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Perceptions of Emaswati Nurses Working in The United Kingdom (UK) About International Migration: Experiences and Plans

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Abstract

Background: *The migration of healthcare staff from developing to developed countries has caused deleterious effects to already crumbling healthcare systems in many third world countries. In eSwatini, 80 nurses graduate each year from training institutions but more than a third of these nurses are lost to the diaspora.*

Methods: *A cross-sectional descriptive qualitative survey was conducted among 48 emaSwati nurses working in the UK to explore their perceptions and future plans concerning their own migration. Questionnaires were mailed to nurses that consented to participate and responses were also mailed back in self-addressed and stamped envelopes.*

Results: *Findings from this study suggest that nurses in eSwatini are motivated by the higher pay and strength of the pound to emigrate (pull factors). Lack of accountability by the system of governance, equipment shortage, poor supervision, high work load and lack of training opportunities were other push factors identified by the participants. The eSwatini Government, through the Ministry of Health, engaged several strategies to reduce overseas migration of nurses. However, with the slow improvement of the country's political and economic developments, the crisis may remain or recur.*

Conclusion: *Increased remuneration, investment in healthcare infrastructure, purchase of appropriate equipment and reduction in work loads could improve working conditions and reduce the loss of nurses to overseas countries. Development of inclusive policies to address migration of all citizens of this country could greatly benefit the practice economically, socially and otherwise, and ensure input of knowledge into the healthcare system from personnel returning with experience from overseas exposure.*

Keywords: *migration, diaspora, remittances, nurses, healthcare workers.*

Introduction:

Nurses and midwives form the backbone of healthcare systems in many sub-Saharan African (SSA) countries where they provide 80% of health care services. The loss of these healthcare staff from developing countries, particularly (SSA), to international migration has far reaching consequences in disrupting an already incompetent healthcare system. Healthcare services and patients suffer greatly from the loss of trained personnel leading to diminished healthcare, reduced talent in the system, diminished management and supervision and a higher unmanaged disease burden. Migration of nurses, in particular, is of important international concern because in developing countries nurses provide 80 percent of healthcare. Dal Poz and Gupta [1] estimated that 36 countries in SSA do not have sufficient workers to provide minimal healthcare services. In 2006, the World Health Organization estimated that there was a shortage of more than 4.3 million healthcare personnel across the world and that low-income countries were particularly hardest hit by the shortage [2]. Sigma Theta Tau International (STTI) recognizes international nurse migration as a serious issue impacting nurses worldwide. Understanding the impact and nature of international nurse migration in ESwatini is difficult due to poor quality and scarcity of reliable data. One of the Millennium Development Goals (MDG4) set up in 2008 stated an intention to reduce mortality rate among children less than 5 years by ⅔ between 2008 and 2015 [3]. Questions are asked about the impact of nurse migration on the achievement of this MDG and others in ESwatini, a country with the highest tuberculosis and HIV/AIDS rates. It was estimated that foreign registered nurses in the UK made 8% of the total (~500 000) nursing force in 2004 and

that about 53 000 more would be required by 2010 [4]. In 2002, the UK Government announced that it had reached its 2004 target of recruiting 20 000 more foreign nurses and midwives [5]. Australia, an establishing destination of emaSwati nurses, was estimated would require about 78 000 foreign nurses by 2011 [4]. This emigration of essential healthcare staff creates deficiencies among many developing countries whose healthcare system could already be on the brink of crumbling due to the burden of disease. For example, in France, there are 80 nurses/midwives per 10 000 population, in Canada 101, Australia 97, the UK 128 and Norway, 162. At the same time in Mali there are 6, Peru 7, India 13, Mozambique 3 and Ghana 9. Across the African continent, the movement of medical doctors has been blamed for declining healthcare standards and for the continued weakening of healthcare systems [6, 7, 8, 9, 10]. This loss of doctors leaves many healthcare facilities in the hands of nurses. In particular, although causality goes in multiple directions, reduced population health can lead to a lower rate of GDP and reduced rate of economic development. On the basis of these growing demands for nurses in developed countries, it is no doubt that receiving countries will continue to gain at the expense of least developed and low-income countries which has a direct effect on current and future well-being of developing country's populations. In turn, developing countries will remain trapped in the vicious cycle of poverty and disease burden.

The past decade (2000-2010) witnessed rapid increase in migration of healthcare professionals from developing countries to developed countries [11]. A number of migrants enter developed countries in many pretexts, such as refugees. For example, between 1980 and 2009, a total of 72,706 humanitarian claims were filed in Canada by people from SADC countries, some of these migrants being healthcare professionals in search of better working conditions. By 2006, 106 325 migrants from SADC countries had entered Canada and 165 of these were from ESwatini [12]. Nonetheless, the largest loss of nurses from ESwatini has been to the United Kingdom (UK). The UK Labour Government in 2000 published the NHS plan to increase healthcare staff including a target of 20 000 nurses beginning in 2002 [13]. After realising that the UK was benefitting from the collapse of healthcare services of under- served countries, the UK Government attempted to tackle the issue by introducing a recruitment policy (code of conduct). However, this code of conduct was reported to be ineffective in preventing mass migration of healthcare staff because of competing NHS policy priorities [14]. Reasons suggested for failure of controls included lack of controls on the private sector, inadequate information and the underlying economic pressure for migration.

The pertinent questions asked are: What are the push factors that lead to nurses wishing to migrate from ESwatini? What experiences have they gone through that make them wish to migrate? What are the social, professional and political factors that are involved in choosing one country of destination over another? What rights do EmaSwati nurses have when they are recruited to work in another country? How are preparations for migration handled between the employing institution and the nurse? Are the nurses working in the UK happy? Do any of them wish to return to ESwatini? For those who have returned, how has been the reception by potential employers, particularly government? What is the economic benefit to the country from EmaSwati nurses working in the UK or technical benefit from returning nurses?

The motivation of an individual healthcare worker to migrate and seek a better life for himself/herself and his/her immediate family and to further his/her career is largely described by 'human rights' activists. Hence, the human rights framework allows us to examine different social, political and economic problems that result to international migration. This study has examined key issues related to the international migration of nurses from ESwatini to the UK in order to better understand the experiences, perceptions and plans from the perspective of the nurses themselves. Information from the study should provide a basis for developing policy options for management of nurse migration in ESwatini. Though this study is based on nurses migrating to the United Kingdom from ESwatini, the findings seek to reframe the understanding of healthcare migration from countries in many developing countries in SSA by taking into account developments in migration theory and practice. Therefore, these findings and recommendations should be broadly applicable to many other developing countries in the same predicament as ESwatini. Local data and information from source countries is glaringly lacking despite efforts from the World Health Organisation, the Organisation for Economic Co-operation and Development (OECD) and the World Bank to develop consistent and internationally comparable global data on the migration of healthcare professionals looking at both developed and developing countries [11, 15, 16]. Findings from this study, will therefore, provide rare and relevant information because it documents perceptions by the nurses that have emigrated from ESwatini.

The National Healthcare System of ESwatini

The problem faced by the Healthcare System of ESwatini, in particular, is the accompanying burden of poverty and under-resourcing, infectious disease and, worthy of distinct mention, the highest HIV/AIDS and tuberculosis prevalence in the world which further accelerate the healthcare system into a collapse. The incidence of tuberculosis increased from 300 per 100,000 people in 1990 to over 1,000 per 100,000 people in 2003 [17]. A sentinel surveillance report [18] on HIV prevalence among TB patients showed that about 80% of TB patients are infected with HIV.

The Healthcare system of ESwatini comprise one referral hospital located at the capital city, two specialised government and four private hospitals, 5 health centres, 8 public health units and several private clinics [19]. Based on the population of the country at 1 018 449 (2007 census), this translates to 22 health facilities per 100 000 population [19]. Forty-four percent of the facilities are owned by government, 2.7% are privately owned and the rest are owned by missions. The World Bank classified the country as a lower middle-income with a GDP per capita income of US$4.700 for 2007 [20]. Despite being perceived as having a reasonable resource base compared to many developing countries, the majority of people (69%) in the country are classified as poor [21]. Available information shows that previous gains on the health status are being eroded by the advent

of HIV and AIDS. Life expectancy at birth increased from 44 years in 1966 to 58.8 years in 1997, but as a result of HIV and AIDS it fell to 37 years in 2006 [22]. Increasing trends have been observed in the country's Crude Death Rate (CDR), Infant Mortality Rate (IMR), Under-Five Mortality Rate (U5MR) and Maternal Mortality Rate (MMR). In fact, Crude death rate per 1 000 population increased from 13 in 1990 to 26.2 in 2005 [23]. Infant Mortality Rate (IMR) per 1 000 live births increased from 94.4 per 1000 in 1990 to 108 in 2005 [23]. The emerging burden of non- communicable diseases such as diabetes, cancers of all type and cardiovascular disease has further increased the burden on the healthcare system. The need for a healthcare system, including healthcare staff to adequately care for the large sick population cannot be overemphasized. The high mortality rate further impacts on the healthcare staff that also suffer from many communicable and non-communicable diseases currently ravaging the country's population. Nurses contract communicable diseases while caring for the ill and also like other members of the population. Because of the low nurse-patient ratio, many are overburdened and opt to migrate to seek better working conditions in developed countries. This study describes the perception and experiences of nurses who have migrated to the United Kingdom about the decisions leading to migration as well as their experiences in the United Kingdom. Documentation of the perception from the nurses themselves is likely to provide valuable and useful information to inform the policy-making and implementation processes of the country and to design coping strategies in the likelihood that the problem remains or increases in magnitude as new developed-country destinations emerge. No study has been done to understand the perceptions, experiences and future plans of nurses involved in migration from ESwatini to seek employment in other countries.

Methods:

Study design

A qualitative descriptive cross-sectional study was conducted between June and July 2019 among 48 nurses employed and working in the United Kingdom's (UK) healthcare system. The UK has been the leading destination for migrating emaemaSwati nurses in the last two decades, Canada and Australia were newly emerging destinations in the last decade.

Recruitment of participants

A few nurses whose contact information was known to the researchers were asked to participate and to identify more participants among their colleagues (snowball technique). All identified potential respondents were contacted by telephone; the details of the study explained and were requested to participate. All those requested agreed to participate and they were sent an information package explaining further about the study and what was expected of them, a consent form for them to sign and return, and a questionnaire consisting of open-ended and closed items. A self-addressed and stamped envelope for mailing back the completed questionnaire and signed consent form was also included.

Data Collection

The recruitment process identified 51 nurses employed in various agencies and healthcare facilities in the UK between June and July, 2019. One of the researchers, who was in the UK during this period facilitated the data collection process. All nurses recruited to participate agreed and were sent the research package to complete within a month. The data was collected using qualitative semi-structured questionnaires which allowed the respondents to freely and adequately elaborate their perceptions and experiences of international migration. Forty-eight fully completed questionnaires were received back from the participants, indicating a response rate of 94%, while forms from 3 potential respondents were not received. It was not possible to follow-up individual non-respondents because the package did not identify who had sent it back. However, all those that had been e-mailed the research package were sent reminders by e-mail a week prior to the deadline for receiving responses.

The study was reviewed and cleared by the University of ESwatini Faculty of Health Sciences Ethics Review Committee (ref: UN/FHS/ERC2019/07).

Results:

The ESwatini Government (ESWATINI GOVERNMENT) attempted within its limited means to train more nurses, fund and support the healthcare system to meet the healthcare needs of the population of ESwatini. The Ministry of Health (MOH) has the responsibility of creating policies pertaining to training and healthcare practice. The bulk of the healthcare staff including nurses are employed by the MOH to serve in hospitals, health centres and clinics. Some are employed by private hospitals and clinics spread throughout the country. Traditional healers also provide a proportion of healthcare to the EmaSwati population.

Demographic Characteristics of Participants

A majority of the nurses that participated in this study (79% n=38) were between 31-40 years of age (Table 1). Only 8% fall between 21 and 30 years, while 13% fall between 41 and 50 years. This assertion suggests that nurses work for some time before they consider options of migration. The length of employment before emigrating was investigated. None of the respondents had been employed for 2 years or less. The majority (42%) had worked for 2 – 5 years and 25% had worked for more than 10 years. The tendency to migrate seems to decrease with increasing number of years of employment.

Table 1: Demographic characteristics of participants

Characteristic	Number (%)
Age	
21 – 30	4 (8)
31 – 40	38 (79)
41 – 50	6 (13)
50+	None
Gender	
Female	42 (88)
Male	6 (12)
Marital Status	
Married	26 (54)
Unmarried	18 (42)
Divorced/Separated	4 (8)
Accompanied by spouses	16 (62)
Had children	46 (96)
Accompanied by children	15 (33)
Length of employment before migration (years)	
< 2	None
2 – 5	20 (42)
5 – 10	16 (33)
10+	12 (25)
Qualification	
Diploma only	8 (17)
*Double-qualified	28 (58)
₱Bachelors' Degree	12 (25)
¥Additional Certificates	2 (4)
*Double-qualified meant a Diploma in General Nursing + Midwifery or Mental Health ₱All Bachelors degree holders also had Midwifery or Mental Health ¥ Additional certificates included Ophthalmic nursing or other	

A majority (88% n=42) of the respondents were female, probably corresponding with the distribution of gender in the nursing fraternity in ESwatini. The nursing profession in ESwatini is still predominately female despite an increase of males in the last few years [24]. The age groups that have been involved in emigration are therefore among the older ones that were predominately female. About 54% of the respondents (n=26) reported that they were married and 62% of these were accompanied by their spouses but only 33% by their children despite that 96% (n=46) of them had children (including those unmarried) (Table 1). While a few mentioned their willingness to bring their children over to the UK, most mentioned the unfavourable social climate for the upbringing of children and said that they would prefer to support them while they remained in ESwatini. Eight percent (n=4) of the respondents were divorced or separated, and these were not accompanied by their children because of differences over the custody of the children with the former husbands. Also worth mentioning is that all these were females. The demographic profile of the nurses probably describes nurses with significant family responsibilities.

A majority of the respondents were double-qualified (i.e. Diploma in General Nursing + Certificate in Midwifery or Mental Health) (Table 1). Rather than these proportions being associated with tendencies to emigrate, they are probably influenced by the existing proportions of qualifications among the nursing population as a whole in ESwatini.

In ESwatini, all school leavers are entitled to a government scholarship loan for their first qualification i.e. Diploma or Bachelor's degree and Certificates such as Midwifery and Mental Health. Recipients of loans are expected to pay back half the amount in a period equivalent to twice the length of the training period. Fifty-four percent (n=26) of the respondents said that they never paid back their scholarship loans. Fifty-four percent of those who owed were not willing to pay back the loan. Only 31% said they would be willing to make arrangements to pay back the loan while in the UK. Unwillingness to pay the loan by a majority suggests a bad relationship between government and the nurses prior to emigrating. However, the authenticity of this response could not be ascertained as there was no way to ascertain whether those who reported to have paid up their scholarship loans had actually done so or not.

Current training capacity for nurses in ESwatini, 2015

Two institutions have traditionally produced nurses with Diploma and/or degree qualification for more than 10 years in ESwatini. These are the University of ESwatini and the then Nazarene College of Nursing (now Southern Africa Nazarene University). Shown below (Table 2) are the institutions that train nurses and the approximate number currently (academic year 2019/20) registered in first year.

Institution	Number of students	Intended Qualification	Number of years to completion
University of ESwatini (UNISWA)	40	Bachelor of Nursing Science & Midwifery	4
Southern Africa Nazarene University (SANU)	42	Bachelor of Science in Nursing and Midwifery	4
*Good Shepherd Nursing College	40	Diploma in General Nursing	3
*ESwatini Christian University (SCU)	30	Bachelor of Nursing	4
TOTAL	152		
*Training started in the academic year 2013/14			

The opening of an additional two schools of nursing (Good Shepherd School of Nursing and ESwatini Christian Medical University) in 2013/14 should significantly increase the number of nurses produced in the country. These improvements are likely to ease off the demand of nurses and improve the challenge brought about by loss of nurses to migration and death.

Recruitment and Departure from ESwatini Employer

Fifty-four percent (n=26) of the respondents claim to have received information about the possibility of working in the UK from friends who were already working in the UK while 29% claim to have got information from friends within ESwatini. Other sources of information mentioned were newspaper adverts and the internet.

Expectedly, a majority of the respondents (88% n=42) cited better pay as the major influence for them to migrate. However, a smaller percentage mentioned that they were single, had no responsibilities, and could survive comfortably with their pay in ESwatini but were motivated by the prospects of working in a developed country. Their interest was in the adventure of exploring the world. As one put it:

"I was single, had no dependents, and was flexible to take a risk and explore available opportunities"

As such, those that were motivated by working in a developed country made 71%. Other factors that had some degree of influence on the decision to emigrate were unfavourable governance in ESwatini (32/48, 67%) and lack of opportunities for further education (54%). Surprisingly, education for children was not an influencing factor (38% p=0.721), and some actually mentioned that they wouldn't like their kids to grow up in the UK environment because they lose people and personal respect as well as engage in unacceptable practices such as smoking, alcohol imbibing, gangs association, drugs and other unruly behaviours. Some felt the education standard in ESwatini was equivalent to that in the UK particularly if they enrolled their children in private schools. As such, many mentioned that migrating to the UK benefitted the education of their children in that they were able to transfer them to private and better schools in ESwatini which they could not afford with their EmaSwati salaries.

The strength of the pound was cited by a majority (81%, n=39) as an important motivating factor for the nurses to choose the UK over other developed countries such as Australia, Canada, Republic of South Africa and the USA. However, it was surprising that the respondents did not rate the ease of entering the UK (50%) as a major influence yet some mentioned the relationship between the UK and ESwatini as an influencing factor. Others still mentioned the tests that are administered in other countries (particularly the USA) prior to employment as major impediments for entry into their job system. The presence of friends already in the UK also had a fair contribution (62%) to the decision to choose the UK. Availability of information about the UK had a low influence (36%), probably because of the limited availability of the internet in ESwatini in the early years (before 2005) where the potential emigrants could access information.

A small percentage of respondents (8%) reported that they wanted to escape unfavourable conditions of their crumbling marriages or from abusive husbands. The same proportion (8%) claimed they had illnesses that could be better taken care of in the UK medical system than in ESwatini. Others even claimed they had been cured from illnesses they had carried in ESwatini for years without resolution. As one put it:

"I was so ill on arrival here that I am sure I would have died if my health had deteriorated while I was in ESwatini"

Arrival and Support in the UK

A majority of the nurses that migrated during the early stages of recruitment were met by the recruiting agent at Heathrow airport. However, those that came later were either met by friends or given directions to travel on their own from Heathrow airport until they were met closer to the locality. Friends have been very im-

portant to these later arrivals for information during recruitment and support at the initial phase of arrival. Some would even go to the extent of loaning arriving friends money or accommodating them until they found their own flats for rent. Such support is promised to the recruited friends before departure from ESwatini and it allays any fears of the unknown. Though information on organisational support is scanty, various support mechanisms by different organisations were reported by the nurses including transition, acculturation, mentoring and programmes that facilitated initial settlement. Assistance towards initial settlement sometimes involved securing accommodation for arriving nurses and even advancing them some money to assist with settling in but such loans were later recovered from the salary in instalments. Such an arrangement was more common with earlier arrivals who had no friends to rely on. Hence, a majority of nurses feel that they had a smooth settling in except a few who had hiccups. Some mentioned loneliness when they arrived, particularly those who were posted to work stations far from their friends e.g. those posted to destinations such as Northern Ireland. They reported very severe moments to the extent that they seriously considered returning back to ESwatini but were prevented by the lack of assurance of re-employment.

Experiences and expectations

Only 46% of the respondents were satisfied with their stay in the UK. Fifty-eight percent were satisfied with the general infrastructure of their workplaces including availability of equipment. Seventy-five percent were satisfied with the protection of human rights. Some claimed they were abused when they arrived but by the second year they were treated like everybody else. However, most mentioned that they never received any form of abuse or discrimination from employers or their representatives. Only 46% (n=22) of the respondents were satisfied with the political climate of the UK. However, the respondents did not mention what they didn't like about the political climate. Most respondents were not happy with the 5 year wait before they could benefit from the UK government's education assistance. They had expected to receive better opportunities in the UK for further education. However, some mentioned that failure to register for courses was sometimes of their own making because they always wanted to take extra hours at work in order to earn more money. As a result, 48% (n=23) of the respondents claimed they attempted to register for a course but failed to start or complete it. Twenty-nine percent registered and completed at least one short course e.g. a certificate qualification of some sort. They mentioned that their main interest was to get a Bachelor's degree or Masters or even better. Seventeen percent (n=8) of the respondents claimed never to have made any attempt to further their training.

Perceptions about type of work in the UK

A majority of the emaSwati nurses were content with their job(s) in the UK. Fifty-eight percent reported that they either work full-time or part-time at a care home for the terminally ill or old aged. Some claim exhaustion from their schedules because they work for more than one agency. Even though some claim that they didn't expect to work in such places but they were content with the work. Fewer nurses (40%, n=19) were actually employed as nurses in healthcare institutions and even fewer (13%, n=6) worked in hospitals (Table 3). Even though participants claimed that mental institutions paid better, only a smaller proportion had the required qualifications to work there, hence only 8% were employed in mental institutions (Table 3). The largest demand of the UK is caring for the large proportion of aged members of the population against a smaller young population, hence a majority of the nurses work in care homes. However, this study could not reveal other factors that may have contributed to the nurses working in care homes as opposed to practising as professional nurses. The younger age-group that is supposed to care for the aged consist of fewer citizens in the UK, hence the demand for labour importation.

Table 3: Employing Institutions of emaSwati Nurses in the UK

Institution	Number (%)
Hospitals	6 (13)
Care Homes	28 (58)
Mental Institutions	4 (8)
Other Healthcare Facilities	10 (21)

Seventeen percent of the respondents (n=8) reported cases of abuse by colleagues and twenty-nine percent (n=14) by patients. Respondents who were abused reported words like "idiot" being used on them by some white patients. A small percentage (8%) of the respondents had received promotion to the managerial level at some home care institutions. One nurse reported to have even received an award for excellence. The promotions and awards suggest that the quality of work from emaSwati nurses is appreciated in the UK.

Future Plans

Only a quarter (n=12) of the respondents said they have no intentions to return to ESwatini. About 13% claimed they had initial plans to return within 3 years, and 17% within 5 years while the majority (46%) claimed they wanted to return to take up employment in ESwatini after 5 years. However, despite these claims, 75% of the respondents indicated that they wished to explore employment opportunities in other developed countries in the future. This assertion suggests that despite original plans to return to ESwatini, the respondents have failed to meet their financial targets and hence plan to try their luck elsewhere. Some mentioned their dissatisfaction with the tax rate and general cost of living in the UK. Others mentioned that they were distracted by the many good items on sale in the UK which end up taking money away from the targeted projects. A reasonable percentage (21%, n=10) said they would return to ESwatini immediately if they were sure they would be re-employed on return. Reports

of the ESwatini government's practice of making them wait for two years ("to fix them for having emigrated") were the major factor preventing them from returning. A majority of those interviewed cited the social life of the UK as a major contributing factor to their willingness to return to ESwatini. They claimed to be missing the free time they enjoyed in ESwatini as opposed to the perpetual shifts and crammed schedules they had to work in the UK. They lamented that they had absolutely no time for recreation. The respondents also claimed that in the UK, every person kept to himself/herself and no matter what difficulty you had your neighbour would not help because often you would never even have seen that

neighbour. This is contrary to the situation in ESwatini where you meet, greet and eventually make friends with a new neighbour. The respondents felt that even the friends from ESwatini were "becoming British" in that they were developing tendencies to keep to themselves. A small majority travel around the UK either single or in groups to some European destinations once or twice a year as a way of recreating. Some nurses claimed to have met and married foreign nationals in the UK (particularly from Zimbabwe or Nigeria) but only two claimed to have married white British nationals. A small proportion reported they had developed relationships with fellow EmaSwatis which have resulted in them starting families there. However, some mentioned that they were forced by lack of options and neglect by potential partners from other countries and the only option was to agree to proposals from fellow lonely EmaSwatis.

Effectiveness on return to ESwatini

Lack of appropriate equipment (83% n=40), and the country's political climate (75% n=36) were cited as major potential impediments of the effectiveness of the respondents if they were to return to work in healthcare facilities in ESwatini. Other factors that did not rank very high included high work load (50%), lack of training opportunities (55%) and poor supervision (40%). The respondents mentioned that working in the UK had trained them to work with minimum supervision because the system is highly accountable. One was quoted:

"When a patient dies, there is a thorough investigation to exclude negligence by the nurse or doctor that was attending him/her prior to demise. In ESwatini, the death of a patient is never investigated".

Low pay was cited as a potential cause for de-motivation by some and the impact of HIV/AIDS was said to affect the patient/nurse ratio, resulting in increased work load and reduced individual output by any healthcare worker.

Discussion

Increasing globalisation of the labour markets suggest that migration of nurses is likely to increase, particularly as new destination countries emerge [25]. Therefore, migration of nurses and other healthcare professionals is an important policy issue for both source and destination countries [26]. Push factors identified by the participants of this study included the political climate and decision-making processes of the country, low pay, lack of equipment and that the nurses felt they were over-worked. Other studies classified push factors into non-economic and economic factors.

Motivation to Migrate:

The motivation of nurses to migrate from ESwatini to the UK is complex and varied but includes the inability for health workers to ensure enjoyment of their rights at work, demand for their skills in the UK and facilitating factors such as friends already working in the UK and agencies who both work as intermediaries. Facilitating factors make the increasingly well- established migration process look easier and possible to a nurse working at a rural health facility in ESwatini. The value of the pound, compared to the local currency of other potential destinations facilitates the choice of the UK ahead of other countries. The UK is further better placed because of the language and the close relationship the UK shares with the Kingdom of ESwatini. This relationship makes information about the UK easily available to a nurse who intends to migrate. Those who migrated later were largely influenced by the presence of a large number of former colleagues that were already working in the UK. However, successful transition and integration of migrating nurses is quite a complex issue that requires a robust support system based on ethical considerations [27] and must involve co- operation from the governments of both sending and receiving countries. The increase of recruited nurses in the UK's health system led to the development of policies aimed at ensuring that recruited nurses are well integrated into the new environment [28]. Such findings are also supported by Woodbridge and Bland [29] in a study aimed at enumerating transition issues affecting Indian nurses migrating to New Zealand. However, policies developed in the UK lack adequate monitoring mechanisms for anti-racist issues that were largely reported by the participants in this study. Racism is a very complex issue that require more robust approaches from overseas governments and has been repeatedly reported in many other cadres including sport. Anti-racist training has to be inculcated into the school system to change the thinking of future UK citizens rather than to depend entirely on policies that are difficult to monitor.

Pull and Push Factors

While there is a diversity of push factors that result in the decision to migrate, economic factors have been cited by a good proportion of the participants in this study. Other studies have also reported economic reasons and better working conditions as pull factors [30]. In Canada, for example, of the three million who entered after 2000, 60 percent arrived as economic immigrants and another large proportion as refugees that were escaping

unfavourable political conditions in their countries [12]. Non-economic factors mentioned by other studies included poor recruitment and retention strategies, poor job satisfaction and working conditions, adventure, socio-political and the poor social image of the nursing profession in their country of origin [31, 32]. Policies are important in creating comfortable living conditions particularly for women. Hence, this study has revealed a proportion of migrant nurses that were forced out of the country by abuse and failure of the country's policies to protect them. A majority of these have no intention to return to the country "unless the abuser dies" and some have found the freedom in new permanent relationships in the UK.

A reasonable proportion of the nurses (75%, n=36) also cited the political climate in ESwatini as a major contributing factor for their decision to migrate. The framework of human rights has much congruence with values associated with political, social and cultural freedoms and entitlements (civil society participation) as well as good governance. The inadequacy of these values in ESwatini has been suggested to hinder good development of public healthcare practice and personal development hence the decision for individuals to seek their own development elsewhere. The framework of human rights also has an objective to ensure that receiving countries give adequate assistance and pursue policies which support human development in low-income countries where recruitment occurs. While, contribution to the training needs of ESwatini by the UK Government is acknowledged, specific and direct contribution to the training of nurses falls short of the need in view of the benefit of the UK in this cadre. The UK can contribute to efforts aimed at increasing training capacity of nurses in ESwatini with the view of flooding the Eswatini healthcare system leaving enough for international migration. Hence, the ESwatini Government is implored to enter into negotiations with the UK government to contribute at least the training needs of each nurse they recruit so that these funds are planted back into training a replacement. Such an arrangement could also go a long way towards solving the high unemployment problem currently existent in the country.

Findings from the survey showed that, though basic equipment like thermometers, refrigerators, latex gloves, blood pressure machines and stethoscopes were available in >90% of all healthcare facilities some other important equipment, such as microscopes (13.5%), otoscopes (58.7%), speculum (61%), examination tables (58.7%), pressure pots (3.6%), glucostix (43%) and uristix (51.1%), suction machines and equipment to ensure safety of workers such as fire extinguishers(43%), autoclaving machines (43%) and steam sterilizers (20.2%) were less commonly available (Fig. 1). The unavailability of adequate and appropriate equipment was confirmed during the Service Availability Mapping (SAM) survey

conducted by the Ministry of Health in 2008. One would expect that nurses working with a population that is likely to have HIV positive clients would always have access to protective gloves but the fact that 0.8% of healthcare facilities did not have these essential protective ware could lead to nurses deciding to opt to migrate to work in safer environments. Post- exposure prophylaxis was found to be available in only 14.3% of all the healthcare facilities [33]. According to the Community-Based Care and Support Report 2008, a number of healthcare facilities in the country were not able to distribute home based care material to patients or their carers. On average 52% of health facilities in the country distributed home based care material and 48% were unable to distribute the material because of high work load at the healthcare facilities, poor staffing, lack of transport and equipment. Unfortunately, while the SAM survey revealed important findings on service availability, an essential component of manpower was not included in the survey.

Nonetheless, if well managed, diaspora can be turned around to be of major benefit to developing countries including ESwatini. This study suggests that the likelihood to migrate decreases with increasing length of employment. This suggests that the first 10 years of employment are crucial in finding ways to make new nurses happy and postpone thoughts to migrate. The ESwatini Government may create easy ways to access housing and motor vehicle loans during the first few years of employment to make the nurses see themselves making progress in their lives. The ESwatini Government may involve the nurses on any plans they may have to migrate so that agreements are made for them to only serve a defined period in diaspora and then return to resume their employment in the country. A majority of the nurses interviewed had plans to return to the country after they met certain financial and general economic targets. Only a small percentage does not intend to return. These reports are contrary to findings from South African health workers that reported family ties in the UK as the main barrier to return [34]. However, both studies suggested maintenance of strong ties with countries of origin of the nurses. After 5 years of work in the UK, migrants can successfully apply for provisional UK residence. This is common practice in many developed countries. For example, in Canada, migrants can apply for citizenship after remaining for 3 years. In SADC, only two countries, Mauritius and South Africa, recognize dual or multiple citizenship. In theory, nurses from ESwatini could, therefore, lose the citizenship of their country of origin upon acquiring UK citizenship. Therefore, migrants from most SADC countries commonly choose to forfeit their original citizenship and opt for that of the developed country such as the UK. Such citizens represent a complete loss because the country neither benefits from their remittance nor will it benefit from transfer of knowledge if they were to return. However, it cannot be assumed that these migrants would not want to return to their country of origin at a later stage, but because they would have forfeited their

citizenship, they would have no option other than remaining in diaspora. Plans to welcome and receive these returnees into suitable positions could only benefit the healthcare system of the country.

Ethical issues of recruitment

Ethical issues dictate that patients have access to the best healthcare in order for them to resolve or manage their illness [35]. As such, international recruitment practices of nurses have to take into consideration this main ethical issue and make sure that recruitment from developing countries remains fair and just [36]. It is a fair assumption that patients are likely to receive just and fair care when there are enough nurses and that the nurses are not overloaded with work, which often results in change of attitudes of the nurse towards the patient. Therefore, a recruitment practice that depletes the nursing staff of a developing country that has far more disease burden is unjust and unfair. This study could not show clearly why English citizens shun nursing as a profession. One possibility is that the working conditions and salaries offered are not attractive to locals. If such is the case, then the recruitment practices become exploitative. Justice oriented international recruitment also suggests respect for the autonomy of the individual nurse. In 2003, the international organization, Physicians for Human Rights, called on industrial nations to reimburse African countries for the loss of healthcare

professionals educated at Africa's expense and to try harder to meet their own health worker shortages. The group pointed to "a trade off between the rights of African health professionals to seek a better life and the rights of people in their home countries to decent health care". It did not, however, recommend that African governments should try and prevent the emigration of health care workers, but did recommend that industrial countries not recruit actively in Africa. In 2001, in response to such calls, the National Healthcare System (NHS) of the UK, promised not to engage in the "aggressive recruitment" of African nurses. However, later it was found that such calls were ineffective because the NHS policies do not cover private facilities and private UK hospitals. It is why in this study it was reported that most nurses were recruited or are employed by private agencies. As such, between 2001 and 2007, i.e. after the adoption of the NHS ethical recruitment policy, over 12 000 African nurses were registered to work in Britain.

Remittance Flows

A major benefit of source countries from international migration is through remittances i.e. the portion of earnings sent home to the country's economy [37, 38, 39, 40]. In 2001, global workers' remittances amounted to US$72.3 billion, which substantially exceeded the global

total amount received as development aid [41]. It was very difficult to estimate exactly how much emaSwati nurses remit back home. Nonetheless, a majority of the nurses make their savings in ESwatini. They send money through their banks in the UK straight into their accounts in ESwatini. The nurses acknowledged to send an average total of about US$120 000 (E1 200 000) monthly among all of them, which amounts to about$1 440 000 (E14.4 million) per annum. This amount has been calculated from submissions of only 48of the nurses working in the UK. Remittance benefit from nurses working elsewhere other than in the UK has not been included. Therefore, an accurate assessment of the remittance benefit from expatriate nurses is likely to reveal a larger figure than that reported here. Even though this money does not go directly into the Eswatini Government coffers, the economy of the country does benefit from the injection of such amounts of money from outside. With the high rate of unemployment in ESwatini, it would benefit the country to train more nurses and export them to such countries as the UK that require their services. Such an effort would no doubt ease the unemployment problem and also benefit the economic status and reduce poverty in the country. Furthermore, a country can have considerable benefit from the return of migrants if the right policies are struck [42, 43]. Policies allowing periodic (short term) return of professionals have been reported to provide additional benefits in the form of technological transfer to the country of origin [44, 45, 38]. For these reasons, the Eswatini Government is implored to develop positive attitudes to emigration of nurses just like it does with other age-old migrant cadres such as miners that emigrate to South Africa with an arrangement (The Employment Bureau of Africa – TEBA) facilitating employment and transfer of remittance.

Scholarship loan repayment

Fifty-four percent (n=26) of the respondents said they were unwilling to repay the scholarship loan. It was not immediately clear why they were unwilling but this negativity could be emanating from dissatisfaction with the current system of governance. A very small percentage suggested that even if they repaid, there was no guarantee that the money would eventually reach government coffers or benefit those who needed scholarship loans. Again, this attitude emanates from the Eswatini Government's lack of accountability for public funds. Efforts to reduce corruption could improve the attitude of many emaSwati, not just nurses, to embrace efforts of the government and make themselves party to such. Nonetheless, efforts to repay the scholarship loan could be made even for nurses that are working in countries such as the UK where the embassy could coordinate such efforts. Efforts to collect scholarship loan repayments in ESwatini have been very poor and sourcing out scholarship loaning and recollection to a private company could benefit the whole exercise.

With or without the repayment of scholarship loans, it remains an important fact that the eSwatini Government could never have sufficient training capacity to improve training so as to improve the local need for nurses while also catering for the effects of migration. The G8 summit in Toyako (Japan, 2008) and the L'Aquila (Italy, 2009), reiterated the need for increased cooperation between receiving countries and source countries in this regard in order to better manage the effects and impacts of international migration of healthcare workers. The World Health Organisation stresses the importance of international co- operation as a major key response to the call for ethical recruitment of doctors and nurses [46]. Co-operation in managing migration and facilitation of return can improve monitoring of healthcare workforce information systems as few countries have been found to have such capacity

Human Rights Abuse:

The findings of this study suggest that international migration of nurses in ESwatini partly results in human rights abuse. Also notable is the catastrophic impact of international nurse migration to the right to healthcare of the patients in ESwatini. Freedom of movement is a fundamental right for any citizen seeking a better life for him/herself and his family members. EmaSwati nurses, with their skills in demand in the UK, exercise this freedom to a considerable extent, and they and their families derive significant economic benefits from working in the UK. Labour migration in ESwatini is not a new phenomenon, having been started a long time ago by migrant workers employed in the mines in South Africa. Despite the issue being an old age practice, no policies were established by the Eswatini Government because the miners represented a group that was not in demand in the country. A proportion of nurses who wish to return to ESwatini have claimed fear of 'punishment' equivalent to two years wait by the Eswatini Government before they are re-employed. This practice, if true, represents a gross violation of human rights of the nurse and of the patients who are denied healthcare just because of individual personal attitudes and lack of policy. The central protection to the right to emigrate in international rights law is enshrined in the International Convention on Economic, Social and Cultural Rights (ICESCR: 1966) article 6 [47]. Therefore,

if there is a vacancy, an applicant should be employed unless restricted by law. Regional human right treaties also enshrine the right to healthcare, as does the new constitution of ESwatini. The practice by the Eswatini Government suggests for lack of accountability to the people who need and benefit from healthcare of the nurses. The human rights law is aimed at protecting the dignity and fundamental freedom of individuals and groups. The practice of singling out nurses from other professions for the 'punishment'

following return from foreign employment is gross discrimination and inequity, both fundamental principles of basic human rights. The Eswatini Government must account for this discrimination and inequity because it has accepted many other professionals who have returned from foreign employment and the country has benefitted from their experience. Accountability is a major defining feature of human rights. Judicial accountability is often weak in many low-income countries. However, other accountability mechanisms such as constitutionary and parliamentary mechanisms could be explored at the domestic level. At international level, practices of such a nature could be reported by the Swaziland Demogratic Nurses Union (SWADNU) to treaty bodies and to UN Special Rapporteurs who could set up investigations. At the World Conference of Human Rights (1993), at which ESwatini also participated, it was recognised and stated that, 'the international community must treat human rights globally in a fair and equal manner, on the same footing and with the same emphasis'. Human rights are enshrined in the Universal Declaration of Human Rights (1993) and in international human rights treaties. Through rectifying international and regional treaties, ESwatini voluntarily assumed obligations, which are binding in international law, to give effect to their provisions.

It is a proven fact that nurses returning from foreign employment gain considerable experience that the healthcare system of ESwatini could greatly benefit from. Side-lining returning nurses deny the healthcare system of the country the opportunity to benefit from contributions of these nurses.

It has been revealed in this study that part of the reasons cited by nurses who migrate to the UK is professional (educational) advancement. However, this dream is not achieved when they find themselves working overtime and for several agencies. The employers do not provide educational opportunities and the costs of university fees become an impossible obstacle to the ambition of the nurses. This is partly the reason many citizens of the UK do not follow a carrier in nursing. Cooperation between recruitment agencies, employers, the Eswatini Government and the UK Government is strongly encouraged to better manage professional training of nurses or any professional while working in the UK. Cooperation between recruitment agencies, employers and countries of origin and destination can ensure protection of human rights of migrants, address educational and professional issues to counteract and benefit from brain drain [48]. Involvement of the nurses through migrant associations in the design of effective policies by the UK government is crucial.

A small percentage of nurses have reported racial abuse by both employers and patients. This finding is largely strengthened by reports of a literature review conducted by Likube [49] on experiences of black African nurses in the UK National Health Service. Participation of trade unions and professional associations, as well as patients – the consumers of health services, [48] in countries of destination and origin is essential to ensure respect of human rights of migrant workers and their welfare. It is encouraging that nurses from ESwatini employed in aged care environments have reported motivation to care and provide the best outcomes for the elderly. Geriatric nursing is considered a specialised requirement in ESwatini due to the small population of the elderly and the absence of care homes for them. Therefore, to strengthen this motivation, specific education focused in clinical leadership and health team management is encouraged to provide these nurses opportunities for promotion to managerial positions. Identification of nurses in residential aged care with their leadership role has been reported to influence paradoxical feelings of being valued by clients [50]. Dwyer also mentions organizational barriers being strong in preventing continuing education and skills development for nurse leaders in aged care environments. Hence, this study found a very small proportion of nurses that had satisfied their intention to further their studies. This gap in the implementation of equal opportunity policies in the NHS in the UK has been reported in a study of the experiences of black and minority ethnic nurses conducted by Alexis and colleagues [51] in the south of England. Strategies, such as those providing professional education opportunities are likely to benefit the nurses satisfy their professional ambitions as well as source countries in knowledge transfer when these nurses finally return to serve in their countries. Such strategies could involve a set period when nurses should work in source countries before migrating and design of specific professional development while in the receiving countries and strategies to receive them into appropriate positions when the nurses eventually complete the set period of service in receiving countries.

Racism, discrimination and xenophobic attitudes have been reported by some of the nurses working in old age care homes in this study. This suggests lack of respect for emaSwati nurses by some UK clients. Racism is an old age global problem reported in sport and many other professions. It has also been largely reported among nurses from other countries such as India and other overseas countries [32, 52, 53]. Recruiting countries are urged to educate their populace about ethical issues of racial abuse and improve respect for the individual nurse and the nursing profession. Nonetheless, more research is needed to aid development of effective programmes to aid smooth recruitment, transition and utilisation of nurses and for source countries to manage and benefit from employment of nurses in destination countries. Use of the findings reported in this and other studies are likely to shape health policy and better management of nurse migration by both source and receiving countries.

Conclusion

Development of inclusive policies to address migration of all citizens of this country should be developed by respective government departments. Workers in all departments should be involved during the development of such policies in order for them to be effective. The ESwatini government should seriously consider the benefit of returnees from diaspora and consider turning nurse diaspora into a national industry. The rights of workers and patients should be observed when developing policies and

governments of overseas destination countries must be engaged to determine their role in the development of healthcare human resources including nurses. The ESwatini government should critically analyse push and pull factors with the aim of striking a balance by making local improvements to reduce the effect of push factors.

Key recommendations:

Delivery of healthcare and healthcare workers are essential to the economic, social and political stability of any country. Policies that provide the desired outcomes rather than uncontrollable and unintended consequences should be developed by those at the decision- making level of any country. If the country's priority is not to export healthcare workers, then it is important to structure policies that will encourage people to stay. However, many countries now favour structure controlled migration so that circular migration becomes a priority or a norm in view of the benefits to healthcare services of a country from the additional knowledge and skills as well as remittance they bring back.

- The ESwatini Government should increase its investment in strengthening training and retainment of nurses. The UK should be made to seriously consider the harm caused by international recruitment of nurses from a country with the highest HIV/AIDS and tuberculosis prevalence. This is by no means suggesting withdrawing the freedom of employment of nurses from ESwatini but the UK government should consider contributing to expansion of training facilities for nurses in ESwatini. Many qualifying school leavers' applications for the nursing course at the four institutions training nurses in ESwatini are rejected because of limited capacity or unavailable financial assistance to potential students. It is no doubt that overseas qualified nurses will continue to form an integral part of the nursing workforce in destination countries. Therefore, cooperation in training, including training needs, are required to overcome barriers such as cultural, ethnic and language differences between nurses and patients [54]. Intercultural communication, transitional barriers and development of communicative competence have been reported as major barriers of practice among nurses arriving to work in destination countries [54]. Developing nurse training curricula that emphasize in these barriers are likely to improve effectiveness of nurses in the quick establishment of nurse-patient rapport that is essential for quality nursing management of patients. Because of the reported major role of emaSwati nurses in aged care homes, provision of a carrier structure and choice in the industry for the nurse to become a clinical leader or manager of health services may improve recruitment and retention.
- An urgent need for a policy to guide government's response to international migration in eSwatini has been identified in this study. Drafting of such a policy should involve all affected stakeholders at all stages of development and must always take into consideration international human right treaties for which eSwatini is a signatory. The Eswatini Government should follow a human rights approach in its response to international migration of nurses. A human rights approach promotes non- discrimination and equality, preventing treatment of nurses differently from other groups of migrants.
- The Eswatini Government should ensure a clear balance between its internal demand and nurse migrants taking into account its healthcare requirements and training capacity. A clear determination of the local supply of nurses and the growing global demand should be used to influence long-term training plans for nurses. Measures to significantly increase the supply of nurses should be considered with immediate effect because such measures could also partly benefit the unemployment challenges currently faced by the country. The UK Department of Health may be involved in curriculum development to ensure that skills developed will suit their expectations as well as those for the eSwatini healthcare requirements.
- The Eswatini Government has a leading role in promoting local political commitment to address push factors identified in this study and ensure that more trained nurses opt to remain and work in the country as opposed to emigrating.
- Nurses in the diaspora are implored to develop overseas subsidiary associations. The ESwatini Democratic Nurses Union (SWADNU) should liaise with the overseas subsidiary association in the organisation of pre-departure orientation meant to raise awareness of the nurses on their rights while in the UK or other employing country in order to safeguard against exploitation and racial abuse.
- The Eswatini Government and the local nurses association (SWADNU) should develop databases of nurses in the diaspora and develop local systems to re-engage returning nurses in appropriate positions where their contribution to the overall development of the healthcare system and overall nursing practice will be realised.
- Participating financial intermediaries have a key role to play in easing the difficulties of remitting income to source countries. They should develop and facilitate transparent, low-cost channels and appropriate financial instruments for transfer of small funds into private accounts. Cooperation between the government of Eswatini, the association of migrant nurses and financial intermediaries is essential in promoting effective schemes for all migrants from Eswatini working abroad.
- The Eswatini High Commission in the UK should embrace the emaSwati nurses arriving for employment in the UK. They should organise social events for the recreation of emaSwati nurses. The Commission could also play a significant role in facilitating relationships between immigrants and financial institutions as well as promoting respect of human rights and respect for the emaSwati nurses.
- The Eswatini Government should engage in true reforms towards a government that will be 'for the people and by the people'. The lack of care for any damages on the healthcare infrastructure by emigrating nurses suggests lack of ownership by the government. Such attitudes could easily be true for a major proportion of the general populace and could be causing severe damages to the nation and the general economy of the country.
- The nurses working in the UK should form their own association under SWADNU which would cater for their welfare in the UK. Such an organisation could make bulk negotiations with the Eswatini Government for better conditions on return from foreign employment. The association could be instrumental in networking all the nurses and even organisa-

tion of periodic social events that could create a recreational initiative for all the nurses. Such an association would also play an important role in promoting effective respect of their rights by recruiting agencies and UK employers. The Eswatini Government could also have a direct link with the nurses through this association which could facilitate their input during the development of policies that may have a direct effect on their welfare.

Consent for publication

Not applicable

Availability of data and material

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SV wrote the first draft which was reviewed by all the authors. All the authors met and developed the data collection tool. SV collected the data and all the authors were involved in the analysis of findings and drafting of the final manuscript.

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