace when they return.
- Accurate information is critical for workers who are considering migration. The Pre-Decision Kit and the Passport to Workers' Rights are a solid beginning. Regular updating and wider

distribution are recommended to ensure that all health and social care workers have access to this useful information. This could be followed up with local workshops and seminars to inform key trade union representatives and distribution through the workplace.

- A union outreach programme and a 'migrant desk' is one way that the trade unions can provide a focal point for information and make the role of unions more visible and attractive to migrant workers. This could help individuals make informed choices about migration. It could help ensure that health and social care workers are not migrating to jobs that exploit or under-value their skills and experience, and provide information and support for returning migrants.
- The outreach programme and 'migrant desk' could also play a key role in informing and supporting newly arrived migrants who have come to work in South Africa from abroad. This is particularly important in providing a contact point to recruit migrant healthcare workers and for the creation of local or provincial support groups.
- Trade unions should develop bi-lateral arrangements with unions in countries of destination to ensure that healthcare workers are aware of their employment and migration rights and responsibilities. Such bi-lateral arrangements could support organizing, information dissemination and capacity building for migrant workers' rights. There is also scope for trade unions to engage in knowledge and information sharing, and exchange programmes of work experience and training.
- Trade unions have a key role to play in advocating for ethical recruitment practices and for improved processes for registering and monitoring the practices of private recruitment companies. The WHO Code of Practice on International Recruitment of Health Personnel provides a comprehensive set of guidelines for the promotion and application of ethical recruitment within and among countries. Trade unions can work with governments, employers and key stakeholders in supporting the national application of the Code through social dialogue.

## Recommendations for the Government of South Africa

- The government should implement a coordinated and holistic policy framework to manage and monitor the migration of health and social care workers. This is essential to HRH planning, to managing internal and external migration flows, and to implementing and enforcing international regulations and bi-lateral agreements on ethical recruitment and migrant workers' rights. A comprehensive migration policy framework can facilitate a 'brain gain' and knowledge and skills transfer from diaspora communities. This requires improved data collection on migration flows and coordination between relevant ministries on migration policy.
- There is an urgent need to improve workforce data collection and monitoring in the health sector. Data on attrition, migration and returns is particularly needed to monitor inward and outward migration patterns and the outcomes for the health sector. Timely data on departures, registrations and returns – disaggregated by sex, age, occupational categories and region – is vital if the government is to systematically monitor and act on migration trends. Similarly, data is urgently needed on South Africans abroad, including their living and working conditions, their intentions to return to South Africa and of the skills and experience gained working abroad.
- Healthcare employment and migration policies should enable nurses and midwives to spend a period of time working overseas, without detriment to their careers, with full respect to workers' rights. Our research shows that many nurses and midwives are considering working abroad for relatively short periods of time in order to pursue training and acquire experience in another country. The government can design exchange programmes with other countries for training and work experience, for example, through secondments, twinning or bi-lateral arrangements, with the full participation of trade unions, employers and stakeholders at all stages of the planning and implementation process.
- Migration policy should actively encourage reintegration of health and social care workers into the public sector workforce so as to benefit from the skills gained abroad and enhance the public healthcare system.

- Migrant health and social care workers must be fully aware of their rights to dignity at work and decent work, of the labour and contractual conditions existing in countries of destination, and recourse to remedies in case of violation of their rights. The government has a duty to provide this information and to enter into bi-lateral agreements with countries of destination. This is a critical area where the trade unions, employers and government can work together to coordinate the provision of information and increase workers' awareness of their rights.
- Improved coordination between government ministries is needed to ensure that there are coherent policies and procedures on the migration of health workers. This is particularly important in monitoring the conditions of workers abroad.
- Labour legislation should be fully compliant with international labour standards. The Government of South Africa is urged to ratify and fully implement the ILO Migrant Workers Conventions No. 97 and No. 1431 and the UN International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families. This recommendation applies to all other International and regional instruments to which South Africa is a party.
- A government agency should be established to coordinate the activities of recruitment agencies, government departments, professional bodies and South African missions abroad which concern migration. This agency must ensure compliance by South Africa with regional and international conventions, including those of the ILO and the UN. ILO Convention No 181 on Private Employment Agencies, ILO Conventions No. 97 and No. 143 on Migrant Workers, the UN International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families and the WHO Code of Practice on international recruitment of health personnel, are particularly relevant. Such an agency could also lead in the in the development of ethical and rights based agreements between South Africa and other countries.
- The WHO Code of Practice on ethical recruitment should be fully implemented in South Africa in a partnership between the government, employers, trade unions and professional bodies. Although the Code of Practice has informed existing bi-lateral agreements, it needs to be further developed with the trade unions and employers to ensure it is fully implemented. This should also lead to the establishment of a register of recruitment companies and the implementation of enforceable ethical recruitment standards. It should continue to inform all bi-lateral agreements with developing countries in order to protect the rights of healthcare workers that migrate to South Africa and to ensure that the healthcare systems of these countries are not adversely affected by outward migration. Similarly, this should inform future bi-lateral arrangements with countries of destination to ensure that recruitment is ethical, that workers benefit from decent work, career development and training opportunities, and are supported in their migration decisions.
- The social dialogue framework in place for wage negotiations and working conditions under the PSCBC and the PHSDSBC could be further extended to strengthen human resources planning, to further develop migration policy and to promote ethical recruitment.
- It is recommended that a specific agreement be established between the trade unions and the government as an employer to ensure that nursing and health personnel are provided with opportunities to reintegrate into the labour market when they return.
- The full implementation of the Occupational Specific Dispensation (OSD) is essential if nurses and midwives are to be recruited, retained and replaced in the public health sector. This requires on-going monitoring of the implementation of the agreement and negotiations to ensure that salary levels and career development opportunities are further enhanced in the longer term. Furthermore, it is essential that the 2011 HWSETA Sector Skills Plan for the Health Sector and the consultations for the implementation of the Human Resources for Health South Africa 2030 be fully implemented in partnership with the trade unions at national and provincial levels.

<sup>1</sup> Convention No. 97 Migration for Employment Convention (Revised), 1949; ILO Convention No. 143 Migrant Workers (Supplementary Provisions) Convention, 1975

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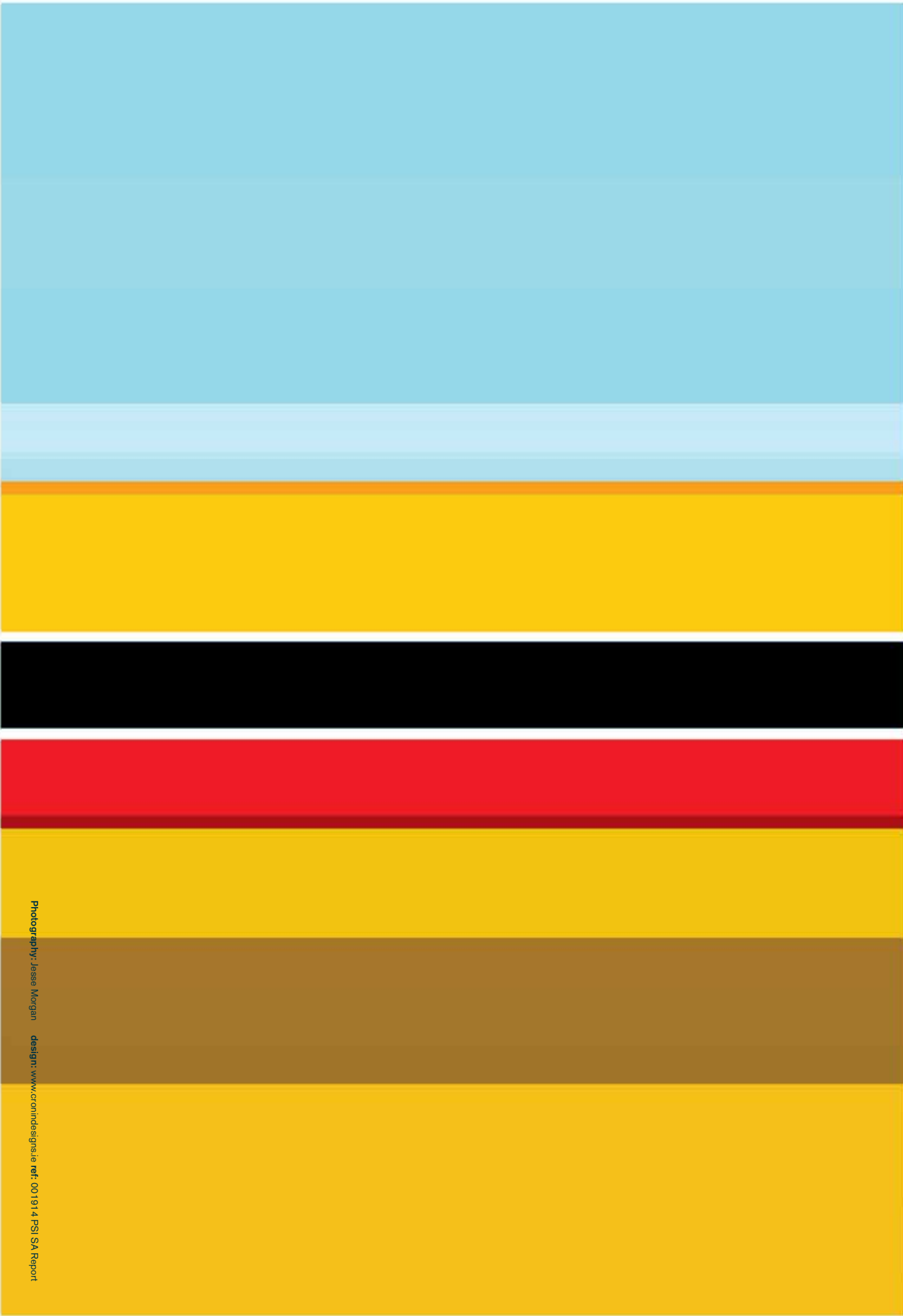
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