Return Migration of Nurses

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by Mary Haour-Knipe and Anita Davies

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She has taught in nursing schools at Columbia University and in Switzerland, and has been involved in a number of studies in the fields of migration and/or of stress, including a longitudinal study of family adaptation to life in a new culture.

From 1989 to 1992, she led a European Union working group assessing AIDS prevention activities for migrants and travelers in European countries, then carried out several evaluation studies of Swiss HIV prevention programmes. From 1999 to 2007, she served as Senior Advisor on Migration and Health at the International Organization for Migration, where she provided technical support and guidance for the development of IOM's HIV/AIDS-related programmes world wide. She also served as an advisor on migration issues to the Joint United Nations Programme on HIV/AIDS.

She is the author of *Moving Families: Expatriation, Stress and Coping,* and editor of *Health, Medicine and Society: Contributions to the Sociology of Health* and of *Crossing Borders: Migration, Ethnicity and AIDS,* as well as of nine published reports and numerous articles in the fields of social equity and health, stress, health sociology, and HIV/AIDS and migration.

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Executive summary

Globalization has greatly affected migration patterns of all categories of migrants, including those of professionals, such as nurses. It is now far easier than it used to be for people to move from one place to another, and for migrants to keep in contact with family and friends spread across several countries. Migration patterns are increasingly circular, with people moving back and forth between countries of origin, transit and destination, returning home, and then frequently migrating on again. More migrants are maintaining family and work lives in two or more countries. The migration patterns of health professionals, including those of nurses, are no different. The patterns are highly complex and shift rapidly. Nurses return home after periods of working abroad. Some then re-migrate, and some maintain transnational families, living in one country or community while partners and children live in another, or even several other countries.

At the same, time gross imbalances exist in the availability and quality of health care throughout the world, and in distribution of health personnel, with acute shortages in some of the very countries and regions with the highest need. The same is true of nurses: in developed countries rapid ageing of the population and high levels of technically demanding health care have increased the demand for nurses able to fill personnel shortages. The demand is being filled by nurses from developing countries, attracted by possibilities for education and training, by salaries far higher than they can earn at home and by what seem to be comfortable living conditions.

This paper, commissioned by the International Centre for Nurse Migration, focuses on some of the challenges and the opportunities created by migration of nurses, specifically focusing on the issue of return. Divided into five main sections, the paper looks at migration and population mobility in general to set the context, then focuses on the migration of health professionals. The literature on return migration is reviewed, with particular reference to skilled migrants and to nurse migration. The paper also highlights current strategies to manage the migration of health workers, and concludes with a discussion of initiatives to facilitate return migration of nurses. The underlying assumption is that, properly managed, return migration of nurses could be an important tool to strengthen health systems in their countries of origin.

1. Migration and population mobility in general

Each year between 5 and 10 million people worldwide cross an international border to take up residence in a different country: in 2005, some 191 million individuals, or approximately 3% of the world population, was an international migrant. Approximately half of these are thought to be labour migrants. About half of all migrant workers are now women, with more women migrating independently and as main income-earners instead of following male relatives. Female labour migration at all skill levels is concentrated in occupations associated with traditional gender roles, with skilled women tending to go into welfare and social professions, such as education, social work and health, in particular nursing.

Migration has long been seen as a one-way process, with people assumed to move to destination countries once and for all. Although migrants have always returned to their homelands for a variety of reasons, it was assumed that those who talked of return were simply dreaming. This is beginning to change, with increasing attention being paid to return. This paper discusses several different typologies of return migration, showing that one, 'the return of innovation', can bring innovation and positive change to the migrant's country of origin.

The paper then goes on to discuss the causes and effects of return migration, the economic, socio-cultural and political factors that influence migrants' decisions to return to their countries of origin. Barbados is used as an example. The processes of reintegration and of circular migration are discussed, as is the concept of transnational identities.

2. Migration of health professionals

In this section, the general theories of migration are related to the migration of health professionals, in general, and of nurses, in specific. Patterns of migration of health professionals between sectors and between countries are discussed, as are the reasons nurses migrate, since the reasons nurses leave are often a mirror image of the reasons they may return. Some data is presented concerning the numbers of nurses migrating, but — more importantly — several problems are noted concerning data. Data related to migration of health professionals is particularly scarce in countries of origin. When it is available, data is often scanty, emerging from different sources thus not comparable between countries. Most of the published information on return migration of nurses is anecdotal.

3. Return of skilled migrants

The section on return of skilled migrants highlights the challenges and opportunities of return. There was limited data on which to base this section: hypotheses about return of nurses must be extrapolated from a limited number of studies of return of other categories of skilled migrants. A number of examples are given in this section, concerning physician entrepreneurs to India, and of nurses to South Africa and especially to Jamaica. Some of the potential difficulties of return are reviewed. Once again, the need to improve the evidence base on nurse migration, and specifically on return migration, is emphasized.

4. Current strategies to manage the migration of health workers

Strategies used to manage migration of health workers are presented in this section, such as England's code of practice for the recruitment of international health professionals to work in the national health services, various bilateral agreements between countries, or the multilateral Commonwealth code of practice for the international recruitment of health workers. The review illustrates some of the lessons learnt from these strategies, and notes the role of professional bodies such as the International Council of Nurses in developing and guiding them.

A close look is taken at some innovative strategies to facilitate return migration of professionals, such as engaging with diaspora networks, the United Nations 'Transfer of Knowledge Through Expatriate Nationals' programme, and the International Organization for Migration's 'Migration for Development in Africa' initiative.

The section ends with a review of some of the policies and practices that have been proposed to promote return or circular migration, such as — to mention just a few — the use of incentives, granting dual nationality and flexible residential rights, 'moving the mind without the body', and creating centres of excellence that will attract returnees.

5. Conclusion: Future policy, research and action

The paper concludes by reinforcing the notion that nurse migration needs to find a balance between the rights of nurses to seek opportunities in other countries and the needs of communities for trained and competent health workers, between industrialized countries' needs for health professionals and the long-term development needs of less industrialized poor countries.

Suggestions as to the way forward to address the issues raised in this paper are grouped around two the major themes. The first is to improve the currently sadly deficient evidence base. The second is to make return attractive: by reducing the factors that make people migrate in the first place, by facilitating return, and by doing all that is possible to make sure that the experience of migration is positive for nurses.

Introduction

This paper focuses on some of the challenges and the opportunities created by migration of nurses, specifically focusing on the issue of return. Increases in migration of nurses over recent decades has been generating grave concern, especially in developing countries, where, when the migration is permanent, the loss of skilled health professionals can seriously weaken health systems. Nurse migration also creates opportunities, however, including those generated by return. Nurses who return home after a period of working abroad are often equipped with new skills and work experience. They may be able to serve as an enriched resource for health services, helping strengthen health systems and thus health in general in their countries of origin.

Although some attention has been paid to the out-migration of nurses in recent years, there is little hard evidence about how much nurse migration may be permanent, or how much might be temporary — very little attention has been paid to return migration of health professionals in general, or to return of nurses in specific. This paper, commissioned by the International Centre for Nurse Migration, attempts to serve as a starting point for addressing this gap, by discussing general theory on return migration as it might apply to nurses and nursing. Searches were performed in PubMed and Google scholar using the key words 'nurse', 'health care worker', 'health worker', 'professional', 'migration', 'circular migration' and 'return'. In addition, e-mail, face-to-face and telephone requests for references were sent to the major authors in the field. The references that emerged are reviewed here.

The document follows on previous ICN reviews on international migration of nurses (Buchan, Kingma and Lorenzo 2005; Buchan, Parkin and Sochalski 2003; Kingma 2001; Kingma 2007). It illustrates the personal, professional and social reasons for which people migrate, since these reasons are a mirror image of the reasons they might return. Migration theory concerning return, a field that has been somewhat neglected until recently, is then reviewed, and what is known about nurses returning is discussed, as are the processes and potential consequences of nurse return migration. The final section of the paper uses the review to highlight a number of key policy issues related to successful return migration of nurses.

1. Migration and population mobility in general

Each year between 5 and 10 million people worldwide cross an international border to take up residence in a different country. In 2005, some 191 million individuals, or approximately 3% of the world population, were international migrants (United Nations Department of Economic and Social Affairs 2006).[1] Only 40% of global migration takes place into industrialised countries, the other 60% taking place between developing countries (International Organization for Migration 2005b). In addition to international migration, significant population mobility also takes place within countries, most commonly from rural to urban areas, but also from poorer rural areas to more prosperous ones. Internal and external migrations are often interconnected: people may move internally from a rural to an urban area then later move on to another country. International migration may also create a demand for internal migrant labour, for example, when the jobs of workers who have gone abroad are filled by people from rural areas, or when women who have gone abroad hire other women to care for the children they leave at home.

While approximately half of the international migrants worldwide have migrated to join family members or to study, the other half, more than 86 million people, are thought to be labour migrants (International Labour Office 2004). About half of all migrant workers are now women, with more women migrating independently and as main income-earners rather than following male relatives as they may have done a generation ago (Martin 2005; United Nations Population Fund 2005). Female labour migration at all skill levels is concentrated in occupations associated with traditional gender roles, with skilled women tending to go into welfare and social professions such as education, social work and health, in particular nursing (Jolly and Reeves 2005).

Although the overall numbers of international migrants have more than doubled since 1960, world population has also increased. Experts point out that the proportion of people living outside their country of origin today is really not much different from other eras when population movements peaked. However, migration flows in today's world are much more complex than they were 30 years ago. The magnitude, density, velocity and diversity of global connections have increased greatly (Nyberg-Sorensen, Hear and Engberg-Pedersen 2002). Global communications networks now provide people with detailed information to help them in moving from one place to another; global transportation networks have made it much faster and cheaper to do so; and the growth of global social networks and diasporas have made it easier for people to adapt to a new society (Global Commission on International Migration 2005). Globalisation has also increased the gaps between the richer and the poorer countries (Stiglitz 2002), with such gaps creating strong pressures for people to move from region to region.

Several types of non-forced migration are pertinent today. **Permanent migration,** where it now occurs, mostly does so indirectly, as a development of previous temporary migrations, mainly through family reunion and family formation. **Voluntary migration** mostly takes the form of temporary labour migration. Voluntary migrants are an enormously diverse group, including the seasonal workers who pick agricultural produce, frontier workers who live in one country but work in another, and the highly skilled who now comprise a numerically important segment of those migrating for professional reasons. Other categories are increasingly important, such as **transit migrants** (people who enter one state in order to travel to another), and **undocumented migrants**, whose labour is in considerable demand (Salt 2001).

Describing such categories of migration helps understand the diverse forms of population mobility, but at the same time it is not helpful to categorise too rigidly. One type of migration or journey is often transposed into another, as when a 'permanent' immigrant decides to go home, a tourist becomes an undocumented migrant when her visa expires, a student marries and stays on, or a nurse is able to flee conflict in her country by finding employment abroad but without formally declaring herself as a refugee. In addition, the status of numerous other international movers easily blends into that of migrant, such as those who derive most of their livelihood from frequent short-term

[1] Other and quite different forms of population mobility also take place. Some are forced from their communities, fleeing political instability, conflict, environmental degradation and natural disasters. At of the end of 2005 the United Nations High Commissioner for Refugees listed some 20.8 million refugees, asylum seekers, internally displaced and 'others of concern' (United Nations High Commissioner for Refugees 2007). Others cross borders for happier reasons: the World Tourism Organization estimates that there were some 806 million international tourist arrivals in 2005, a worldwide increase of 5.5% and an all-time record (World Tourism Organization 2006).

visits to other countries, such as cross-border commuters, labour tourists or petty traders. Finally, tourists and business travellers are important in relation to migration; they "help reduce the friction of distance which ultimately makes migration easier for everyone" (Salt 2001). For many, and as will be discussed following, brief trips abroad become fact-finding missions that ultimately lead to longer-term moves.

Return migration

Return migration is: *"The process of a person returning to his/her country of origin or habitual residence…"* (International Organization for Migration 2004).

Migration has long been seen as a one-way process (King 2000; Oxfeld and Long 2004). Migrants were assumed to move once and for all to destination countries, sending for their families as soon as they were able and staying permanently. If some migrants talked of return it was assumed that they were simply dreaming (see page 14 on 'the myth of return'): neither origin nor destination countries realized the actual volumes of returns (Thomas-Hope 1999). This is beginning to change, with increasing attention being paid to return, particularly, as we have just seen and shall see again following, as globalisation is radically changing the way people move around the world.

Box 1: Typologies of return migration (King 2000)

Based on a thorough review of the existing literature on return migration, King has defined several ways of classifying return. Each helps shed some light on this complex phenomenon.

1. **Seeing return migration by level of development:**
   - **From less-developed to more highly developed countries,** often from colonies or ex-colonies (for example return of British expatriates from India and East Africa, of French from Algeria, or of Portuguese from Angola and Mozambique);
   - **From developed industrial countries to less-developed home countries** (for example Caribbean labour migrants returning from Britain and North America, Turks returning from West Germany, or Portuguese from France);
   - **Between countries of broadly equal economic status** (for example British returning from Australia, Canadians from the United States, or people moving amongst West European countries).
2. **Seeing return migration by length of time spent back in the home country:**
   - **Occasional returns,** when migrants make short-term, perhaps periodic, visits to see relatives, stay for a holiday, or participate in a family event such as a wedding or a funeral;
   - **Seasonal returns** dictated by the nature of the work (for example construction or hotel work);
   - **Temporary returns** when the migrant returns, but intends to re-emigrate abroad;
   - **Permanent returns** when the migrant resettles in the home country for good.
3. **Distinguishing between intention and the eventual migration outcome:**
   - **Emigration with the intention of returning, return in fact:** the migrant goes abroad with a specific aim in mind (for example to accumulate a certain sum of money, or obtain an educational qualification) and returns home when the target is reached;
   - **Emigration intended to be temporary, but return continuously postponed until it never happens:** students who stay to work are an example — the typical 'brain-drain' phenomenon — or labour migrants who decide to stay and settle rather than to return;
   - **Intended permanent migration in fact followed by return:** the change may be due to external factors, or to homesickness or other personal factors, or may take place because of an improvement in the economic, social or political conditions in the home country;
   - **Intended permanent migration without return**: even here the idea of return might be surprisingly important.
4. **Seeing return migration by the evolution of the migration process and of acculturation (Cerase 1970, cited in King 2000):**
   - **Return of retirement:** at end of migrants' working lives;
   - **Return of failure:** when migrants fail to adapt to the host society and return quickly to their homeland. Integration was never really started, so the returnees are easily reabsorbed into their home society. When it is voluntary, this type of return involves a certain amount of courage: some who have failed do not dare to return, since they are afraid of the shame of not having succeeded in the destination country, of being seen as not having been good enough to keep the job or to find another one abroad (Agunias 2006);
   - **Return of conservatism:** when migrants had always intended to return: return is the logical outcome of a calculated strategy, defined at the level of the migrant's household, and resulting from the successful achievement of goals or targets (Cassarino 2004). Acculturation was fairly minimal, even if the migrant stayed several years. Remittances and savings were heavily channelled to the home country. Conservative returnees do not aim at changing the social context they had left before migrating: instead, they help to preserve it;
   - **Return of innovation:** when migrants may have remained in the destination country beyond the target return, and may have largely adopted the host country's cultural values, but later realize that their acculturation can never be complete and they return. When they do so they take back new ideas, values and ambitions. They view themselves as innovators, believing that the skills they have acquired abroad, as well as their savings, will have turned them into 'carriers of change'.

Although elements of each of these ways of seeing return migration will be discussed, it is the latter typology that is most suited to the purposes of this paper. The return of innovation, in particular, can provide a significant boost to change and development in the country of origin. Authors writing in the 1970s noted that this is also the rarest type of return as "the migrants with the most drive and ambition, who succeed in the destination country, are those who are least likely to return" (Böhning 1975, cited in King 2000). It is quite possible, however, that new types and trends in migration patterns will make the return of innovation more likely today (see below about circular migration).

Numbers and problems with numbers

Return migration is now known to be significant, even among immigrants who had been admitted to destination countries for permanent residence. For example, the United States Bureau of Census estimated that between 1908 and 1957, some 30% of the 15.7 million immigrants to that country returned to their country of origin. The numbers are even higher when seen from one of the countries of origin: of all immigrants from Western Mexico who entered the United States between1980 and 1990 (including both settlers and non-settlers), a sample survey showed that 50% had returned to Mexico after only two years, and 70% after 10 years (Ghosh 2000a; Ghosh 2000b).

Data such as this is limited, however, for a number of reasons. Some countries simply do not keep statistics on emigration: any data they have on migrants abroad is obtained from destination countries. Destination countries, for their part, are traditionally more concerned about monitoring entries than about monitoring departures making them poorly equipped to provide accurate numbers of migrants living in the country at any particular time (Thomas-Hope 1999).

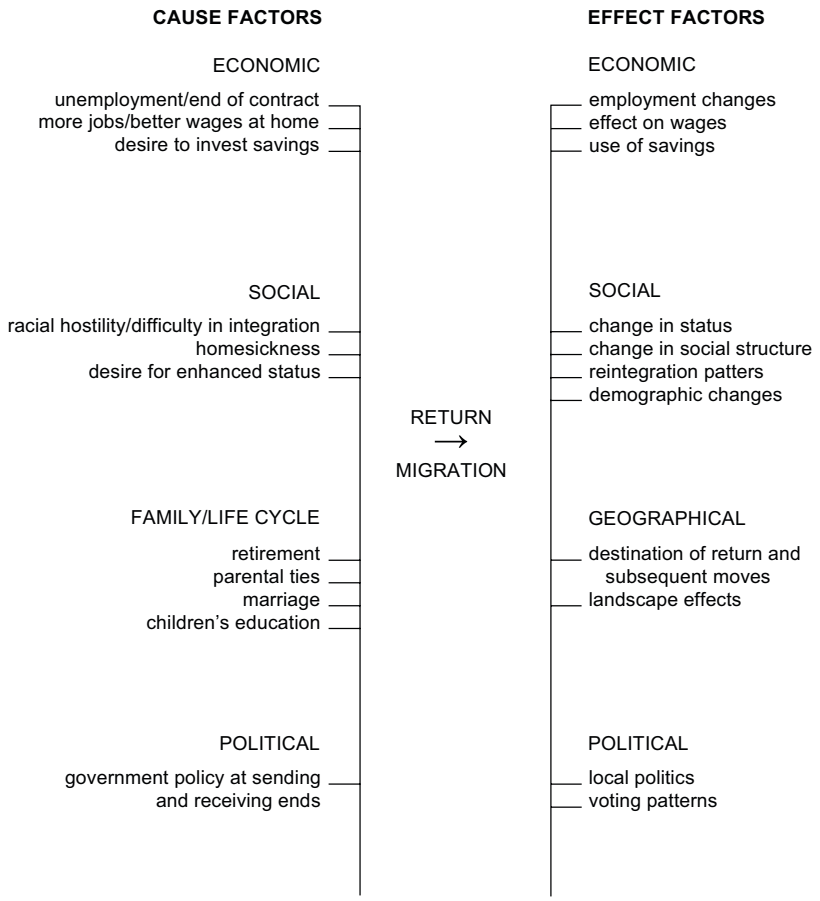
Even when they do monitor returns, different countries may adopt different criteria. For example, definitions of 'temporary migration' can range from nine months up to 10 years, depending on country conditions (Stilwell et al. 2003). Countries also define 'return migrant' in different ways, making inter-country comparisons almost impossible. Even where the same flow is being measured, the data may not match; returns of Italians from West Germany during the 1960s, for example, were three times larger according to the German statistics on exits than according to Italian data on entries (King 2000).

Even if the data-recording were perfect, however, the complexity of the movements themselves makes it difficult to pin down return. A high proportion of return migration involves multiple moves that occur over varying periods of time, in some cases over several years; people move back and forth between countries of origin, transit and destination, returning briefly for visits, or envisaging a permanent return but then leaving again. Finally, some migrants may be reluctant to disclose information about their migration, especially if their legal status is irregular (Thomas-Hope 1999). Data on return migration must therefore be obtained from indirect sources, for example, through detailed examination and cross-comparisons from census data and immigration records. Other sources include surveys of migrants and of return migrants, estimates based on monetary remittances and return savings, biographies and life histories and even city directories and church registries (Oxfeld and Long 2004).

Causes and effects of return migration

In his review of the literature on return migration, King (2000) illustrates the basic causes and effects of return migration as depicted in Figure 1.

FIGURE 1: CAUSES AND EFFECTS OF RETURN MIGRATION



Source: King (2000), p 14.

Return migration is usually driven by a complex mixture of economic, social, family and political factors. **Economic** stimuli for return migration may involve push factors in the country in which the migrant is living, such as economic downturn or unemployment, or pull factors from the region of origin, such as economic development and higher wages. **Social** motives for return may involve the push factors of racism or xenophobia, or difficulties integrating in the destination country. The related pull factors may be homesickness, or the prospect of enhanced status when one has returned, for example, through being able to launch a business venture, build a new house, or contribute to the community. Return migration often involves **family** or **life cycle** factors such as finding a spouse, having one's children educated 'at home' and in one's native language, or retiring. Migrants, not infrequently, return home to look after ageing or ailing parents, sometimes earlier than they had expected. Migrants who return home to care for their elderly parents usually return to their communities of origin, which may be rural, and where economic possibilities may be less than they would be in urban centres. **Political** pushes behind return may range from limitations initiated by the host country (for example, non-renewal of visas from a given country), or even expulsion, to less direct restrictions, for example, on possibilities for changing jobs, for bringing one's family, or for enjoying other citizenship benefits. Examples of political pull factors are policies to encourage and facilitate return on the part of the home country, such as tax benefits, social assistance, and housing grants.

King finds in his review that pull factors generally have more influence in the decision to return than do push factors, and that non-economic factors generally weigh more heavily than do economic factors. This is in contrast to the original decision to migrate, which is often strongly determined by economic motives, at least at the micro level (on the other hand at the macro level several studies point to unfavourable economic conditions in the immigration country as the key to episodes of mass return; in case of a recession it is often the migrant workers who are made redundant because of their marginal and unprotected status). On the micro, or individual level, most studies show that economic arguments are contextual rather than paramount: migrants may return when economic conditions in the country of origin improve but — when they are asked in questionnaires and interviews — most report that their reasons for return are family ties, and the desire to rejoin family and old friends. Push factors occasionally emerge in such surveys, such as racial harassment or difficulty adapting to a different climate, but it is generally the positive attractions of the home society that are reported to dominate in the decision to return. Feelings of patriotism or nationalistic sentiments have been found to be important motivators of return in studies of both developing and developed countries. Homesickness, and desire to reconnect with the national culture, can play an important role here.

The effects of return migration are illustrated on the right side of Figure 1 (p9).

Concerning **economic** effects, King's review points out that a large-scale return of working-age migrants could act to depress wages in the home region by contributing to an over-supply of labour. The two key economic variables associated with return are the human capital accumulated abroad through education, training and gain of on-the-job skills, and the financial capital channelled into the home region through remittances and savings. A key factor is whether or not the migrant has been able to work at his or her level of skill abroad.[2] Overall, King finds that the economic benefits of return migration are chimerical. Personal prosperity may be achieved by some, but this can make the distribution of income in the sending country more unequal. He concludes:

> "Migrants *can* be given relevant training by the receiving country; they *can* be given incentives to invest and reintegrate upon return for the general good of the home societies; and industries and other sustainable economic activities *can* be encouraged to locate in areas where returnees' skills can be maximized. But these policies need careful planning and can only happen if there is greater cooperation between sending and receiving countries." (King 2000).

Concerning the **social** effects the evidence is mixed. King's review of the literature concludes that migration abroad (or to higher wage urban areas within the same country) does enable some upward mobility and fluidity in social structures, and also ensures upward mobility for the generations to come, since migrants are able to invest in the education of younger family members. Much depends on the occupations migrants have left and on those to which they return. There is some evidence that migration can contribute to changes in the social structure of the emigration region, but this will depend on such factors as the numbers of people migrating, the length of time they have been away, the nature of the training they have received, the work they have done while abroad, how the return is organised, and the extent of social and economic change in the societies of origin.

Returnees may change the **geography** of the communities to which they return, in particular by the houses and other buildings they construct. Concerning **political** effects, there may be expectation in some communities that returnees will become active in local politics and other community activities on their return,[3] or become leaders. In contrast, migrants in other communities become detached from contact and patronage during their absence, and lose the possibility to influence local politics.

2 In a study of all migrants returning to Jamaica between 1992 and 1997 (between 1500 and 2500 people per year), Thomas-Hope found that in destination countries migrants had invariably filled positions that they regarded as being of lower status than their positions prior to migrating. This was especially true of skilled blue collar or white collar workers, who were obliged to work in unskilled or semi-skilled jobs at destination. On return the situation was usually reversed, however; migrants usually returned to an improved level of employment (Thomas-Hope 1999).

3 Returnees may also have significant political consequences in war torn societies (Oxfeld and Long 2004).

Box 2: The example of return migration to Barbados (drawn from Gmelch 2004)

With considerable movement between islands of different levels of economic development, as well as migration to and from the countries that had established colonies on the Islands, migration has long been an integral part of life in the Caribbean. Barbados serves as an excellent example of the factors that precipitate migration in the first place, and of the forces and potential difficulties surrounding subsequent return migration. In need of labour to help with post-war reconstruction and for a booming economy, the United Kingdom began to actively recruit workers from former colonies such as Barbados in the 1950s. Potential emigrants found to be qualified by recruiters from British companies and government agencies were trained and transported to England, where they immediately found jobs, including in nursing. The massive flow of emigrants to the UK ended a decade later, but in the meantime the USA and Canada reopened to immigrants and new streams of migrants began to head north. Between 1951 and 1970, 14% of the population of Barbados had left the island.

A dominant theme in the migrants' stories is how hard they worked. Some held two jobs, and most volunteered for all the overtime available. Family separations were common; when both parents migrated, children were left in the care of grandparents or other relatives, in the belief that they would be better off at home where the environment was safer and healthier. Most emigrants intended to return, and many did. Pull factors included the wish to contribute to the home country's development, and also the strong economy linked to the growth of tourism in Barbados. Push factors included unemployment in the destination countries, racial tension and hostility toward immigrants, disappointment with the education abroad — especially in inner-city schools and sometimes such personal problems as break-up of a marriage, trouble with children or ill health.

A hundred and thirty five people who had returned after an average of some 15 years abroad were interviewed in the mid 1980s and reported that returning was seldom as easy as they had expected. Images of home acquired during short holiday visits often turned out to be misleading. Friendships did not happen as they had hoped, or old friends had emigrated. Relatives and friends from youth — especially those who had never lived abroad — now seemed provincial and narrow-minded. Neighbours who had seemed friendly during holiday visits when presents were distributed became disinterested once the migrants returned for good. Migrants who had been living in more anonymous urban areas and who returned to small towns felt a loss of privacy, that every action and new possession was open to public scrutiny. Many sensed that those who had stayed behind were jealous of their large houses, new cars and of their children's higher education. As one returnee commented, "You can't win. If you come back with money, they are jealous. If you come back with nothing they ridicule you" (Gmelch 2004, p214). Some of the difficulties were caused by the returnees themselves. Some were insensitive, straining relationships with friends and neighbours with their frequent comparisons of Barbados to the society in which they had been living — comparisons on which Barbados usually came out short. Some tried to remind people that they had been away by putting on accents or dressing differently, or portrayed the idea that they were better than their provincial compatriots. Some simply seemed to refuse to try to assimilate.

There were special problems for women who returned, particularly in finding jobs in a society in which fewer women were professionally active. Those who could not find jobs were dissatisfied with their reduced autonomy and with the lack of stimulation and the loss of the status they experienced. Some reported missing the leisure activities they had had abroad, such as shopping. Women, especially, but also men, reported missing the grown children who had remained in the country to which the family had migrated. Parents hoped, often somewhat wistfully, that the children they had raised overseas would someday return.

In the meantime, Barbados was not the same place the migrants had left. The cost of living was higher; traffic, crime and drug use had increased; and young Barbadians seemed less courteous than a generation before. Gmelch notes that the returnees who had been the least realistic about what Barbados could provide were the most disgruntled; their discontent may in fact have been caused less by the actual social, economic and environmental conditions at home than by their own unrealistic expectations. Overall, the first year after return more than half of the returnees believed they would have been happier abroad, but the difficulties gradually faded. Returnees learned to cope with inefficiency and petty annoyances. They lowered their expectations about what can be accomplished in a day's work, so that the slower pace of Barbadian life was no longer an irritant. Many also coped by occasionally leaving the island. Business trips, visits to relatives, or holidays abroad reminded them of the drawbacks of life in the metropolitan society, of feeling anonymous, of not feeling safe on the streets at night, of racial prejudice and of the pressures that had helped push them back home. After a year or two most returnees were satisfied to be home and, by the end of their third year back, only 17% of the returnees were still dissatisfied. (Gmelch 2004).

Factors affecting the decision to return

As exemplified in Box 2 (p11) on Barbados, a decision to emigrate back home involves a mixture of professional and personal motivations in both the country of origin and the country of destination (see 'stick' and 'stay' factors, p21). Thomas-Hope's study of migrants returning to Jamaica, for example, noted that the decision involves a combination of two sets of factors: the personal and domestic circumstances of the individual and his or her family (factors such as age and stage in career and household life cycle) and perceived conditions in the country of origin (including 'comfort level', environment, cost of living, level of crime, opportunities for investment, political stability and attitudes towards returning migrants) (Thomas-Hope 1999). Life stage is particularly important. Thomas-Hope noted that 60% of the professionals who returned — and almost half of all of the returnees — had been abroad for less than five years. Those at the early stages in their careers, when they were not yet fully established in their careers and less significantly affected by income and pension structures at the migration destination, were more likely to respond to incentives to return. Those that remained abroad longer were less likely to return. Similarly, a study by Iredale et al. of return amongst skilled migrants in four Asian countries found that individual decisions to return home are made in response to a careful weighing up of personal factors, career-related prospects and the economic/political/environmental climate (Iredale, Rozario and Guo 2003). These authors also noted that social and family factors remain important for some potential returnees, but that the growth of transnational communities, better communication and ease of travel are changing the impact of this element — returning home for family reasons still carries weight, but it is only one factor. They find that family factors may be more important when successful integration has not occurred in the host country or when the emphasis on extended families and national pride is still very strong (for example, among the Vietnamese in this study).

Tiemoko's study (2003) of African migrants indicates more emphasis on family factors. By studying 304 return migrants to Ghana and 300 to Côte d'Ivoire, half of whom had university education and held managerial and professional positions, and carrying out in-depth interviews with migrants in London and Paris, Tiemoko found that family was amongst the three most important factors influencing return. Families (as well as friends) were a main source of information for returning, providing insights on jobs, legal matters, social tensions and security. At the same time, returnees cited family-related problems as amongst the most common difficulties they encountered, and the expectation of such problems delayed the return of some migrants. Migrants abroad were reluctant to return if they would not be able to help their families who had remained behind. Not being able to return with cars, or money to build a house, for example, would be difficult. After having been independent abroad, migrants also feared dependency after return, especially the prospect of having to depend on family members for housing: African migrants living in London and Paris repeatedly mentioned that a main condition for returning would be to have a house in the country of origin (Tiemoko 2003).

The myth of return

> *"As any displaced and disposed person can testify, there is no such thing as a genuine, uncomplicated return to one's home"* (Said 1999, cited in Oxfeld and Long, p15).

Although recent thinking on 'transnational communities' has shifted arguments to a certain extent, the literature on migration has often stressed the central role that homeland plays in the consciousness of migrant communities abroad. Even if the homeland exists only in memory, the idea of return is critical for many dispersed communities, and it extends beyond those who personally remember the home country (Oxfeld and Long 2004) (see also Box 2 on Barbados, p11). Migrants may maintain *'the myth of return'* (Anwar 1979, cited in King 2000). Much has been written, for example, about Asian migrants in the UK, where, in the face of unease about cultural characteristics and racism, immigrants may use the myth of return to legitimize continued adherence to the values of the homeland. In any destination country, and no matter how settled, migrants may talk and behave as if they will return home one

day, although work, family settlement, and their children's education make it increasingly unlikely that they will ever do so. When they do return, people do not necessarily return to the same specific locale from which they originally migrated. Even if they do return to the same place, that place may be profoundly changed (Oxfeld and Long 2004). The notion that time does not stand still is echoed over and over again in migrants' experiences of return; not only has the society of origin changed, but returnees also confront how much they themselves have changed while abroad. In addition, the return itself forces further alterations (see also Box 2 on Barbados).

Return is often accompanied by considerable ambivalence (King 2000). On one side, returning migrants are back in their own culture — they no longer need to worry about language, about being a foreigner, about being treated as an inferior. They enjoy seeing old friends and re-identifying with the local way of life. Yet they begin to realize that they have 'been away', that they are viewed differently, that certain things are expected of them, that there can be no return to the *status quo ante.* King cites several anthropological studies that explore the ways returnees must display their 'success', such as the Chinese restaurant workers who are expected to throw lavish banquets and make generous donations to community projects when they return to their Hong Kong villages. He notes that while such extravagant behaviour may appear to be economically irrational, it has an important effect in legitimizing the individual returnee's new social position. He also notes that returnees' own attitudes and actions may contribute to their difficulties on return, especially when, having 'seen the world', they seem arrogant and superior. Citing a 1973 study by Dahya, for example, King describes the way Pakistani factory workers returning from Britain wore suits, carried briefcases and displayed expensive watches and fountain pens, affectations which had little or no practical meaning — but great symbolic meaning. Numerous studies, including more recent ones, have noted that the most outwardly visible signs of returnee status are the new houses that appear in villages deeply affected by emigration, in Italy, Spain, Portugal, Morocco, Tunisia, India, Pakistan, China, Thailand, Mexico and numerous other countries throughout the world (King 2000) (see also Box 2 on Barbados, p11).

Along with previous authors on adaptation after return migration (Austin 1986; Werkman 1980), King notes that returnees' readjustment problems may also be a function of their own unrealistic expectations; migrants' memories of their home society may be out-of-date, idealised, nostalgic or inflated by festive moods and relatives' urgings during holiday visits home. The positive elements are stressed and the negative aspects recede from memory. Returnees' expectations are higher than can actually be satisfied by the reality of the economic situation to which they return, so that after a while back home they may suffer from a sense of 'relative deprivation' — they compare their lives not with what they were like in the past, but with what they think they should be like now and in the future. He notes that such disillusionment often leads to re-emigration.

Return, reintegration and circular migration

Today's cheap and easy transportation and communication have significantly influenced return migration, allowing people working away from their home countries to maintain physical ties, person-to-person communication and social networks with their home communities (Castles 1999). It is now much easier for migrants to make frequent visits home, permitting them to revisit their mental maps and to measure changes, thus reducing the likelihood of the illusions discussed previously. The return visit also acts as a conduit through which migrants can maintain 'social visibility': when he or she returns, a migrant who has gone back regularly will be more likely to be treated as one of the locals, less likely to be treated as a visitor about whom a neighbour who has not migrated may comment:

> "They contribute financially but they themselves were absent … They come back … but we don't know them. Where have they been all these years?" (cited in Duval 2005, p253).

In her study of return to the Caribbean, Thomas-Hope found that migrants overwhelmingly returned regularly or periodically, maintaining family obligations and investing in land and housing in preparation for the final move back (Thomas-Hope 1999). Cassarino (2004), in a theoretical review on return migration, and Oxfeld and Long (2004), in their book on return migration to several countries, make similar points, remarking that provisional returns may be used to overcome the fears and hesitations that had surrounded the act of leaving in the first place, giving people a

chance to decide if they want to return on a long-term basis. Returnees still face social and professional difficulties on return, but the contacts they have maintained and their back-and-forth movements reduce these. All three authors point out that many returns are tentative: migrants thinking of return often prepare a safety valve, for example, by ensuring that residency or citizenship status in the country to which they have migrated is in order, just in case.

Returns also reinforce cultural hybridism and strengthen transnational identities (Castles 1999; Oxfeld and Long 2004). While return was formerly seen as the end of a migration cycle (a cycle involving a place of origin, and places of transit, destination, then return), the return phase is increasingly being seen as simply one stage… the story continues (Cassarino 2004). Return may be the prelude to further episodes of spatial mobility, embedded in a cyclical process of repeat migrations increasingly referred to by such terms as 'circular migration', 'shuttle migration' or 'commuter migration' (see terminology in Appendix 1, p44). The phenomenon has mainly been studied in Asian countries such as China, Taiwan, South Korea and India, but also in Ireland and in the Caribbean (see Box 7 on Jamaica, p26). For some of today's migrant workers, return is no longer necessarily permanent, but could be temporary and even cyclical … a "stage along a process of increasingly fluid movements between countries" (Ammassari and Black 2001, cited in Agunias 2006, p14). For some migrants, such as Asians working in the Gulf States, temporary migration becomes a permanent way of life: they return only to migrate again. In another variant, migrants are based in destination countries but run businesses in their native countries, to which they return regularly. Examples include Chinese, Indians, Salvadorans and Dominicans resident in the USA. Rather than returning to the cultures from which they came, or integrating into the one in which they are living, such migrants develop 'transnational' lifestyles and perspectives, from which they live 'between' or 'across' two countries, economies and cultures (Sussex Centre for Migration Research 2002, cited in Redfoot and Houser 2005). In the case of families, members may also simultaneously belong to two households. Transnational identities result, combining those of migrants' origins with the identities they acquire in the host countries, a combination which is increasingly being seen as leading more to the development of 'double identities' than of the conflicting identities experts worried about a generation ago (Cassarino 2004).

Such transnational migration is also closely linked with economic development; by remaining in the host country, transnational migrant workers maintain their skills and continue to generate financial resources, but by remaining in close contact with their country of origin they provide a bridge for capital, skills and training that may aid the development of that country. The traditional migration framework, in which migrants who depart are seen as being 'lost' to the sending country — and arriving immigrants are therefore 'gained' by the receiving country — is being eroded in favour of a transnational framework, where migrants continually forge and sustain multiple attachments across nation-states and/or communities (Agunias 2006). As transnational migrants return home, it is argued, they can facilitate the transfer of critical financial and human capital to the developing world, reversing 'brain drain' into 'brain gain' (Hunger 2004; Kingma 2006; Skeldon 2005).

Much has been written about the negative sides of migration, in the form of 'brain drain' (the idea that when skilled workers or professionals are working abroad their talents are unavailable to the home country) and also of deskilling (when people working abroad take jobs at a lower level than they had prior to departure, such as Filipino college graduates who work as maids, Jamaicans who move from skilled posts before departure to unskilled or semi-skilled jobs in destination countries), or when nurses are required to spend lengthy periods of 'adaptation' in low-paying positions for which they are over-qualified). The other side of the equation has been receiving increasing attention, with a great deal of attention paid to remittances, the money migrants send home (International Organization for Migration 2005a). In 2005, migrants worldwide sent home more than US$233 billion, $167 billion of which was sent to developing countries.[4] Governments such as that of the Philippines, indeed, have promoted emigration of nationals in order to benefit from the remittances and savings such workers return to their economies (Salt 2001). The money migrants send home may initially be spent on improving housing and on family maintenance (including health care) but also in investments that will result in social mobility, such as education. Remittances are also invested in economically productive activities (Nyberg-Sorensen, Hear and Engberg-Pedersen 2002). Numerous returning

4 http://www.iom.int/jahia/Jahia/lang/en/pid/1

migrants have used their personal savings to set up businesses[5] (see Kingma 2006 and Box 5, p23, on Indian physicians). Return migrants may also contribute by sharing knowledge and skills, directly if the social and economic environment permits (Thomas-Hope 1999) or in some cases from abroad, for example, by building transnational networks for the transfer of knowledge and technology (Hunger 2004).

5 While many of these efforts fail in the absence of previous experience or training, and because of lack of local support, there are also numerous success stories. Return migrants have created small business enterprises in several East African countries of origin, for example. In another often-cited example Indian returnees from Silicon Valley have become a main driving force for the growth of the software industry in India (Ghosh 2000b). Indeed, a large proportion of the top-level management positions in the software sector in that country is now filled by Indians who had emigrated in the 1960s, 70s and 80s (Hunger 2004).

2. Migration of health professionals

Migration of professionals is: *"the voluntary movement of workers from one employment station to another in search of different working arrangements"* (Martineau, Decker and Bundred 2004).

The migration of health professionals has moved up on the policy agenda in recent years, with increasing attention being paid to worldwide inequalities in health resources. One of the most flagrant examples of such inequities concerns sub-Saharan Africa, which has 11% of the world's population, but 24% of its disease burden (including 69% of the world's HIV/AIDS cases) and only 3% of its health workforce (World Health Organization 2006a). The permanent loss of health human resources, while certainly not the only factor behind such imbalances, can seriously compromise the capacity of health systems in developing countries to deliver equitable health care (Stilwell, Diallo, Zurn, Dal Poz, Adams and Buchan 2003).

Complex shifts in political and labour market conditions prompt the movement of health professionals towards developed countries (Pond and McPake 2006). A main underlying reason, though, is a growing demand for health workers in high income countries, due in part to the health needs of rapidly ageing and highly medicalized populations (Simoens et al 2005). Internationally recruited health workers provide what has been described as a 'quick fix' to the lack of health personnel in developed countries — such professionals are able to start functioning immediately in the posts that need to be filled. In addition, such workers are often more flexible than local health professionals, and employers appreciate their willingness to work in less desirable areas and under conditions that are less socially acceptable to local workers [6] (Dovlo and Martineau 2004). From the point of view of the health worker, in many developing countries and for reasons ranging from lack of advanced health facilities in the first place to funding cutbacks, some of which are caused by structural adjustment policies,[7] highly skilled health professionals may not be able to be productively employed locally. Emigration may be the only rational alternative if their skills are to be fully utilised (Skeldon 2005).

Some numbers

The WHO 2006 World Health Report, which was dedicated to the subject of the health workforce, estimated a global shortage of almost 4.3 million physicians, midwives, nurses and support workers.[8] As noted above, the health workers who *are* active are distributed unevenly. In Europe, for example, the average ratio of nurses per inhabitant is 10 times that of Africa and South East Asia (Buchan and Calman 2004). Table 1, p17, lists the numbers and proportions of medical doctors and nurses working in the Organisation for Economic Co-Operation and Development (OECD) countries who were trained abroad.

6 For example, 14% for foreign-born versus 9% for native-born health professionals in 27 EU countries work more than 41 hours per week. Proportions of those who regularly work at night are 40% for foreign-born versus 26% for native-born. And 47% of the foreign-born usually work on Sundays versus 35% of the native-born (Dumont and Zurn 2007). Examples of exploitation of migrant health professionals — as of other migrant workers — of course exist, but exploitation cannot be blamed for all such differences. Physicians and nurses who have sought employment abroad in order to improve their economic wellbeing may be only too happy to work long hours, especially since they are away from their families and friends.

7 Structural adjustment policies have had major effects on the development of human resources for health since in some countries conditions for loans led to the lay-off of human resources including health staff, as well as to freezing of positions and non-recruitment of new personnel in the civil service (Labonte et al. 2006).

8 There has also been an increase in the movement of other health care professionals such as pharmacists, physiotherapists, health administrators, biomedical researchers, and other groups involved in the health care systems (Marchal and Kegels 2003). A 2006 study of international migration of pharmacists (International Pharmaceutical Federation 2006) reveals the same issues and patterns as those concerning other health workers (lack of data, and severe country- and regional-level imbalances in personnel available) but such studies are rare. In general, statistics and information on the mobility patterns of health care workers other than physicians or nurses is still lacking in the literature on human resources for health.

TABLE 1: DOCTORS AND NURSES TRAINED ABROAD WORKING IN OECD COUNTRIES

	Doctors trained abroad		Nurses trained abroad	
OECD country	**Number**	**% of total**	**Number**	**% of total**
Australia	11,122	21	NA	NA
Canada	13,620	23	19,061	6
Finland	1,003	9	140	0
France	11,269	6	NA	NA
Germany	17,318	6	26,284	3
Ireland	NA	NA	8,758	14
New Zealand	2,832	34	10,616	21
Portugal	1,258	4	NA	NA
United Kingdom	69,813	33	65,000	10
United States	213,331	27	99,456	5

NA = not applicable
Source: World Health Organization 2006b, p 98.

As Table 1 shows, physicians who were trained abroad account for a third to a quarter of those working in Canada, Australia, the United States, United Kingdom and New Zealand. The proportion of nurses trained abroad are less, ranging from 21% in New Zealand to 14% in Ireland, 10% in the United Kingdom, 6% in Canada and 5% in the United States.[9] As for source regions, physicians trained in sub-Saharan Africa and working in OECD countries represent close to a quarter (23%) of the current physician workforce in the source countries, although in proportions that vary widely (World Health Organization 2006b).[10] Nurses and midwives trained in **sub-Saharan Africa** and working in OECD countries represent some 5% of the total nurse workforce in the source countries, but, again, in proportions that vary, from almost none in some countries, to up to 34% in Zimbabwe, 18% in Lesotho and 13% in Ghana (World Health Organization 2006b). In 2000, over 50% of the nurses from Liberia (67%), Mauritius (50%) and Sierra Leone (56%) were working abroad (Dumont and Zurn 2007) (a table listing expatriation rates for physicians and nurses, circa 2000, can be found in Appendix 2).

The potential negative impact of migration on health resources in Africa is exemplified by the case of Zimbabwe, where massive inflation, social turmoil and drastic worsening of conditions in what had formerly been some of the region's best health facilities have pushed numerous health professionals to leave the country. Between 1997 and 2001, Zimbabwe is thought to have lost roughly 20% of its nurses (Awases et al. 2004). While the absolute numbers may not be large, in cases such as this, the outflows can be fatal for disadvantaged people in the source countries. The 382 nurses who migrated from Zimbabwe to the United Kingdom in 2001 increased the UK nursing stock by 0.1%, but the loss to Zimbabwe's nursing stock was 40 times greater in percentage terms (Buchan, Parkin and Sochalski 2003). Similarly, Ghana's loss of 382 nurses through international migration in 1999 was equivalent to 100% of the annual output of its nursing schools (Padarath et al. 2003). Predictions for the future for sub-Sahara Africa are not optimistic. A study carried out by the WHO regional office for Africa found that between 26% and 68% of the health care professionals interviewed in six African countries indicated an intention to emigrate (Awases, Gbary, Nyoni and Chutora 2004).

Although Africa is arguably the continent most affected by such losses, it is not alone. The **Asian** country most discussed in relation to nurse migration is the Philippines, which actively supports the mobility of its citizens, of whom an estimated 7.3 million are working abroad. A significant proportion of these workers are nurses. It is estimated that 70% of nurse graduates in the Philippines have 'travelled on' to other countries in recent years (Redfoot and Houser

9 For detailed examination of the rapidly-shifting numbers of nurses abroad see (Aiken et al. 2004; Buchan, Parkin and Sochalski 2003; Kingma 2007).

10 More than 23% of America's physicians (771,491) received their medical training outside the USA, the majority (64%) in low-income or lower middle-income countries. A total of 5,334 physicians from sub-Saharan Africa are among that group, a number that represents more than 6% of the physicians practicing in sub-Saharan Africa. Nearly 86% of these Africans practicing in the USA originate from only three countries: Nigeria, South Africa and Ghana. Furthermore 79% were trained at only 10 medical schools (Hagopian et al. 2004).

2005) and that more than 15,000 nurses leave the country each year (Bach 2006). India and Korea also export nurses and there are said to be more Bangladeshi nurses in the Middle East than in Bangladesh (Woodward et al, 2002, cited in Kingma 2006).

As for **the Caribbean**, where circular migration is part of the regional development process (Potter, Conway and Phillips 2005), aggressive international recruitment by the United States, Canada, the United Kingdom and other countries has given rise to a dramatic loss of nurses (Yan 2006). Over 50% of the nurses from several countries were working abroad in 2000 (Antigua and Barbuda 74%; Barbados 78%; Belize 82%; Dominica 66%; Grenada 88%; Guyana 81%; Haiti 94%; Jamaica 88%; Saint Kitts and Nevis 77%; Saint Vincent and the Grenadines 82%; Trinidad and Tobago 73%) (Dumont and Zurn 2007).

In **Latin America,** the movement of nurses echoes the migration patterns of other workers, taking place northward from Mexico and Central American countries towards the United States, within Latin American countries and overseas towards Spain and Italy (Malvárez and Agudelo 2005). For example, nurses from Ecuador migrate to Chile (Velasco and Granada 2002, cited in Malvárez and Agudelo 2005), where jobs in the public sector are becoming available to migrant workers because increased numbers of Chilean health professionals are moving out of municipal employment and into the private sector (Van Eyck 2004, cited in Bach 2006).

In **Pacific** countries the migration of health workers is greatest in Fiji, where 56% of the country's nurses were working abroad in 2000, and also in Samoa (62% of the nurses working abroad), Tonga (58%), Micronesia, Papua New Guinea and Polynesia, with the main destinations being Australia and New Zealand (see table in Appendix 2 for expatriation rates for physicians and nurses circa 2000).

Some comments on the numbers

The loss of health workers may have serious repercussions for sending countries, when, for example, the exodus of health workers starts a downward spiral. With fewer health workers, disease prevalence rises, and as prevalence rises so does the need for more health workers (World Health Organization 2006b). In health facilities already faced with staff shortages and unfilled vacancies, the migration of existing staff adds to the workload of those who remain, increasing their caseloads and leading to fatigue, loss of motivation and eventual burnout. These pressures provide an impetus for remaining workers to themselves migrate out, perpetuating the vicious spiral (Joint Learning Initiative 2004).[11]

Not all sending countries are equally affected, however. The Joint Learning Initiative on Human Resources for Health classifies southern countries that export health workers into two types. Countries such as Cuba, India, Egypt and the Philippines are strategic exporters;[12] they purposefully export workers, including health personnel, to gain skills, earn foreign exchange, or fulfil humanitarian aims. In fact, in one of the rare studies to examine the specific effects of remittances from migrating health workers, it was found that nurses from Pacific Island states migrating to Australia were more likely to send remittances than were their co-nationals from non-nurse migrating households. In addition, in migrating households with nurses, the remittances were higher and the flow of remittances lasted over a longer period. The study concluded that, over time, the economic benefits of the remittances from nurses outweighed the human capital costs involved in nurse training in the countries studied (Connell and Brown 2004).

11 HIV and AIDS, in particular, are adding to complex and self-reinforcing negative influences on nursing personnel, especially in high prevalence countries. Heavy workloads fuel burnout and frustration. Fear of occupational exposure may be reducing entrants into the workforce as well as encouraging current members to leave. Infection among health workers themselves has resulted in significant illness and deaths among the very people tasked with assisting the general population to fight the epidemic (Buchan 2004; Simoens, Villeneuve and Hurst 2005). The resulting frustrations, fears and discouragement may well be adding to push factors that encourage some nurses to look for work abroad (Dovlo 2005).

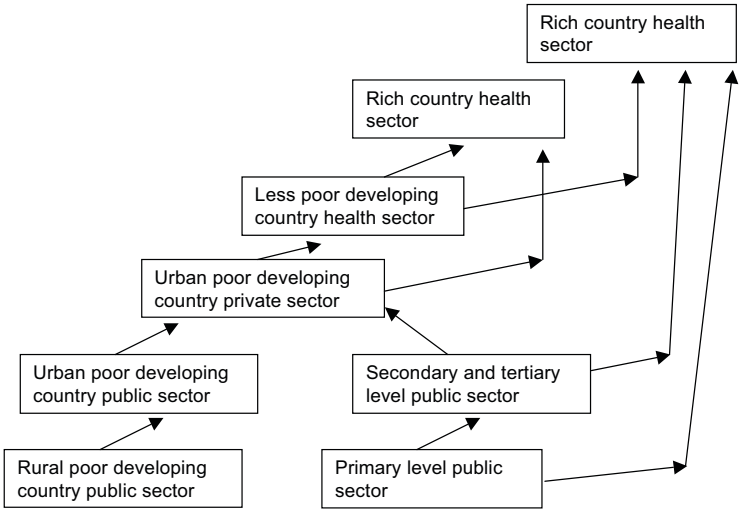
12 Some of the same countries are also beginning to import a certain health business. A global market in health care appears to be emerging with countries such as India, South Africa, Cuba, Costa Rica, Malaysia and Thailand promoting medical care for patients from overseas (Gent and Skeldon 2006) (see Box 5 on India).

Other countries, conversely, including many in Africa, the Caribbean and Asia, are unwilling exporters, whose migratory streams are not necessarily supported by national health policy. Out-migration in these countries is driven by global labour market forces. The Joint Learning Initiative on Human Resources for Health points out that in some of these countries, ministries of finance and planning may in fact be in conflict with health ministries over the loss of health workers: the former encourage nationals to migrate for the remittances they will send back, whereas the latter are concerned about effects on national services when large numbers of health professionals migrate.

Furthermore, the data on overall migrant stocks just discussed masks complex patterns, both within countries and between countries. Migration of health workers from rural to urban areas within a country occurs in both developing and developed countries, and may also affect the distribution and availability of human resources in the health sector.[13] Significant migration may also take place to other sectors within countries, for example, from the public sector to private facilities, such as for-profit or faith-based hospitals, or to international and development aid organisations. As just one example, health professionals in southern Africa who join the staffs of international agencies can expect to double their income (Huddart et al. 2003, cited by Dovlo and Martineau 2004). And, of course, in both developing and developed countries, in yet another very significant form of mobility, health personnel may leave the health work force altogether.

Data on 'stocks' of health workers in any particular country also hide considerable sub-regional and inter-regional movement between countries. Although South-North migration of health professionals is often discussed, international migration of health workers occurs in dizzying patterns in all regions in the world: North-North, South-South, North-South and East-West. Many countries are both points of origin and destination. India, for example, is a source of supply of foreign physicians in the United Kingdom, United States, Australia and Canada. However, physicians in the United Kingdom also migrate to Australia and Canada. South Africa is a major source of physicians for the United Kingdom and Canada[14] whereas, in Canada, significant numbers of health workers have migrated to the United States[15] (WHO data presented by Skeldon 2005).

FIGURE 2: PATTERN OF MOVEMENT AND MIGRATION OF HEALTH PERSONNEL



Source: Padarath, Chamberlain, McCoy, Ntuli, Rowson and Loewenson 2003.

13 In Ghana, for example, just over a third (35%) of all public sector health staff are to be found in just two teaching hospitals located in the two main cities (Dovlo and Martineau 2004).

14 In the province of Saskatchewan, for example, at least 17% of the physicians were recruited from South Africa (Martineau et al. 2004). See also Buchan 2004; Labonte, Packer, Klassen, Kazanjian, Adalikwu, Crush, McIntosh, Schrecker, Walker and Zakus 2006; Labonte, Packer, and Klassen 2006 for detailed discussions of migration of health professionals from sub-Sahara Africa to Canada.

15 It should also be noted that out-migration is not the most significant cause of shortages of health professionals in developed countries. Such shortages are the result of past policy decisions that have led to underinvestment in health human resource development and a failure to recruit and retain adequate numbers locally (Labonte, Packer, Klassen, Kazanjian, Adalikwu, Crush, McIntosh, Schrecker, Walker and Zakus 2006). Additional reasons for the scarcity of health care workers in all countries are intensity of work, difficult working conditions and high levels of responsibility coupled with inadequate remuneration. These factors lead to low entry levels into and high exit rates from health professions.

Figure 2 depicts the overall movement of health personnel. Health worker migration starts with internal mobility from rural to urban areas or from the public to the private sector, then moves to countries of increasing levels of development. The pattern may reflect the movement of one individual who successively moves on, or of several workers, each replacing someone who has left. The United States, 'the epicentre of international migration' (Kingma 2006, p183), is often the final destination country of health professionals who have worked for a time in other countries, and is the only net receiver of physicians and nurses via-à-vis all other countries in the world — about half of the foreign-born physicians or nurses working in OECD countries are located in the United States, 40% are in Europe, and the remainder in Australia and Canada (Dumont and Zurn 2007). Finally, there are significant problems with the data concerning migration of health professionals, as outlined next in Box 3.

Box 3: Problems with data concerning migration of health professionals

Understanding the phenomenon of migration of health professionals in general and of nurses in specific requires documenting migration flows in terms of:

- The numbers of migrants
- The direction of flows
- The characteristics of the migration (temporary or permanent)
- The socio-demographic characteristics of the migrants themselves (Dovlo and Martineau 2004).

There are difficulties in each of these realms. The relevant data is collected from several different sources, which were established for different purposes, thus making comparison extremely difficult. The difficulties include:

For the sending country

- When health personnel resign, there is no formal way of recording their destination;
- Staff who leave may not actually resign but just take an extended leave of absence, or simply abscond without giving notice;
- Internal migration is poorly tracked;
- Poor management also contributes to the difficulty of tracking staff movements as data may simply not be recorded, or not recorded in a timely way.

For the receiving country

- Migration data kept by receiving countries may not capture sufficient detail about socio-demographic characteristics, so that it is difficult to define information about entering health workers.
- Data on stocks of international registrants does not reveal the direction or destination of flows, or whether they are permanent, temporary or short term.
- Most of the data comes from professional registration, but such sources can only serve as a proxy.
- Registration caries across countries: the organisations involved differ, registration might be at national or regional level, different registration statuses exist across countries (full, temporary, limited, provisional, conditional, internship, etc.) and information systems may also vary across countries depending on the level of centralisation.
- Different sources vary in the way they define 'foreign' nurses. In some instances, these are 'foreign born', in others they are 'foreign educated'. [16] Comparisons between counties can thus be confusing and/or misleading.
- Someone who is registered is not necessarily employed, or employed in the country in which he or she is registered.
- Exiting staff are much more difficult to track than are entering staff.
- Most of the information that is available concerns physicians and nurses; there is relatively little information on other health professionals who migrate.

(Diallo 2004; Dovlo and Martineau 2004; Dumont and Zurn 2007).

Numbers and difficulties aside, we now turn to the reasons nurses may migrate in the first place before discussing return migration.

16 A 'foreign-born' nurse may be an immigrant who grew up and was educated in his country of adoption. A 'foreign-educated' nurse may have been specifically recruited from abroad to work as a nurse. The implications for health human resources are quite different information concerning foreign-born nurses usually comes from census data. That about foreign-educated from registration data.

Push and pull factors behind nurse migration

Dovlo and Martineau (2004) put the classical 'push' and 'pull' factor discussion of migration in terms of gradients as far as health professionals are concerned. Inter-regional differences in the following may create a push for a nurse or a physician to migrate from one country, and/or a pull to migrate to another country:

- Income (differences in salaries and living conditions between home and target country). This includes differences in housing, and in education opportunities for family (Marchal and Kegels 2003).
- Job satisfaction (perceptions of good working environment, and of whether it is possible to best utilise one's technical and professional skills).
- Organisational environment and career opportunity (differences in opportunities for professional education and for advancement).
- Governance (general political governance, as well as differences in administrative bureaucracy, and in the efficiency and fairness with which government services are managed).
- Protection and risk (differences in how safe it is to live and work in a particular place, including levels of crime and risk at the workplace).
- Social security and benefits (differences in availability of health insurance, unemployment protection, fair retirement benefits, etc.).

One important motivation for many nurses to work abroad should be added to the above: this is a sense of adventure, or desire to travel and to 'see the world' (Allan and Larsen 2003; see Box 4, p22, on a typology of nurse migration).

In addition to the classic 'push' and 'pull' factors, the Network on Equity in Health in Southern Africa adds 'stick' and 'stay' influences. 'Stick factors' keep people at home — they must be overcome before an individual becomes willing to migrate. Factors that help retain health workers in source countries include family ties, psychosocial links, the expense of migration, language and other social and cultural factors. Work-related factors may also serve as 'stick factors' encouraging people to study rather than to migrate. Examples include such intangibles as high levels of morale that give workers the feeling they are able to effectively deliver good quality care, or a perception of being valued by society, as well as more tangible rewards and incentives (Padarath, Chamberlain, McCoy, Ntuli, Rowson and Loewenson 2003). At the destination end of the migration continuum, 'stay' factors are those that operate in favour of health workers' decisions to remain in recipient countries rather than to return to their country of origin. These include reluctance to disrupt family life and schooling, lack of good professional employment opportunities in the home country, and a higher standard of living in the recipient country. An additional 'stay factor' might simply be that health workers abroad are unaware of job opportunities in their countries of origin (Padarath, Chamberlain, McCoy, Ntuli, Rowson and Loewenson 2003). Another way of seeing nurse migration, specifically (although the typology might well be applied to a range of other professionals who may migrate), is presented next in Box 4.

Box 4: A typology of nurse migration

In her book on nurse migration, Kingma (2006) discusses the various motivations behind the migration of nurses. An important motivation is undoubtedly financial. The **economic migrant** is attracted by a better standard of living or by the possibility of providing additional income for her family. In countries with significant unemployment of nurses, such as India, working abroad may in fact be the only way to meet financial needs. The **quality of life migrant** is more interested in questions of safety and well-being. Such nurse migrants are less motivated by differences in salary or benefits and more concerned about such issues as crime rates or the status of women. The **career move migrant** is motivated by the enhanced professional opportunities that are more available abroad than at home, for herself or for her family. The **survival migrant**, in contrast, is trying to escape a situation of political oppression or armed conflict. Nurses may be able to find work abroad and thus not need to apply for political asylum, but the situation of such nurse migrants is often more critical than that generally associated with the economic migrant. The **partner migrant**, a category rarely discussed in and of itself in the labour migration literature, is particularly important in a female-dominated profession. Many women (and some men) migrate to follow partners whose work has taken them to a different country. Many of these may later find employment in the destination country. The **adventurer migrant** is also a neglected category. The adventurer uses nursing qualifications to finance travel abroad; travel which may end up taking her to several countries and last for years. The main motivation is to have new experiences and to visit unfamiliar places. Closely related are the **holiday worker** (usually a recent graduate or young professional who wants to acquire new knowledge and experience while exploring unfamiliar cultures and broadening personal horizons) and the **contract worker** (who goes abroad for a predefined short period of time to earn additional income or improve job prospects in the home country).

A particular nurse envisaging migration may well have a mixture of several motivations. An example, that is frequently exploited by recruiters, is a wish for adventure thatoften gives the final push to many whose motivation is essentially economic.

3. Return of skilled migrants

Skipping the very significant phase during which nurses and other skilled migrants are working in foreign countries, which could well be the focus of a monograph of its own, we now move to what is known about return migration.

Attention is beginning to be paid to the return migration of qualified professionals. As noted previously, overall numbers of return migrants are hard to come by and information concerning the specific socio-demographic characteristics of return migrants — such as their profession — is even more difficult to obtain, but studies are nevertheless beginning to focus on the sub-group of skilled (or in some studies 'elite') migrants. One example, concerning the return of physicians to India, is given following in Box 5.

Box 5: Return Migration and Diaspora Investments in the Indian Health Care Industry

Physicians may be beginning to return to India, in particular to work in new private hospitals that provide care which meets international standards. A series of in-depth interviews carried out with physicians, entrepreneurs, venture capitalists, government ministries and academics (Ganguly 2003) helps shed light on the phenomenon.

The reasons the physicians gave for their return were quite mixed. Family-related reasons predominated (especially going home to care for elderly parents and wanting to have their children brought up with Indian socio-cultural influences), followed by issues of discrimination abroad and a desire to serve the country. Returnees said that in fact they had always wanted to go back to India, but had been held back by the infrastructure, technology and systems — they would not have been able to practice medicine the way they had learned abroad. The rise of the corporate health care industry has removed some of these constraints, allowing returning physicians to practice even rare specialisations in the private hospitals. In turn, the availability of highly specialised care (ocular oncology was one example given in Ganguly's study) helped attract domestic and international patients. In addition, the hospitals were able to financially assist physicians immediately after their return. Such assistance helped smooth over the difficulties of getting established in medical practice at home, a problem for the younger returnees who had not had time to acquire capital abroad.

The physician entrepreneurs who had established their own institutes are particularly interesting. These were experienced physicians, returning after 10 to 20 years overseas. Many had been involved in academic medicine. These entrepreneurs all said that their motivation was to improve the state of medical practice in India. They used their own personal savings to establish the hospitals, as well as funds raised from overseas friends and colleagues, notably from overseas Indians. The hospitals they founded emphasise professional management; creation of medical knowledge (eg, by establishing libraries, holding clinical meetings, setting up training and fellowship programmes); and in particular improving community health. Inpatient and outpatient facilities have been earmarked for the poor and rural outreach programmes have been created. Paying patients often help support non-paying patients. Patients for these new hospitals are mainly domestic, with some additional patients from the Gulf, Bangladesh, Nepal and other surrounding countries. They are attracted by the hospital's reputation for providing affordable treatment that meets international standards.

Although the process is just beginning, the existence and success of such institutions is inclined to change the character of medical practice in India. It is also, in a relatively immediate term, liable to create jobs for nurses who may wish to return to their home countries and to give care similar to that which they had been giving abroad.

Another example is the study of Iredale, Rozario and Guo, which focused on people with an overseas university degree and on business migrants (people already in business overseas or who were intending to establish a business at home). The study took place in four Asian countries of different levels of development (Bangladesh, Mainland China, Taiwan and Vietnam) as well as amongst potential or intending returnees in Australia. The authors noted that, with a few exceptions (such as the Grameen bank, which was started by a return migrant) individual returnees do not usually 'drive' social change but that, on the other hand, skilled migrants start to return following change in their countries of origin. Stated the other way around, unless there is overall development or social transformation at home, skilled and business emigrants are reluctant to return.

In their study, Iredale et al. observed that the stronger the economic growth and the more 'globalised' the economy, the greater the rate of return migration. Skilled emigrants who wished to be professionally active were reluctant to drop out of the loop by going home to a less dynamic environment. Conversely, for those migrants who returned and

felt hampered by overly bureaucratic environments, poor equipment and working conditions, there was a level of frustration that may lead to re-migration in the future. In discussing the factors that were important in their decision to go back to their home countries, the returnees participating in the study highlighted the importance of the overall context and infrastructure within the country, the level of democracy, policies to improve civil society, environmental amenity, security and basic services such as health and education. As one emigrant commented about a home country much less developed than the destination country: "there's no way we can go back now, what will happen to our children?"

Iredale and her colleagues noted that governments have a critical role in facilitating return migration; in fact they observed that a government's role is as important as the economic, social and political environment of the country. Such mechanisms as centres of excellence, for example, may start the process, acting as 'meccas' for attracting skilled professional and business people to the country, including returnees. Other government-sponsored mechanisms for encouraging return are discussed below.

Return of nurses

There is very little data on return migration of nurses to or from developing and developed countries, except what may be gathered anecdotally from pilot programmes organised for the return of professionals, such as the MIDA and TOKTEN programmes illustrated on page 31. Some nurses are known to have returned independently to strengthen capacity in their home countries, but such migration has not been specifically studied, or even formally documented. In the absence of hard data and of studies specifically examining the return migration of nurses, some of the scattered bits that are available may help shed some indirect light. For example, it has been observed that:

In general, some 50% of skilled workers return to their countries of origin (Lowell and Findlay 2002), usually after about five years.

- The rate of return of nurses in general is higher than that of physicians (Padarath, Chamberlain, McCoy, Ntuli, Rowson and Loewenson 2003).
- Except for a return for retirement, the longer a person stays abroad the harder it is to return (King 2000).
- Return migration is more likely to take place if spouses, children or dependents have been left behind in the home country (Kingma 2006).
- Return migration may be individual, or facilitated by an assisted voluntary return programme, or by a bilateral agreement. Return is greatly facilitated when frameworks are in place and links through diaspora networks can also make the return process considerably easier (Martin 2003).
- A sense of change, particularly change for the better, is critical if return migration is to occur. If the economic and political conditions that encouraged migration in the first place have not changed, then there is little impetus to return.
- The propensity of migrants to become actors of change and development at home will depend on the extent to which they have been able to prepare. Successful preparation for return requires time, mobilisation of tangible and intangible resources, and willingness on the part of the migrant. This preparedness can be shaped by public programmes promoted by the governments of countries of origin and aimed at repatriating skilled and business returnees (Cassarino 2004).

We can only assume that, as working hypotheses, these general observations about skilled workers will also apply to nurses. We do know that many nurses are interested in returning to their home countries. Concerning health workers in Africa, for example, and according to a survey conducted by Africa Recruit, 70% of the nurses asked were interested in returning permanently, and fully 95% said they would envisage a temporary return (Save the Children 2006). Concerning overseas nurses working in Europe, Buchan et al. (2005) noted that among international nurses in the UK, 85% planned to return to their countries of origin within five years.[17]

17 Nurses from Africa and India were more likely to stay longer; those from Australia, New Zealand and South Africa were planning to return home; and those from Philippines were planning to move on to the USA.

As for putting such plans into action, the UK register of 1995 reported that more than half of foreign nurses stayed less than three years, and that some 85% of departures occurred within four years of entry to the UK. Those remaining after four years were more likely to become permanent emigrants (Buchan and O'May 1999, cited in Padarath et al, 2003). For the specific case of South Africa, where return migration of nurses is facilitated by a memorandum of understanding with the United Kingdom, press reports appearing at the beginning of 2007 about return of South African nurses are optimistic (one such report appears next in Box 6), although as of the end of 2007 no overall data was yet available concerning the numbers of nurses actually returning to South Africa.

Box 6: Return of nurses to South Africa (from Pretoria News, January 2007)

The grass is not greener on the other side, as South Africa's health professionals have learned. They are now coming back in droves. Lured by huge salaries, they left frustrated Health Minister Manto Tshabalala-Msimang with vacant posts to fill.

Professional nurses in the country earn R8 000 to R18 000, according to Denosa, a nursing organisation, and about £2 500 in London, which amounts to R30 000. The good news is that health professionals' organisations are inundated with requests from practitioners who left the country to work overseas, to help them come back. This will help ease the problem of staff shortages in hospitals and clinics. Sources who wished to remain anonymous said that currently over 40% of posts in clinics and hospitals were vacant. "Many are desperate to come home, but they have been sending money home and do not have cash. They live in terrible conditions. Sometimes 10 nurses share five single beds in tiny rooms. They also do not have the luxury to quit their jobs overseas and start looking for work here. They are living a month away from bankruptcy," said Eileen Brannigan, Netcare group nursing director. Brannigan said South African doctors and nurses overseas also feared rejection because many of their colleagues had criticised them for leaving and they said they were deskilled as they were doing work that they were over-qualified for.

The Netcare group, which also has a 20% shortage of nurses in its wards and 40% in its intensive care units, has as a result joined hands with the Homecoming Revolution for the Woza Ekhaya campaign, to help the professionals return home. "We have seen over 100 nurses. Some will start working this month and we are still interviewing," she said. The Netcare Group will offer nurses a refresher course and a sign-on bonus. "We had to give others their bonuses in advance so they could buy their air tickets," said Brannigan.

Mpho Manana is one of the nurses enjoying the fruits of the Woza Ekhaya campaign. She is working at the Union Hospital in Alberton. "I cannot say I have gained any experience in London. South Africa has very high nursing standards but we were all treated like newly-qualified nurses because we did not train in Britain," she said. One doctor — who wants to remain anonymous — worked in London for two years and is now employed at the Johannesburg Hospital. She said she had no intentions of staying in the UK. "I left because of the pressure to pay off my student loan," she said. One had to understand, she continued, that a lot of doctors only wanted to work in the UK for five years so they could get British citizenship and others — especially whites — were despondent about South Africa or wanted to travel. "Travelling from South Africa to Greece will cost you an arm and a leg. It is much cheaper if you earn pounds, but life in the UK is very expensive. It's fine to work there and live a frugal life because you are sending money back home. But if you spend your money in Britain, that pound does not go as far. Your average doctor cannot afford a housekeeper. Also, the weather is so miserable and at a petrol station you have to get out of the car and pour your own petrol." She added that many loved South Africa for its sunshine and its lifestyle.

Other nurses have appealed to the South African Nursing Council to help them cancel their overseas contracts, said a spokesperson who refused to give her name. "They complained about being discriminated against and the stringent laws under which they have to work," she said.

Nurses returning to SA in droves' originally published in the **Pretoria News, January 13, 2007,** http://www.queensu.ca/samp/migrationnews/article.php?Mig_News_ID=4362&Mig_News_Issue=25&Mig_News_Cat=8

As for other continents, as of the early 2000s Irish trained nurses were know to be returning to Ireland with the economic boom in that country, but, at the time of writing, numbers of returnees are not yet available, nor have the push and pull factors surrounding their return, or the processes of their adaptation, been specifically studied.

For the Pacific Island nations, Tonga, in particular, is experiencing a return of nurses who had been working in Australia (Brown and Connell 2004). Indeed, Brown and Connell suggest that in situations where opportunities for domestic employment and income may be limited, such as those of the Island states they have been studying, individuals may deliberately choose nursing as a career precisely because of the migration opportunities it offers. Nurses send regular remittances while working abroad, and return home once their goals have been achieved (Brown and Connell 2006). Nurses returning to the Philippines after having worked abroad give family reasons as their predominant motivation (Joyce and Hunt 1982; Lorenzo et al. 2007).

This review found no studies have examined the process of return migration to or from Canada, or from the United States. And, with the exception of the study of return migrants to the Caribbean described next in Box 7, little is known about return migration of nurses to Latin America.

Box 7: Nurse return migration in Jamaica

Brown (1997) has carried out one of the rare studies to specifically focus on nurse return migration. He compared Jamaican nurses who had gone abroad to work and then returned, with Jamaican nurses living and working in the United States, with another group of nurses working in two hospitals in Jamaica and finally with a group of trainees. Nurses reported that their motivations for going abroad to work were mainly financial (51%), as well as having family abroad (30%), and professional (19%). Motivations to return to Jamaica were mainly for family and also for love of their country (24%). Nurses with higher socioeconomic status were more disposed to return home.

The study found much evidence of circular migration, with a large number of nurses living in Jamaica regularly travelling abroad to work. Most of the returnees had gone abroad to work several times. Almost a third of those working in the US said they intended to return to Jamaica. They maintained strong links with the home country: 80% had returned for visits since they emigrated, 70% provided support for relatives other than children in Jamaica and 33% owned a home there.

Most of the nurses living abroad had not been particularly attracted by the American lifestyle, instead expressing a strong sense of belonging and love for their home country. They usually went abroad expecting to acquire material goods and, indeed, were significantly financially better off after having done so. The percentage of those who owned a home moved from 40% to 70%, for example, and the proportion who owned a motor vehicle rose from 37% to 63%. Meeting their goals in working abroad usually took longer than expected, however. Worse, having acquired a home, automobile and some savings, nurses reported that government regulations and oppressive taxation prevented them from bringing their possessions back to Jamaica. Brown remarks that, thus, frustrated and demoralised professionals frequently decide to return to live abroad.

Of the returnees, 67% returned to bedside nursing. Those who left nursing, who unfortunately were among the most highly qualified, said they had done so because of poor salary, bad working conditions, decline in professionalism and lack of appreciation by officials. Brown commented that at the time the study was being carried out the Government of Jamaica was attempting to meet the country's shortage of nurses by increasing training, but that since working conditions had not improved the new trainees would find the same conditions as those that made their colleagues migrate in the first place. These included inadequate salary, poor working conditions, difficulty with transportation to and from work, lack of affordable housing, insufficient opportunities for further training and shortage of medical equipment. Indeed, approximately a third of the nurses in training said they intended to migrate at the end of their training. The lack of nursing personnel meant that newly trained nurses were thrust into positions of responsibility for which they were not adequately prepared and for which they would not receive adequate supervision. Many of the more experiences nurses who might have supervised them had migrated to the United States.

Brown remarked that at the time, the shortage of nurses had not yet affected health care in Jamaica, since it had been compensated for by physicians filling the gap and by the fact that fewer patients were admitted to the hospitals. (Brown 1997). Neither, clearly, can be economical or sustainable solutions.

Overall, the literature contains a number of variants on the theme of professional success and its positive or negative effect on return. Some nurses have gone abroad with a specific aim in mind, such as professional or economic advancement. They return to their home countries when they have met their goals, presumably satisfied. The situation for others is far less happy. The 'return of failure' described above is far less likely to be admitted, but it concerns nurses who will have been unable to adapt to working or living conditions in the host country. It should be noted that, in some instances, the situation to which a nurse has been asked to adapt is in fact extremely difficult. Among

other reasons, failure to adapt may be due to unsatisfactory working conditions at destination, exploitation, racism or xenophobia (see Kingma 2006, and Allan and Larsen 2003 for excellent discussions of work-related discrimination and harassment of nurses working in foreign countries). In addition, as illustrated next in Box 8 on deskilling, nurses working abroad may not be able to exercise their skills at the level for which they were trained.

Box 8: Migrant nurses and elder care

In developed countries, aging of populations, combined with a shortage of local caregivers, is leading to the importation of people to provide long-term care for the elderly. In the United Kingdom, for example, while only 5% of UK-trained white nurses work in private nursing homes, where the work has relatively lower status and salaries are substantially lower, 14% of foreign trained nurses do so. Nurses who were first qualified overseas are twice as likely to work in "older people's nursing" than are those who were first qualified in the UK — 27% compared to 13% (Royal College of Nursing 2002, cited in Redfoot and Houser).

Levels of education are unusually high among migrant nurses working in long-term care facilities in the UK. While only about 30% of UK-born aides have some college education, 70% of aides from the Philippines and 50% of aides from Africa have been to college (Redfoot and Houser 2005). Some experts feel that the pool of nurses available to work in long-term care in the UK is increased by the registration procedures. The vast majority of foreign nurses and midwives who apply for registry are accepted only after a "period of adaptation" (Nursing and Midwifery Council 2005, cited in Redfoot and Houser). During this adaptation period, trained nurses often work as carers in homes for older people. Many international nurses report feeling that the adaptation period is arbitrary and exploitative since they are asked to perform many of the functions of a nurse but are not paid at that level (Allan and Larsen 2003).

Similarly, in Australia, a study by Hawthorne (2001) found that overseas nurses actively recruited to compensate for Australian nurses who go overseas to work or who leave the profession for other reasons experience difficulties actually entering the profession. In particular, those from non English-speaking countries often find themselves consigned to sub-professional employment or even temporary labour market withdrawal. Barriers at the time the study was carried out included unfair biases in screening of pre-migration qualifications and language testing that also barred nurses from taking courses that would have helped them qualify more quickly. Those who did not speak English also experienced barriers to professional advancement once they did qualify, resulting in significant and persistent labour market segmentation, with East European and non-Commonwealth Asian nurses disproportionately concentrated in the stigmatised geriatric care sector (Hawthorne 2001).

Concerning private care, an informal business exists to help people who have entered countries as tourists find employment in the informal sector (Salt 2001). Such tourist workers serve as an undocumented, cheap and dispensable labour force, especially for personal services such as care of children, the elderly and the handicapped. It is difficult indeed to estimate how many nurses may be working in such jobs in developed countries, but the numbers may be substantial. Given a choice, it would be natural for a family looking for someone to care for a child or a grandparent to prefer a caregiver with a high level of training. But since they are undocumented and working in private settings, such workers are unprotected, thus vulnerable to abuse and exploitation.

In all the cases described above the nurses who return to their home countries to work are likely to find that their professional qualifications have deteriorated rather than increased while they were abroad.

Gender and family factors are highly pertinent in the return of nurses, the vast majority of whom are female. Women's decisions to return to their countries of origin are very often linked to those of their partners. Independently of their own careers, they return once the family is financially stable or once the partner's professional goals have been met. Moving may cause a host of strains within families, particularly when dual careers are involved, although the transitions have been shown to be more successful — and even to strengthen families — when the potential difficulties have been anticipated, acknowledged and talked through (Haour-Knipe 2001). A family's decision to return is often highly influenced by the ages and educational level of the children. Families with younger children may be afraid their children will have difficulty integrating in a 'home' country they barely know. For those with grown children, return may be difficult for parents whose children have established careers and their own families in destination countries and wish to remain (Ray, Lowell, and Spencer 2006).

Other difficulties come not from the individual or the family level, but at the level of policies. Migrants are often unable to transfer the social capital they have accumulated in the destination country (Ray, Lowell, and Spencer 2006). Nurses who leave public service positions and are refused leave without pay, in particular, may face serious problems when they return home. Although they have new skills, rather than being greeted with open arms, they find themselves in effect demoted to the bottom of the career ladder. They receive lower salaries, lose any accrued benefits and are denied prestige and professional recognition. "The return migrant's only reward may be a different form of the frustration and dissatisfaction that led them to leave in the first place." (Kingma 2006, p201). In fact, according to the nurses interviewed by Kingma for her book on nurse migration (2006), given the amount of concern expressed about nurses leaving, countries of origin are surprisingly reluctant to establish policies that would facilitate their return. Measures such as allowing nurses long-term leaves of absence from their places of employment, or acknowledging the professional accomplishments and advanced skills and knowledge acquired abroad, have specifically been avoided in the mistaken belief that their refusal will dissuade nurses from migrating. Kingma concludes that such policies — intended to discourage initial migration — will be an obstacle to nurses' return and thus ultimately prove counterproductive. A group of experts on migration of health professionals takes the argument a step further: they point out that governments may be reluctant to make special arrangements for people they see as having already benefited from going overseas. Indeed, governments may perceive those who migrated as having 'voted with their feet', their migration being an expression of objection to those in power. When those who are the most educated or discontented simply leave, emigration may be seen as a way to prevent government overthrow. Thus a government may not necessarily wish such migrants to return (Ray, Lowell and Spencer 2006).

Still other work-related difficulties for nurses who return may be caused by colleagues. Some returning nurses may discover that their co-workers are jealous, feeling that they have not had the same sorts of opportunities. Paradoxically, the very programmes meant to encourage return by giving special incentives may actually feed such jealousy, raising levels of resentment and frustration among those who stayed behind (Kingma 2006; Ray, Lowell and Spencer 2006). Finally, returning nurses may be unable to put their new skills to work because the technology and other resources required to do so are simply not available. In such a situation the returnee may leave the health service or go abroad again (see Box 7, p26, on Jamaica).

4. Current strategies to manage the migration of health workers

A number of strategies have been designed in an attempt to manage the migration of health workers. These include national directives, bilateral agreements and multilateral agreements. One of the first such agreements was established in 2001, when the Department of Health in England developed a code of practice for the recruitment of international health professionals to work in the National Health Service (Department of Health 2001). The code sets out the guiding principles to promote ethical recruitment of international health professionals. Since then, the UK has signed bilateral agreements with countries such as South Africa, Malawi and Ghana to manage the migration of health workers, as well as to encourage retention of health workers in their country of origin, and return.

At the level of multilateral agreements, the most often-cited example is that developed by the Commonwealth countries. The Commonwealth Code of Practice for the International Recruitment of Health Workers (Commonwealth Secretariat 2003a) upholds the right of health workers to migrate, while stressing transparency, fairness and mutuality of benefits. The instrument can be used to facilitate return migration; the section of mutuality of benefits between source and recipient countries, for example, suggests that recruiters consider repatriation of skilled health workers as one means of assisting source countries. The companion document to the Code further specifically suggests that as part of the recruitment package health professionals could be positively encouraged to return to their country of origin at the end of the contract period, for example, by the provision of air tickets and other incentives (Commonwealth Secretariat 2003b).

Various professional organisations, such as the International Council of Nurses (ICN 2001) and national nursing councils have also published position statements on ethical recruitment that can be applied to return. The Commonwealth Code of Conduct, in particular, has been the object of reviews in an attempt to formulate lessons learned (Buchan 2003; Martineau and Willetts 2006; Pagett and Padarath 2007). One of the major conclusions is that while such agreements provide essential normative guidance, the codes of conduct have not been as effective as had been hoped. One reason is that they are not legally binding. Another is that the codes are limited to the public sector: they cannot be enforced in relation to recruitment of health workers to the private sector, where in fact many migrant health workers are employed. Among the recommendations made for strengthening such codes are that the private sector and other relevant non-governmental stakeholders should be involved in the subsequent development of codes of conduct for international recruitment of nurses; that monitoring mechanisms should be put in place; and that — to return to the subject of this document — they be complemented by bilateral agreements between countries of origin and countries of destination to include the return of nurses. There has also been a call for a regulated recruitment process, for ethical hiring practices and for governments and employers faced with shortages to address the contributing factors, before aggressively recruiting nurses or students from other countries (ICN 2001).

Although governments will continue to play a leading role in developing and implementing policies and programmes for effective management of human resources, adequately addressing the economic, social and political dimensions of health workforce management will require a wide range of partnerships at national, regional and international levels. Innovative strategies to encourage health workers to return need to be explored in both source and receiving countries (Chen et al. 2004) and some positive examples do exist. The example of return of physicians to India was given in this document (see Box 5). Other examples are Thailand and Ireland, both of which have implemented reverse brain drain programmes by offering incentives, services and assistance to attract health professionals back to their home countries (Pang, Lansang and Haines 2002). In Africa, the New Partnership for Africa's Development (NEPAD) has recognised the significance of health worker migration for the continent's overall health strategy and committed to seeking international agreement on ethical recruitment of health professionals, while at the same time putting into place mechanisms to address adverse working conditions of health professionals (New Partnership for Africa's Development 2005). Private recruitment agencies are also beginning to facilitate the return of nurses, in collaboration with officials from countries of origin and destination and with international organisations (see Box 9, p30).

Box 9: The role of the diaspora

In 2006, the UK-based Africa Recruit Limited hosted a forum among health professionals in African diaspora and other relevant stakeholders. The forum recommended that the expertise and skills of professionals abroad be encouraged to support and strengthen national health systems, for example, by using consulates to develop databases of migrant health workers willing to return home to work. It was noted that many African nationals working abroad support their countries through individual initiatives and projects, and a great deal of emphasis was placed on the ways in which diaspora professionals might help their countries without necessarily committing to permanent physical return. The diaspora was advised to organise into structured and properly co-ordinated networks in order to be effectively heard by national governments and international donors (Save the Children 2006).

Diaspora organisations are a promising avenue through which migrant nurses may contribute to their countries of origin while abroad, and also facilitate return. Such associations of health workers abroad may be able to significantly contribute to programmes for developing health sector capacities, for example, by identifying, implementing and monitoring projects, Meyer and Brown (1999) set out some ground rules for helping scientific diasporas contribute to reversing brain drain.

- Such networks must ensure that members are mostly nationals of a particular country living abroad to work or study.
- Members must be highly skilled and active in a number of professional fields or conducting scientific research.
- The main purpose of such networks must be the economic and social development of the country of origin.
- There must be a degree of connection or linkage between network members and their counterparts in the country of origin.

A list of relevant diaspora networks can be found in Appendix 3 on page 49.

Two pilot programmes run by international organisations are currently focusing on short-term returns, but show promise for eventually helping nurses and other health professionals make longer returns home to work. These are described next in Box 10.

Box 10: Facilitating short-term return: two examples

TOKTEN

The **Transfer of Knowledge Through Expatriate Nationals (TOKTEN)** programme of the United Nations Development Programme (UNDP) facilitates the return of professionals in the diaspora for periods ranging from two weeks to three months (UN Volunteers 2007). The programme, initiated in 1977, is intended to help reverse brain drain in developing countries by using the services of highly qualified national expatriates, by transferring recent knowledge, technology and business and management practices to developing countries through national professionals (scientists, engineers, physicians, economists, environmentalists and business executives) and by using technical expertise and policy advice to promote institutional capacity building.

China, India, Iran, Lebanon, Mali, Palestine, Pakistan, Rwanda, Sudan and Turkey are among the countries that have utilised TOKTEN consultants for nursing and medical education. Volunteers have facilitated short courses for trainers currently working in the health system in their countries of origin. Some of the advantages of the approach are that the consultants' cultural and linguistic affinities — and their knowledge of the context and constraints operating in their home country — help greatly in identifying needs; the involvement of the consultants increases acceptance and cooperation among local staff; costs are low since the consultants volunteer their services;[18] consultants are usually talented professionals motivated by a desire to give something back to their countries; the programme does not require bureaucratic procedures and; its non-contractual nature allows it to have access to national expatriates with a minimum of legal complications. TOKTEN programmes are often multi-sectoral and have been effective in mobilizing resources for financing not only public but also private sector and civil society organisations.

MIDA

The International Organization for Migration's (IOM) **Migration for Development in Africa (MIDA)** initiative makes it possible for African professionals in Europe and North America to return to give short-term assistance and expertise in a number of fields, including health care. The initiative has facilitated the return of health workers and also supported hospital twinning and other diaspora activities in several African countries. One of the initiative's main aims is to promote strategic dialogue and cooperation between stakeholders, for example, by organising a meeting among representatives of NEPAD, the African Union, NGOs and UN agencies to discuss the implementation of government policies addressing the migration of health workers (International Organization for Migration 2007).

Other activities take place at country level. The Ghana MIDA Project, for example, has facilitated the transfer of diaspora skills and knowledge to Ghana through periodic, temporary and/or circular return. Over a two-year period, the 20 health workers participating in the project made a total of 25 temporary returns, giving them an opportunity to test the ground and to re-establish contacts in their home country. Twelve of the participants were physicians, five were nurses and three were non-clinical public health specialists, a balance that reflects the current human resource shortages in Ghana. The evaluation of this pilot project (Long and Mensah 2007) pulls out many lessons to be learned. Just one example is to proactively try to match volunteers with national human resource needs. In this instance, psychiatrists predominated amongst the volunteer physicians, whereas the most acute shortages among Ghanaian health professionals were in obstetrics and gynecology. The numbers of participants in this pilot project are still small, so it is difficult to measure the impact of the activities of the returned health workers, but there are some interesting 'knock on' effects that may not have been envisageable from the outset. For example, the diaspora physicians reported that they had become the cultural interpreters for various twinning and institutional projects. Returnees thus not only contribute directly, but may also serve as mediators. Diaspora-host relationships have been positive and the enthusiasm and motivation of participants has been remarkable. Several were willing to volunteer unpaid leave time — and even to take extended leave — as well as to contribute supplies, materials and equipment to colleagues in their home country. Several also wished to involve their children in activities contributing to the development of their country of origin.

Options for policy and practice

The final section of this review illustrates some options drawn from three reviews concerning other populations, but that could also be related to return migration of nurses.

18 The Palestinian programme demonstrated that an average TOKTEN consultancy costs around US$3,000 per month, roughly one-quarter as much as would be spent on an international expert.

The first series of options was proposed in an expert review related to migration of the highly skilled. Lowell and Findlay (2002) propose a number of policies that would protect the domestic labour markets of developed countries, while at the same time also protecting the economic interests of developing countries. These include:

- **Encouraging temporary stays:** In economic terms there are strong reasons for issuing work permits that will encourage return, especially to developing countries.
- **Making recruitment agencies and employers accountable:** Employers should agree to abide by a set of ethical guidelinesand international recruitment agencies should be accredited.
- **Establishing best practices on the employment of foreign workers:** Best practice guidelines or handbooks help protect both domestic and foreign workers.
- **Facilitating return migration:** Return migration may be facilitated through specific programmes, internet information exchanges and job databanks. Some migrants may envisage return more easily if they are allowed to retain the right to work in the future in their adopted country (adapted from Lowell and Findlay 2002).

Lowell and Findlay propose that bilateral and multilateral agreements are the most appropriate way to create harmonized expectations and movement of highly skilled persons from developing countries. Their review stresses that emigrants may serve as a significant resource for development, for example, through the investments and entrepreneurial efforts they create in their home countriesand through the sorts of expatriate organisations discussed in the previous section.

Concerning what may in fact be a very similar population, but from the point of view of a quite different employer, Salt (2001) suggests that lessons might be learned from the corporate sector. He points out that at the beginning of the present century transnational corporations in the UK alone were spending about $4.2 billion per year on moving their highly-skilled staff.[19] Throughout the world, companies are backing off from transferring staff, however, and instead moving towards combining physical movement with transmission of knowledge that does not require physical presence at the destination — moving the mind without the body. One way this can be done is by using information technology. Multinational companies are also developing a corpus of a highly-skilled internationally mobile elite personnel with very specialised skills who can be employed and deployed for limited periods on a sub-contractual basis (Ray, Lowell and Spencer 2006; Salt 2001).

A final set of recommendations comes from a review of the literature on circular migration. Agunias (2006) proposes a number of measures for attracting migrants to return, of which several are potentially quite relevant to nursing. Several of these are similar to measures proposed above, but some additional possible measures include:

- Offering material and non-material incentives such as salary top-up, subsidised mortgages, duty-free purchases, air fare, medical insurance and 'testing the waters' visits;
- Creating centres of excellence that will attract returnees;
- Maintaining a database to help returnees find jobs;
- Organising training exchanges and annual symposia for professionals abroad in order to build on the observation that professionals who maintain active contact are more likely to return to the home country;
- Promoting indirect measures, such as granting dual nationality and flexible residential rights;
- Re-introducing temporary worker schemes that acknowledge and correct the faults of previous such schemes. The main such fault is that migration meant to be temporary in fact often became permanent. New schemes must thus find ways to ensure that temporary migrants do indeed return through:

19 In comparison, the annual budget of the Office of the United Nations High Commissioner for Refugees at the time was around $625 million (Salt 2001).

- Carrots, such as longer contracts (one year is not enough), financial return incentives (transfer of pension benefits back to country of origin, preferential interest rates on savings lodged in approved home country accounts)and allowing multiple re-entries (migrants often overstay their visas partly out of fear they will not be able to come back again if they leave for a visit home);
- Sticks, such as financial penalties, mandatory savings schemes redeemable only on return and strict enforcement of laws (including fining employers for violations).

Agunias is careful to acknowledge that each of the above has potential disadvantages and limitations, but points out that the problem of disequilibrium in distribution of health human resources is too important not to try to find creative solutions. This brings us, quite naturally, to the conclusions that may be drawn from this review of return migration of nurses, and to defining some of the needs for policy, research and action.

5. Conclusions: Needs for policy, research and action

This document has highlighted two major shifts in current thinking about migration. Firstly, although migrants have always returned to their homelands for a variety of reasons, it is only recently that research and policy attention is beginning to be paid to the issue of return migration. Secondly, today's migration is increasingly being recognised as circular, and/or transnational. People move back and forth between countries of origin, transit and destination, return home, and then frequently migrate on again. Additionally, more and more migrants maintain family and work lives in two or more countries, travelling back and forth at frequent intervals and in regular contact by telephone and e-mail in the meantime. The migration patterns of health professionals, including that of nurses, are no different. The reasons nurses **migrate** have been reviewed in this document — they range from fleeing inadequate and dangerous living and working conditions to simply wanting to discover another country. Nurses also **return home** after working abroad and some then migrate again. Other nurses maintain transnational families, living in one country or community while partners and children live in others.

Worldwide patterns of nurse migration and return are highly complex and they shift rapidly. The conclusions drawn from this review of return migration as it applies to nurses are thus wide-ranging. They are organised around needs for information, for policy and for action concerning two overarching themes: improving the evidence base and making return attractive.

Improving the evidence base

Lack of data has been a leitmotif throughout this document. Data about return migration in general (and often about out-migration) is often simply not available. When it does exist, such data often fails to contain such basic socio-demographic information as the migrant's profession and level in the profession. Data concerning out-migration of nurses is available for some countries, but not for others, and is difficult to compare internationally since it comes from different sources in different countries. Many of the sources quoted in reports about nurse mobility are drawn from media coverage or anecdote and are often misleading or inaccurate. Although there are anecdotal mentions of return of nurses in the literature and a substantial number of mentions of the importance of return for potentially helping to correct world imbalances in the distribution of health workforces, very little hard data is available. And very few specific studies have examined return migration of nurses or its sustainability. Missing or incompatible data means that it is difficult to gain an accurate picture of trends in nurse return migration, let alone any assessment of the actual or potential impact of such migration on health services.

Reliable information must be gathered about numbers of nurses departing and returning and about their socio-demographic characteristics, reasons for departure and for return, destinations, moves while they are away from their home communities and wishes and intentions concerning return. Specifically, the following actions are required to improve the evidence base concerning return migration of nurses:

Sensitizing governments, employers, professional associations, academics and other relevant stakeholders as to the importance of collecting such data.

- **Strengthening capacity** to collect and analyse such data in both countries of origin and of return.
- **Encouraging collaboration** in gathering such data**,** including between immigration authorities, national registration or regulatory bodies and employers. Facilitating the transfer of such knowledge and skills between countries.
- **Harmonizing** core data sets across countries — where possible emphasising information about actions rather than about intentions — and encouraging triangulation (use of data from diverse sources and comparisons).
- **Carrying out studies** of nurses who return to their home countries, examining the factors they take into account in their decision, their processes of re-adaptation and the factors that may facilitate or hinder their return.

- **Examining the issue of skill levels in migration and return —** the extent to which nurses may be working abroad at levels that will hinder the contributions they can make on return needs to be examined. Measures that might increase rather than diminish the skills and qualifications of such nurses.

Making return attractive

> All returns of nurses should be voluntary and everything possible should be done to assure that return will be safe.

Nurses usually migrate for mixed reasons, but among the personal and professional factors that push and pull them, this review found that economic factors usually predominate in the original decision to work abroad. This shifts. For return migration the wish to return home, family ties and old friendships become stronger than the economic reasons to be away. Factors related to working and living conditions in the destination country, such as racism and xenophobia, or high costs of living, may also help push some nurses back home. Others simply return when they have met the goals they set before they left. The actual decision to return involves a combination of two sets of factors: 1) the personal and domestic circumstances of the individual and his or her family (especially age, stage in career and household life cycle) and 2) the perceived conditions in the home country (ie, political stability, quality of the environment, cost of living, level of crime, professional opportunities and attitudes towards returning migrants). Studies of return migration consistently find that numerous skilled professionals abroad also wish to contribute to their countries and that some make very significant efforts to do so. Many also want their children to remain in contact with their culture of origin.

These various factors will vary from country to country and between individuals, thus there can be no universal strategy for encouraging return, but a certain number of themes consistently emerge from the literature review. Encouraging positive return migration amongst nurses will involve:

a) Decreasing the factors that made people migrate in the first place and encouraging return

There is an inherent link between migration of health professionals and development. Experts agree that skilled professionals, including nurses, will not return in any sustainable way until the basic social and economic push factors that made them migrate in the first place are reduced or eliminated. Return migration would be encouraged if there were clean water, good roads, adequate housing, schools and other basic amenities available in countries of origin. Similarly, some nurses will be unable to return as long as good governance is lacking, particularly as long as governments perceive people moving abroad as a potential threat, as citizens who have 'voted with their feet'.

One of the findings consistently reported in the literature is that migration decisions are very often tentative and that they frequently change as conditions prove to be different than expected. When considering return, and when they can, migrants take precautions to keep their options open, for example, by obtaining dual nationalities. They often prefer not to return permanently, at least at first. Paradoxically, people working abroad are more likely to envisage permanent return to their home country if they have the option of returning to the host country should they later decide to do so. Similarly, when they do return, most appreciate being able to maintain relationships with family and friends by making visits to the country to which they had migrated. Thus the literature stresses the importance of **cooperation between sending and receiving countries to facilitate temporary and circular migration of nurses.**

Codes of conduct have been proposed as one means of promoting return, although the review found consensus that while such agreements may provide critical guidance, they are limited by the fact that they are not binding and they concern only health workers in the public sector, not the private health sector.

b) Facilitating return

The literature reviewed contains many examples of **administrative hindrances,** such as taxation and customs regulations, that make return difficult or prohibitively expensive. Seen the other way around, the literature also contains a great many suggestions as to **measures employers in both migration destination countries and in those to which they return** may take to encourage the return of nurses — to help returnees not only re-integrate successfully, but possibly become leaders and change agents. Examples include providing incentives for return (among which the importance of housing deserves to be highlighted — housing is a leitmotif throughout the literature on migration, and its availability and quality, is an extremely significant factor influencing whether or not people will return to their home countries); granting long-term leaves of absence when nurses leave to work abroad; encouraging 'on time' return; making sure the skills, training and experience nurses have acquired abroad are taken into account in the posts to which they return; providing positive support from hierarchy; and placing returnees together so that they will have peer support in proposing changes. Related to the question of incentives is the question of potential jealousy of co-workers on return. Paradoxically, the very programmes that are meant to encourage return by giving special incentives may actually feed such jealousy, raising resentment and frustration on the part of those who have stayed behind and those who feel that their detailed location-specific knowledge is under valued.

The importance of **envisaging return from the outset,** when nurses are recruited, is stressed in the literature, as is the fact that **the way in which return is organised affects its success**. Returns that are supported by policy for the development of health systems, and that are well organised, are more likely to be positive for the individual returnee — and for the contribution he or she may be able to make — than are returns that are unprepared and uncoordinated.

The literature stresses the importance of **involving governments, private employers, international bodies, development agencies, professional associations and diaspora organisations** in promoting and sustaining return. Where skilled professionals are concerned, the notion of diaspora occurs again and again. Studies of health professionals living and working abroad have often found them to be eager to contribute to their country of origin, even if they are not willing to move back permanently.

Several authors also point out that **return to one's home culture is often more difficult than anticipated.** The home country and community will have changed. Economic and social conditions, the media, and possibly even socio-cultural norms will have modified. Relationships with family and friends will be different than they were before the nurse left, and while s/he was away, and the returnee may be expected to share what are seen as the privileges of having been able to go abroad. At the same time, the nurse's attitudes will have changed, while those of friends and neighbours at home may not, or not in the same way. The same authors point out that returnees may be responsible for some of their own interpersonal difficulties: nostalgic, they may talk too much about how good life was abroad, and make comparisons that offend those who have remained at home. They must navigate a narrow and often somewhat shifting line between sharing experiences and being seen as boasting, a process that requires tact, sensitivity and attitude management.

Among the several possible models of return reviewed, one — the 'return of failure' — can be particularly negative. Especially in the past, when most migration was thought to be permanent, but also today, and for a large number of possible reasons, some migrants do return home having failed to achieve the goals they set out to achieve.

c) Making migration positive

The literature on return migration stresses the **importance of life stage** for both the potential returnee and for the contribution s/he will be able to make. At early stages in their careers, when they are not yet fully established, and also less significantly affected by income and pension structures at destination, nurses are more likely to respond to incentives. And the longer they remain abroad, the less likely they are to return. **Families** have consistently been shown to be a major reason for migrants to return and also a potential major source of difficulties when they have extremely high expectations as to what the returnee will be able to give back. Many nurses have partners and

children to factor into their migration decisions, with difficult issues to resolve concerning dual careers. Possibilities of education for children are an important theme in the literature and throughout all phases of migration: people migrate in the first place to give their children better chances of education — and they often return for the same reasons — to have their children educated in their native language and according to the values and norms of the culture of origin.

The review touched on a number of ways in which employers in **destination countries** may work development aspects into the employment conditions of foreign nurses, for example, by providing training and stressing the importance of effective collaboration with the country of origin for helping to define gaps. On the negative side, the review contains scattered evidence of deskilling: nurses may earn significantly more abroad than they would in home countries, even when working at levels inferior to that at which they were trained. Although it is clearly in the interest of the employer in the destination country to assure that all nurses are properly qualified and that patients are safely cared for, nurses who have been working at levels below their skills and qualification may find themselves less well off when they return than when they left, and a health system in need of competencies is cheated. Abuses are also thought to exist, with foreign nurses artificially kept in lower positions and at lower salaries.

Measures proposed

Listed in increasing levels of abstraction, the following actions are proposed on the part of countries, employers and professional associations to support positive return migration of nurses:

- **Developing human resource policies to accommodate temporary or permanent return of nurses working abroad.** These include, *inter alia,* allowing nurses long-term leaves of absence from their places of employment; acknowledging professional accomplishments, skills and knowledge acquired abroad; ensuring that time spent overseas is counted when determining salaries and promotions; and guaranteeing that returning nurses will still have access to pension programmes. Human resource policies intended to discourage initial migration, on the other hand, will be an obstacle to nurses' return and thus ultimately prove counterproductive.
- **Encouraging countries to institute measures that will facilitate return migration of nurses and make it sustainable,** such as allowing dual nationality, according return visas to citizens living abroad and taking measures to encourage returnees to invest in their home countries, such as allowing tax-free importation of personal goods and money earned while abroad.
- **Encouraging individual positive motivations to return,** such as the wish to contribute to one's country or to pay back the investment that has been made in one's education. All efforts should be made to facilitate return for such reasons, for example, by making successful contributions known and reducing bureaucratic and other hassles that hinder such efforts.
- **Paying careful attention to timing and to family factors** when recruiters and employers attempt to attract nurses back to their home countries. The nurses most likely to contribute positively on return will have been abroad long enough to gain experience and knowledge, and with enough time to apply their new knowledge, but not so long as to be tied down. Employers sensitive to and supportive of family issues, especially of children's needs, are more likely to attract nurses to return successfully.
- **Assuring that nurses' returns are adequately prepared and that their expectations are realistic.** The potential returnee, the employer, professional associations and other stakeholders should promote and maintain linkages with the home country, encourage return visits while nurses are abroad, and support groups of returnees who can provide assistance and peer support. The returnee should be aware that re-adaptation difficulties are to be expected, especially during the first year back. Those dealing with returning nurses should be aware of the stereotype that return migration indicates failure and should take measures to objectively contradict the image when appropriate and relevant. Return should not be promoted at any price: efforts should be made to promote the return of 'the best and the brightest'. Employers in establishments to which nurses return should make special efforts to strengthen communication and understanding between returnees and their colleagues who have stayed.

- **Establishing programmes through which nurses working abroad who are unable or unwilling to physically return can nevertheless contribute to building capacity in their countries of origin,** for example, through virtual or e-health programmes, or through exchanges. Engagement with diaspora associations of health workers abroad should be promoted in this end. Similarly, the goodwill and volunteerism of nurses abroad should be drawn upon to formulate creative solutions to the problem of worldwide maldistribution of health resources.
- **Factoring the possibility of return into the experiences and training offered to nurses from developing countries working in developed countries** by proactively assuring they will gain the knowledge needed on return. On the other hand, practices exploiting foreign nurses, such as artificially maintaining them at sub-optimal levels of employment in order to keep salaries down, are unfair and do disservice to the professionals thus abused, both while they are working abroad and when they return. Such practices should be exposed and regulated against. Nurses willing to testify against such abuses should be protected and supported.
- **Establishing formal and informal institutional arrangements in both sending and receiving countries to facilitate return migration of nurses,** ranging from codes of conduct to providing financial and non-financial incentives. The efficacy of such measures should be monitored and evaluated.
- **Taking leadership in awareness raising, promoting stakeholder dialogue, policy formulation and monitoring concerning return migration of nurses,** especially by neutral international bodies such as professional organizations and other relevant international organizations.
- **Formulating strategies to encourage and manage the return migration of nurses in harmony with development agendas.** To be effective in the medium- and long-term, measures to encourage nurses to return must be integrated into development assistance and education, initiatives to strengthen institutions and human rights, and targeted economic development.

Gross imbalances exist throughout the world in availability and quality of health care and in distribution of health personnel. Rapid ageing of the population and high levels of technically demanding health care have increased the demand for nurses able to fill personnel shortages in developed countries, a demand that is being filled by nurses from developing countries who are attracted by possibilities for education and training, salaries far higher than they can earn at home and what seem like comfortable living conditions. Imbalances also exist within developing countries, with nurses moving from unsatisfactory and depressing working conditions in inadequately funded public sector employment, to more rewarding conditions in such institutions as private health facilities, international organisations and non-governmental organisations. A vicious downward spiral is established, in which some of the very countries and regions with the highest need experience the most acute shortages in the trained workers to help meet these needs.

Return of foreign nurses to their countries of origin is not a panacea to definitively resolve the problems of shortage and maldistribution of health human resources, but it can help. When nurses have been able to increase their skills, knowledge and experience by working abroad; when these bits of knowledge, skills and experience are relevant to the needs of the home country; when nurses are willing and able to return home and to use them, then they can be at the origin of the 'return of innovation'. Nurse migration, in the first place, has often been said to require balance between the health needs of countries and communities and the short-term right of individuals to seek enhanced opportunities and to build skills elsewhere, to balance richer regions' needs for short-term 'quick fixes' with poorer areas' needs for long-term development.

Discussions of nurse return migration also require balance. They need to take place between the cruel and xenophobic jabs of 'go back where you came from' and an idealised and unrealistic return to a quasi-mythologised homeland. Negotiating feasible paths between the two will require creativity and intelligence, of governments, of employers, of professional associations and of nurses themselves. But successfully doing so may bring renewal and refreshment, opening doors to new sources of fresh ideas and ways of doing things that will contribute to the improvement of health and social services in nurses' countries of origin. Nurses who return are a potentially important, but heretofore neglected tool for the development of desperately needed health resources.

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Appendix 1

Terminology on the International Mobility of Skilled Workers

Mobility of highly skilled persons
Refers to the movement of tertiary, educated persons, primarily those with at least four years of education after primary and secondary school (12 years). Mobility refers to any type of international movement from one-time target to recurrent or permanent patterns.

Brain drain
A brain drain can occur if emigration of tertiary educated persons for permanent or long stays abroad reaches significant levels and is not offset by the feedback, effects of remittances, technology transfer, investments or trade. Brain drain reduces economic growth through loss return on investment in education and depletion of the source country's human capital assets.

Optimal brain drain
Some economists argue that developing countries benefit from the right amount of skilled emigration (not too much, but not too little). The possibility of working abroad for higher wages creates an incentive to pursue education; this may raise domestic educational levels and stimulate economic growth.

Brain waste
When developing country labour markets cannot fully employ native-born workers there is a brain waste and emigration poses little economic threat. This might be the case if, for example, there are few jobs for mathematicians. Likewise, emigrants may be underemployed in receiving countries, as when scientists can only find work as cab drivers.

Brain circulation
Lively return migration of the native born, or brain circulation, re-supplies the highly educated population in the sending country and, to the degree that returned migrants are more productive, boosts source country productivity.

Brain exchange
A given source country may exchange highly skilled migrants with one or many foreign countries. A brain exchange occurs when the loss of native-born workers is offset by an equivalent inflow of highly skilled foreign workers.

Brain globalisation
Trade sometimes follows in the wake of skilled mobility; in fact, some level of tertiary migration appears to be integral to trade. Multinational corporations and the forces of globalisation necessarily require international mobility.

Brain export
In a few cases, developing countries choose to educate and export their highly skilled workers, either in bilateral contract programs or in free-agent emigration. The strategy is to improve the national balance sheet through return of earnings and the return of more-experienced workers, or though remittances, technology transfer and investment.

From: *Lowell L and Findlay A (2002). Migration of Highly Skilled Persons from Developing Countries: Impact and Policy Responses. International Migration Papers.* Geneva: International Labour Office. 44, p7–8.

Appendix 2

Source: Dumont JC and Zurn P (2007). *Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration*, OECD.

Expatriation Rates for Doctors and Nurses, Circa 2000

Table III.A2.1. **Expatriation rates for doctors and nurses, Circa 2000**

	Nurses			Doctors			
Country of birth		Number of persons working in OECD countries	Expatriation rate	Country of birth		Number of persons working in OECD countries	Expatriation rate
Albania	ALB	415	*3.5*	Afghanistan	AFG	613	*13.0*
Algeria	DZA	8 706	*12.4*	Albania	ALB	271	*6.2*
Angola	AGO	1 703	*11.5*	Algeria	DZA	10 793	*23.4*
Antigua and Barbuda	ATG	678	*74.4*	Angola	AGO	1 512	*63.2*
Argentina	ARG	1 288	*4.3*	Antigua and Barbuda	ATG	100	*89.3*
Australia	AUS	4 620	*2.6*	Argentina	ARG	4 143	*3.7*
Austria	AUT	2 914	*3.7*	Australia	AUS	2 067	*4.1*
Bahamas	BHS	560	*29.7*	Austria	AUT	1 599	*5.5*
Bahrain	BHR	77	*2.5*	Bahamas	BHS	178	*36.3*
Bangladesh	BGD	651	*3.1*	Bahrain	BHR	74	*8.4*
Barbados	BRB	3 496	*78.0*	Bangladesh	BGD	2 127	*5.2*
Belgium	BEL	4 125	*6.4*	Barbados	BRB	275	*46.1*
Belize	BLZ	1 365	*81.8*	Belgium	BEL	2 438	*5.0*
Benin	BEN	166	*3.2*	Belize	BLZ	76	*23.2*
Bolivia	BOL	358	*1.9*	Benin	BEN	215	*40.9*
Botswana	BWA	47	*1.0*	Bolivia	BOL	717	*6.5*
Brazil	BRA	2 258	*0.3*	Botswana	BWA	33	*4.4*
Brunei Darussalam	BRN	129	*12.6*	Brazil	BRA	2 288	1.1
Bulgaria	BGR	789	*2.6*	Brunei Darussalam	BRN	94	21.9
Burkina Faso	BFA	16	*0.3*	Bulgaria	BGR	1 856	*5.2*
Burundi	BDI	57	*4.1*	Burkina Faso	BFA	65	*7.6*
Cambodia	KHM	1 119	*12.2*	Burundi	BDI	71	*25.2*
Cameroon	CMR	1 938	*4.9*	Cambodia	KHM	609	*24.6*
Canada	CAN	24 620	*7.4*	Cameroon	CMR	572	*15.5*
Cape Verde	CPV	261	*38.9*	Canada	CAN	9 946	*13.0*
Central African Republic	CAF	92	*8.4*	Cape Verde	CPV	165	*41.7*
Chad	TCD	117	*5.2*	Central African Republic	CAF	63	*20.0*
Chile	CHL	1 965	*16.4*	Chad	TCD	69	*16.7*
China	CHN	12 249	*0.9*	Chile	CHL	863	*4.8*
Colombia	COL	2 625	*9.9*	China	CHN	13 991	*1.0*
Comoros	COM	64	*11.7*	Colombia	COL	3 685	*6.2*
Congo	COG	452	*12.3*	Comoros	COM	20	*14.9*
Congo, Dem. Rep. Of	COD	404	*1.4*	Congo	COG	539	*41.6*
Costa Rica	CRI	562	*13.4*	Congo, Dem. Rep. Of	COD	350	*5.7*
Côte d'Ivoire	CIV	337	*4.2*	Cook Islands	COK	16	*53.3*

Table III.A2.1. **Expatriation rates for doctors and nurses, Circa 2000** (Cont.)

	Nurses			Doctors			
Country of birth		Number of persons working in OECD countries	Expatriation rate	Country of birth		Number of persons working in OECD countries	Expatriation rate
Cuba	CUB	4 209	*4.8*	Costa Rica	CRI	340	*6.1*
Cyprus	CYP	706	*19.1*	Côte d'Ivoire	CIV	261	*11.1*
Denmark	DNK	2 641	*4.5*	Cuba	CUB	5 911	*9.2*
Dominica	DMA	620	*66.2*	Cyprus	CYP	627	*25.2*
Dominican Republic	DOM	1 857	*10.8*	Denmark	DNK	1 629	*9.4*
Ecuador	ECU	1 126	*5.4*	Djibouti	DJI	25	*16.2*
Egypt	EGY	1 128	*0.8*	Dominica	DMA	58	*60.4*
El Salvador	SLV	2 396	*32.0*	Dominican Republic	DOM	1 602	*9.3*
Equatorial Guinea	GNQ	98	*31.0*	Ecuador	ECU	970	*5.0*
Eritrea	ERI	548	*18.8*	Egypt	EGY	7 243	*15.8*
Ethiopia	ETH	1 421	*9.1*	El Salvador	SLV	833	*9.5*
Fiji	FJI	2 025	*56.2*	Equatorial Guinea	GNQ	78	*33.8*
Finland	FIN	5 870	*7.3*	Eritrea	ERI	104	*32.6*
Former Czechoslovakia	CSFR	2 835		Ethiopia	ETH	633	*24.6*
Former USSR	F_USSR	18 034		Fiji	FJI	382	*58.5*
Former Yugoslavia	F_YUG	12 946		Finland	FIN	1 018	*5.8*
France	FRA	8 589	*1.9*	Former Czechoslovakia	CSFR	2 509	
Gabon	GAB	106	*1.6*	Former USSR	F_USSR	11 360	
Gambia	GMB	62	*3.7*	Former Yugoslavia	F_YUG	3 772	
Germany	DEU	31 623	*3.8*	France	FRA	4 131	*2.0*
Ghana	GHA	5 230	*24.9*	Gabon	GAB	57	*12.6*
Greece	GRC	1 367	*3.1*	Gambia	GMB	46	*22.8*
Grenada	GRD	2 131	*87.6*	Germany	DEU	17 214	*5.8*
Guatemala	GTM	1 204	*2.6*	Ghana	GHA	1 469	*31.2*
Guinea	GIN	94	*2.1*	Greece	GRC	2 830	*5.6*
Guinea-Bissau	GNB	227	*18.0*	Grenada	GRD	109	*72.7*
Guyana	GUY	7 450	*81.1*	Guatemala	GTM	485	*4.7*
Haiti	HTI	13 001	*94.0*	Guinea	GIN	99	*9.1*
Honduras	HND	917	*9.9*	Guinea-Bissau	GNB	182	*49.2*
Hungary	HUN	2 117	*2.4*	Guyana	GUY	949	*72.2*
Iceland	ISL	287	*6.8*	Haiti	HTI	2 209	*53.1*
India	IND	22 786	*2.6*	Honduras	HND	329	*9.2*
Indonesia	IDN	3 449	*2.7*	Hungary	HUN	2 538	*7.2*
Iran	IRN	4 284	*4.8*	Iceland	ISL	435	*29.2*
Iraq	IRQ	415	*1.3*	India	IND	55 794	*9.0*
Ireland	IRL	28 166	*24.8*	Indonesia	IDN	2 773	*9.6*
Israel	ISR	980	*2.4*	Iran	IRN	8 991	*12.9*
Italy	ITA	6 945	*2.2*	Iraq	IRQ	3 730	*18.0*
Jamaica	JAM	31 186	*87.7*	Ireland	IRL	4 029	*26.6*
Japan	JPN	4 711	*0.5*	Israel	ISR	2 435	*9.0*
Jordan	JOR	368	*2.0*	Italy	ITA	4 586	*1.8*
Kenya	KEN	2 523	*6.4*	Jamaica	JAM	2 114	*49.4*
Kiribati	KIR	19	*9.0*	Japan	JPN	2 674	*1.1*
Kuwait	KWT	152	*1.6*	Jordan	JOR	1 014	*8.2*
Laos	LAO	857	*13.0*	Kenya	KEN	2 385	*34.6*
Lebanon	LBN	1 400	*25.2*	Kuwait	KWT	465	*11.5*
Liberia	LBR	1 240	*66.9*	Laos	LAO	331	*10.5*
Libya	LBY	100	*0.6*	Lebanon	LBN	4 562	*29.3*
Luxembourg	LUX	104	*2.4*	Lesotho	LSO	7	*7.3*
Madagascar	MDG	1 157	*24.4*	Liberia	LBR	122	*54.2*
Malawi	MWI	200	*2.7*	Libya	LBY	592	*8.5*

Table III.A2.1. **Expatriation rates for doctors and nurses, Circa 2000** *(Cont.)*

	Nurses			Doctors			
Country of birth		Number of persons working in OECD countries	Expatriation rate	Country of birth		Number of persons working in OECD countries	Expatriation rate
Malaysia	MYS	7 569	*19.8*	Luxembourg	LUX	549	*31.3*
Mali	MLI	227	*3.7*	Madagascar	MDG	889	*14.6*
Malta	MLT	649	*22.0*	Malawi	MWI	162	*37.9*
Mauritania	MRT	96	*5.5*	Malaysia	MYS	4 679	*22.5*
Mauritius	MUS	4 502	*50.4*	Maldives	MDV	6	*1.9*
Mexico	MEX	12 357	*12.2*	Mali	MLI	160	*13.2*
Morocco	MAR	5 730	*20.5*	Malta	MLT	458	*26.8*
Mozambique	MOZ	779	*16.5*	Mauritania	MRT	38	*10.8*
Myanmar	MMR	418	*4.1*	Mauritius	MUS	725	*35.7*
Namibia	NAM	30	*0.5*	Mexico	MEX	4 234	*2.1*
Nepal	NPL	205	*3.5*	Mongolia	MNG	39	*0.6*
Netherlands	NLD	6 798	*3.0*	Morocco	MAR	6 221	*28.0*
New Zealand	NZL	7 564	*19.5*	Mozambique	MOZ	935	*64.5*
Nicaragua	NIC	1 155	*16.5*	Myanmar	MMR	1 725	*8.8*
Niger	NER	19	*0.8*	Namibia	NAM	75	*11.1*
Nigeria	NGA	13 398	*9.5*	Nepal	NPL	288	*5.1*
Norway	NOR	1 700	*2.5*	Netherlands	NLD	2 412	*4.5*
Oman	OMN	18	*0.2*	New Zealand	NZL	1 904	*17.4*
Pakistan	PAK	1 803	*3.6*	Nicaragua	NIC	722	*26.1*
Panama	PAN	1 902	*29.5*	Niger	NER	26	*6.5*
Papua New Guinea	PNG	455	*13.8*	Nigeria	NGA	4 611	*11.7*
Paraguay	PRY	130	*1.3*	Norway	NOR	712	*4.8*
Peru	PER	2 807	*14.1*	Oman	OMN	23	*0.6*
Philippines	PHL	110 774	*46.5*	Pakistan	PAK	10 505	*9.3*
Poland	POL	9 153	*4.6*	Panama	PAN	1 026	*18.8*
Portugal	PRT	2 655	*5.7*	Papua New Guinea	PNG	136	*33.1*
Romania	ROU	4 440	*4.9*	Paraguay	PRY	283	*4.3*
Rwanda	RWA	54	*1.5*	Peru	PER	2 546	*7.9*
Saint Kitts and Nevis	KNA	711	*78.7*	Philippines	PHL	15 859	*26.4*
Saint Lucia	LCA	369	*52.7*	Poland	POL	5 821	*5.8*
Saint Vincent and the Grenadines	VCT	1 228	*81.6*	Portugal	PRT	792	*2.2*
Samoa	WSM	566	*62.1*	Qatar	QAT	45	*3.3*
Sao Tome and Principe	STP	138	*35.0*	Romania	ROU	5 182	*10.9*
Saudi Arabia	SAU	151	*0.2*	Rwanda	RWA	45	10.1
Senegal	SEN	256	*8.9*	Saint Kitts and Nevis	KNA	15	*22.7*
Seychelles	SYC	151	*19.2*	Saint Lucia	LCA	39	*4.9*
Sierra Leone	SLE	2 057	*56.3*	Saint Vincent and the Grenadines	VCT	115	*53.2*
Singapore	SGP	1 913	*9.9*	Samoa	WSM	46	*27.7*
Solomon Islands	SLB	38	*10.1*	Sao Tome and Principe	STP	71	*46.7*
Somalia	SOM	250	*14.4*	Saudi Arabia	SAU	421	*1.2*
South Africa	ZAF	6 016	*3.2*	Senegal	SEN	449	*43.0*
Spain	ESP	3 527	*1.1*	Seychelles	SYC	36	*22.9*
Sri Lanka	LKA	2 032	*8.1*	Sierra Leone	SLE	236	*58.4*
Sudan	SDN	183	*1.0*	Singapore	SGP	1 356	*19.1*
Suriname	SUR	18	*2.5*	Solomon Islands	SLB	11	16.9
Swaziland	SWZ	37	*0.8*	Somalia	SOM	155	*33.3*
Sweden	SWE	3 028	*3.2*	South Africa	ZAF	7 355	*17.4*
Switzerland	CHE	1 839	*2.3*	Spain	ESP	2 687	*1.9*
Syria	SYR	319	*1.0*	Sri Lanka	LKA	4 668	*30.8*
Thailand	THA	3 050	*1.7*	Sudan	SDN	778	*9.3*
Timor-Leste	TLS	61	*4.0*	Suriname	SUR	39	*17.0*

Table III.A2.1. **Expatriation rates for doctors and nurses, Circa 2000** *(Cont.)*

		Nurses				Doctors	
Country of birth		Number of persons working in OECD countries	Expatriation rate	Country of birth		Number of persons working in OECD countries	Expatriation rate
Togo	TGO	78	*4.0*	Swaziland	SWZ	9	*5.0*
Tonga	TON	449	*58.2*	Sweden	SWE	1 532	*5.0*
Trinidad and Tobago	TTO	9 808	*72.9*	Switzerland	CHE	1 125	*4.2*
Tunisia	TUN	410	*1.6*	Syria	SYR	4 721	*16.6*
Turkey	TUR	3 565	*2.9*	Thailand	THA	1 390	*5.8*
United Arab Emirates	ARE	11	*0.1*	Timor-Leste	TLS	35	*30.7*
United Kingdom	GBR	45 638	*6.1*	Togo	TGO	153	*40.5*
United Republic of Tanzania	TZA	970	*6.8*	Tonga	TON	23	*39.7*
United States	USA	6 022	*0.2*	Trinidad and Tobago	TTO	1 206	*54.6*
Uganda	UGA	1 210	*7.4*	Tunisia	TUN	2 415	*15.3*
Uruguay	URY	506	*14.9*	Turkey	TUR	2 311	*2.4*
Vanuatu	VUT	20	*4.5*	United Arab Emirates	ARE	44	*0.7*
Viet Nam	VNM	5 778	*11.5*	United Kingdom	GBR	17 006	*11.3*
Yemen	YEM	231	*1.7*	United Republic of Tanzania	TZA	1 018	*55.3*
Zambia	ZMB	820	*4.6*	United States	USA	4 354	*0.6*
Zimbabwe	ZWE	3 619	*27.9*	Uganda	UGA	1 084	*32.9*
				Uruguay	URY	493	*3.8*
				Vanuatu	VUT	5	*20.0*
				Venezuela	VEN	1 710	*3.4*
				Viet Nam	VNM	7 591	*15.2*
				Yemen	YEM	248	*3.5*
				Zambia	ZMB	567	*31.0*
				Zimbabwe	ZWE	828	*28.4*

Note: Countries for which expatriates are under 10 for nurses (5 for doctors) or resident in the origin country are below 50 for nurses (10 for doctors) are not reported.

StatLink http://dx.doi.org/10.1787/022648658554

Appendix 3

Source: Meyer JB and Brown M. (1999). *Scientific Diasporas: A New Approach to the Brain Drain,* UNESCO, Paris, Discussion Paper No. 41. (available at http://www.unesco.org/most/meyer.htm)

Country	*Name of Network*	*Type of Network*
Arab Countries	The Network of Arab Scientists and Technologists Abroad (ASTA)	Intell/Scien Diaspora Network
Argentina	Programa para la Vinculacion con Cientificos y Tecnicos Argentinos en el Exterior (Program for the Linkage of Argentine Scientists and Technologists Abroad) (PROCITEXT)	Developing Intell/Scien Diaspora Network
Assam	Transfer of Knowledge and Technology to Assam	TOKTEN Programme
China	Chinese Scholars Abroad (CHISA) Society of Chinese Bioscientists in America Chinese American Engineers and Scientists Association of Southern California (CESASC)	Student/Scholarly Network Local Association of Expatriates Local Association of Expatriates
Colombia	The Colombian Network of Researchers and Engineers Abroad (Red Caldas)	Intell/Scien Diaspora Network
El Salvador	Conectandonos al Futuro de El Salvador (Connecting to El Salvador's Future)	Developing Intell/Scien Diaspora Network
France	Frognet	Student/Scholarly Network
India	Silicon Valley Indian Professionals Association (SIPA) Worldwide Indian Network The International Association of Scientists and Engineers and Technologists of Bharatiya Origin Interface for Non Resident Indian Scientists and Technologists Programme (INRIST)	Local Association of Expatriates Intell/Scien Diaspora Network Developing Intell/Scien Diaspora Network Developing Intell/Scien Diaspora Networks
Iran	The Iranian Scholars Scientific Information Network	Intell/Scien Diaspora Network
Ireland	The Irish Research Scientists Association (IRSA)	Intell/Scien Diaspora Network
Japan	Japanese Associate Network (JANET)	Student/Scholarly Network
Kenya	Association of Kenyans Abroad (AKA)	Developing Intell/Scien Diaspora Network
Korea	Korean Scientists Engineers Association of Sacramento Valley The Global Korean Network	Local Association of Expatriates Intell/Scien Diaspora Network

Latin America	Latin American Association of Scientists (ALAS)	Intell/Scien Diaspora Network
Lebanon	TOKTEN for Lebanon	TOKTEN Programme
Morocco	Moroccan Association of Researchers and Scholars Abroad (MARS)	Student/Scholarly Network
Nigeria	Association of Nigerians Abroad (A.N.A)	Intell/Scien Diaspora Network
Norway	Association of Norwegian Students	Student/Scholarly Network
Pakistan	Return of Qualified Expatriate Nationals to Pakistan	TOKTEN Programme
Palestine	Programme of Assistance to the Palestine People	TOKTEN Programme
Peru	Red Cientifica Peruana (Peruvian Scientific Network)	Developing Intell/Scien Diaspora Network
Philippines	Brain Gain Network (BGN)	Intell/Scien Diaspora Network
Poland	The Polish Scientists Abroad	Intell/Scien Diaspora Network
Romania	The Forum for Science and Reform (FORS)	Developing Intell/Scien Diaspora Network
South Africa	The South African Network of Skills Abroad (SANSA)	Intell/Scien Diaspora Network
Thailand	The Reverse Brain Drain Project(RBD) Association of Thai Professionals in America and Canada (ATPAC) The Association of Thai Professionals in Europe (ATPER) The Association of Thai Professionals in Japan (ATPIJ)	Developing Intell/Scien. Diaspora Network Intell/Scien Diaspora Network Intell/Scien Diaspora Network Intell/Scien Diaspora Network
Tunisia	The Tunisian Scientific Consortium (TSC)	Intell/Scien Diaspora Network
Uruguay	Red Academica Uruguaya (Uruguayan Academic Network)	Developing Intell/Scien Diaspora Network
Venezuela	In Contact with Venezuela El Programa Talento Venezolano en el Extrior (Program of Venezuelan Talents Abroad) (TALVEN)	Developing Intell/Scien Diaspora Networks

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