The policy brief is part of the series titled ‘Impact of COVID-19 on Africa’s Labour Migration Landscape’ developed by the AU Labour Migration Advisory Committee (AU-LMAC) in the framework of the AU-ILO-IOM-ECA Joint Programme on Labour Migration Governance for Development and Integration in Africa (JLMP), with support from the International Organization for Migration (IOM).
The ongoing pandemic has highlighted gaps in the management of health workers’ mobility in both sending and receiving countries. In high-income countries, the health care industry has a large number of migrants; in the Organisation for Economic Cooperation and Development (OCED) countries, for example, one in four health workers were born abroad and one in five were trained outside Europe (OECD, 2020; IOM, 2014). Even though health workers are at the forefront of the fight against the current pandemic, there are still lingering challenges, especially around ensuring the potential benefits of migration are maximised by countries of origin, destination and migrants themselves.

Despite the risk of placing themselves at the front line of the pandemic, migration to high-income countries remains attractive to health workers in Africa and the Caribbean due to better working conditions, including remuneration and workload. If not managed well, increased demand for health workers, especially in specialties like anaesthesiology, will leave considerable gaps in Africa’s already weak health systems. While global demographic changes present an opportunity for Africa, migration and mobility must be managed well through responsive policies.

1 Health workers are all those engaged in the promotion, protection or improvement of the health of the population (Adams et al., 2003; Diallo et al., 2003)
The ongoing COVID-19 pandemic has implications for African migrant workers at various levels. Many workers have been adversely affected, whether by being stranded, losing employment, or the inability to send money to their families, creating a cascade of adverse effects on communities (AU, 2020).

It is risky to be on the front line of the pandemic and the World Health Organization (WHO) reported that, as of April 2020, over 35,000 health workers globally were infected with COVID-19. However, it is likely that the true figure was higher but unknown, due to underreporting (WHO, 2020). Despite the risks, migration to high-income countries remains attractive to health workers from low-income countries due to better working conditions, something that calls for better policies to manage mobility in this sector, for instance through creating decent working conditions for the migrants in countries of origin as well as skills recognition and skills partnership schemes between countries of origin and destination.

The WHO has further reported that there is a critical Health Workforce (HWF) shortage across the world, with a significant deficit in Africa and the Caribbean. As of 2015, the African Region had an average of 1.30 health workers per 1000 population; far below the 4.5 per 1000 called for in the Sustainable Development Goals (SDGs). Out of the estimated 14.5 million shortage in healthcare workers globally – the number required to provide Universal Health Coverage (UHC) and meet the SDGs – the African Region is the most severely affected, as it is estimated that the HWF shortage will be 6.1 million by 2030. This is in the context of calls for all communities to have universal access to health workers by 2030 (WHO, 2017).

A significant number of health workers in the US, Europe and UK are from Africa. For example, 22 out of every 1000 UK NHS staff are from Africa and around 170,000 out of the total 1.28 million report holding non-British nationality (Baker, 2020). This shows there is considerable dependence on migrant workers in the health sector. The high percentage of foreign-born health workers working in OECD countries also partly shows why there are shortages of this critical skills base in Africa. The region’s limited capacity to recruit and retain health workers is compounded by the high rate of emigration amongst this demographic due to growing demand in high-income countries. If not managed well, this trend will lead to increased gaps in an already fragile health system on the continent.

The precise number of migrants to and within the Middle East is unknown, as well as their demographic and socioeconomic characteristics. However, research shows that the vast majority of the HWF in GCC countries are foreign-born and foreign-trained: 75 per cent of physicians and 79 per cent of nurses are expatriates (El-Jardali, Jamal, Abdallah and Kassak, 2007).

In 2011, a study found that 77 per cent of physicians trained in Liberia were working in the US (Tankwanchi, Özden and Vermund, 2013). In addition to inter-regional migration, there is also a robust intra-Africa movement, especially within the Southern and Eastern African regions. However, better data collection methods are needed to track these movements.
CASE STUDY: ENGAGING DIASPORA IN ORIGIN COUNTRIES

There are strategies governments can employ to engage with diasporas and have them contribute to their countries of origin (Dhlamini, 2020). In 2001, for example, the IOM launched the MIDA programme in Somalia, which helped to mobilise the skills acquired by African nationals abroad through the short-term return of African professionals (IOM, 2020). In the health sector, this programme aimed to enhance public health institutions and build staff capacity to deliver and implement quality maternal, child, and mental health services, as well as to develop related policies. The MIDA programme’s achievements included:

- The development of a curriculum for Somalia National University Faculty of Medicine
- The review of Jubaland Pharmaceutical and Drug Regulation Policies
- Support for the establishment of neonatal units at Hargeisa, Lasanod and Borama Hospitals
- Support for the establishment of a dialysis unit at Burao Regional Hospital.

Similarly building on the Sudan Health Workers Migration Policy, Sudan has also found success by collaborating with Ireland and Saudi Arabia. In this model, education and training costs are shared and newly qualified health workers are encouraged to return and practise in rural areas, whilst also engaging in technology transfer (Carzaniga et al., 2019).

The general picture is, worldwide the health sector increasingly relies on migrants. However, policies restrict their movement and impede their ability to work. The COVID-19 pandemic has shown that it is feasible to lift the numerous restrictions currently in place, such as on recognition of qualifications. There is an opportunity to explore how policymakers can come up with more impactful policies.

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2 “Migration for Development in Africa” (MIDA) is a capacity-building programme which helps to mobilize competencies acquired by African nationals abroad for the benefit of Africa’s development. The Organization for the African Unity (OAU) endorsed the MIDA programme at the 74th Ordinary Session of the Council of Ministers and the 37th Ordinary Session of the Assembly of Heads of State and Government of the OAU that took place from 5 to 7 July 2001 and from 9 to 11 July 2001 respectively, in Lusaka, Zambia. [https://www.iom.int/mida]
PREDICTING THE FUTURE OF MIGRATION OF HEALTH CARE WORKERS AFTER COVID-19

As of March 2020, all regular migration pathways had come to a halt (Yayboke, 2020); most controls applied to those from restricted regions, but exemptions were made for keyworkers. Indeed, higher-income countries are already moving towards more lenient visa and immigration requirements for health workers, such as the UK’s exemption of NHS workers from the Immigration Health Surcharge (UK Home Office News Team, 2020). According to the Centre for Global Development, refugee health workers in the UK have had their recognition fast-tracked. Germany has allowed them to practise without local qualifications, and Australia has lifted working hour caps for nursing staff (Dempster et al., 2020). Canada’s Ontario province has activated a thirty-day supervised renewable medical licencing during the state of emergency to accelerate the integration of internationally trained medical doctors into the health care and meet the increased demand for health workers. Without the right policies in place, tackling the brain drain from Africa will become an even more challenging endeavour, inevitably leading to an increase in global inequality and neglect of already inadequate health systems.

The migration of health workers from African countries is expected to continue both during and after COVID-19. Owing to multiple economic and political factors, the migration of health professionals will continue internally, from rural to urban, from the public to the private sector, whilst international migration also will continue to rise (WHO, 2004). Investment in African countries was affected by the 2009 economic downturn (WHO, 2009), as remittance flows contracted and aid declined (Allen and Giovannetti, 2011). The current crisis may affect African countries even further, potentially deterring investment in health personnel and infrastructure.

There are several necessary steps for the successful recruitment and retention of health workers, including: better remuneration, improved working conditions, access to training, and increased resources in the health sector. This would go a long way in helping to reduce the proportion of health professionals who migrate out of the region in search of greener pastures. Unfortunately, the data is not up to date and there are no recent reports on the pattern and number of skilled health migrants within the region or abroad.

RECOMMENDATIONS

SHORT TERM

- African Union member states need to conduct an urgent review of current frameworks for the regulation of mobility generally, and medical workers particularly.
- Countries of destination need to recognise migrant’s medical training, even as a temporary measure, as a critical step towards ensuring a stronger response to Covid-19.
- AUC needs to assist Member States in development of Skills Partnerships on Health Workers Migration with main regions and countries of destination, including Europe, North America and the Gulf region.

MEDIUM TO LONG TERM

- Investment in training, recruitment, and retention, ensuring such training and recruitment meets the needs of the current pandemic and achieves the required capacity. This includes opportunities for improved career paths and appropriate remuneration, to reduce the gap in pay between countries and regions and provide incentives.
- Long-term strategy to increase global stock of health workers in Africa, that includes faster processes for recognition and vetting of skill certifications among African countries.
- Collection and utilisation of data and research on workforce mobility, migration, movement, and recruitment.
- The development of policies that ensure protection for returnees and integration in their professional fields. This includes implementing existing and complementary frameworks and regulations to mitigate movement, provide conducive working conditions, and ensure the safety and wellbeing of health workers and their families.


College of Physicians and Surgeons of Ontario: https://www.cpso.on.ca/Physicians/Your-Practice/Physician-Advisory-Services/COVID-19-FAQs-for-Physicians


About LMAC

The AU Labour Migration Advisory Committee was established in 2015 to facilitate ongoing structured dialogue, exchange and technical consultations among social partners and relevant government entities, to monitor and promote better governance of labour migration as well as encourage regional migration and mobility regimes. LMAC is composed of various stakeholders including the RECs, social partners namely Business Africa, OATUU and ITUC-Africa, representatives of Diaspora organizations and cross border women traders’ organizations as well as relevant AU organs such as Pan African Parliament, Pan African University, ACRWC, Pan African University ECOSOCC, and IOM and ILO.

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MOBILITY AND MIGRATION OF AFRICAN HEALTH WORKERS POST COVID-19

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