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To Stay or to Go?

Recruitment and Outmigration of Nurses from India

A GPN / JNU Project

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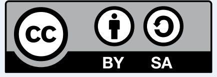

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Contents

Christa Wichterich: **Introduction** **3**

Reema Gill, Sneha Maji, Sanjeet:
Movement of Female Nurses from India:
A Discourse on Existing Migration Theories **6**

Daisy Zacharia:
Literature Review of International Migration of Nurses from India **22**

Vaishnavi Mangal:
Exploring Fairness in International Healthcare Workers Recruitment:
A Review of International and German Perspectives **42**

Ajit Kumar:
Current Newspaper Debates on Migration of Nurses from India **60**

Santosh Mahindrakar:
Navigating the Healthcare Maze:
Challenges and Issues faced by Foreign Nurses in Germany **84**

The Global Partnership Network **96**

Introduction

The Global Partnership Network (GPN) is a unique network of 12 universities and 18 civil society groups for research, teaching, and training in all continents around SDG 17 "Global Partnership for Sustainable Development". The GPN has been functioning since 2020, headquartered in Germany at the University of Kassel and funded by the German Federal Government. It aims to provide policy-relevant research in three areas: development cooperation, global economy, and knowledge production, keeping in mind that international partnerships have historically been shaped by colonial relations between North and South and continue to reflect them. GPN is an excellent forum to analyse transnational processes in the global economy and to organise comparative research in countries from different regions of the world, taking into account the prevailing global inequalities and neocolonial asymmetric power relations.

The project "To stay or to go? Recruitment and Outmigration of Nurses from Ghana and India" focuses on so-called Global Care Chains. Since the 1960s, transnational health care chains have been established as a labour regime in a post-colonial context to overcome crisis situations in social reproduction and a severe shortage of health care personnel in the OECD world. Health care workers, the majority of whom are women, migrate from poor to wealthier countries, from the Global South to the Global North.

A mapping of interests in migration of skilled nurses shows: governments in the South become labour brokers and use the export of cheap care workers as a development strategy which earns them foreign currency through remittances, and which is supposed to reduce problems of un(der)employment and poverty in their countries. Governments and municipalities in the Global North launch recruitment programmes which use migrant health care labour to restructure their domestic regime of social reproduction and manage the crisis with the help of a spatial fix at low costs. Furthermore, private training institutions are booming and commercial agencies in sending and receiving countries make money by facilitating the recruitment and placement. The key actor, the nurse, has a right to mobility and often a desire to migrate due to push and pull factors, and personal interests. Many decide for themselves to escape the low wages and often appalling working conditions in their home country, and get into debt due to the high fees they have to pay to training institutions and placement agencies. Their decision is informed by an economy of hope to earn more money, pay back debt, and support their family back home, get more respect as professionals and to achieve a higher standard of living.

This complex scenario of migration-oriented interests is confronted with the dramatic shortage of health care staff in most of the sending countries (even if figures are sometimes contested). It is well known that each care chain implies a care drain, and each migrant care

worker is missing in her/his home country and household. As the transnationalisation of health care work got increasingly normalised but not regulated, in 2010 the WHO published as a means of regulation a code for the recruitment of health care workers with a list of countries which suffer from a critical shortage of health personnel, and therefore should be spared from recruitment. The notion of fair and ethical recruitment was coined; however, the code is not binding but voluntary. A revised list was published by the WHO in December 2021. India was on the first list but doesn't appear in the revised list.

Immediately after the revision of the WHO recruitment code, Kerala was included in the 'triple win'-programme of the *Gesellschaft für Internationale Zusammenarbeit* (GIZ) and the *German Federal Employment Agency*. The German state normalises through this programme the spatial fix of the German crisis of social reproduction. The 'triple win'-formula assumes equal opportunities in a set-up of global inequalities, disguises care extraction and the maintenance of globally stratified relations of reproduction between North and South, West, and East, rich and poor.

Since the 1970s, India has been leading export country of doctors and nurses, primarily to Gulf states and to a lesser extent to the West. Nurses particularly from Kerala ventured out, with the majority being Christians. Facilitated by catholic networks, migration of nurses was organised informally from Kerala to European countries with a catholic stronghold such as Germany, Italy etc. From the 1980s onwards, we find a continuity of the trend of international nurse migration from India to the Gulf countries and to OECD countries like the US, UK, Ireland, New Zealand, and Australia with Kerala as the main source of outmigration. In the 2000s, some important changes have emerged with respect to the diversification in the composition of nurses in the migration chain. The entry of male nurses, as well as nurses from Hindu and Muslim backgrounds and from regions other than Kerala, such as Punjab or the Northeast, are now noticeable trends.

The Covid-19-pandemic however, when in India like in many countries of the Global South due to the lack of health care staff patients couldn't be treated in hospitals and lost their lives, made the violation of people's right to health apparent. Nonetheless, after the pandemic OECD countries intensified their recruitment and care extraction strategies vis-à-vis the Global South, often assuming a surplus of nurses in those countries who wouldn't find an employment. Some states facilitate easier immigration – e.g. Germany with a new Skilled Immigration Act - and thus refuel the transnationalisation of nursing. This resulted in more nurses leaving India. The conflict of rights between the collective right to health and the individual right to migration is obvious.

Government recruitment programmes or placement agencies mobilise possible candidates. However, most of the time they should be skilled, meaning: the sending state has to organise the training. This raises another serious question about the international division of labour and reaffirms the pattern of a spatial gap between skill training and skill usage in the transnationalisation of nursing. Due to privatization of nursing training, the costs of education are shifted to the individuals and their families who often accumulate a considerable debt burden.

The objective of the GPN-project "To stay or to go. Recruitment and outmigration of nurses from India" is to initiate and support debates about the contradictions, ambivalences, and contestations in the trend of outmigration of Indian nurses. In India, Prof. Praveen Jha, Prof. Sanghmitra Acharya and Prof. Ramila Bisht acted as research coordinators at Jawaharlal Nehru University, the institutional partner of GPN. Under their guidance, between August and December 2023 five papers were produced by Indian scholars and PhD students analyzing actors, driving forces, policies, and debates. These five papers are the centerpiece of this working paper.

- **Dr. Reema Gill, Sneha Maji, Sanjeet**: Movement of Female Nurses from India: A Discourse on Existing Migration Theories
- **Daisy Zacharia**: Literature Review of International Migration of Nurses from India
- **Vaishnavi Mangal**: Exploring Fairness in International Healthcare Workers Recruitment: A Review of International and German Perspectives
- **Ajit Kumar**: Current Newspaper Debates on Migration of Nurses from India
- **Dr. Santosh Mahindrakar**: Navigating the Healthcare Maze: Challenges and Issues faced by Foreign Nurses in Germany

Additionally, on November 29, 2023, a webinar was organized by JNU and GPN with five presentations by scholars and practitioners. The purpose was to discuss the topic in its complexity and to inspire a critical public debate about the latest trends in outmigration of nurses from India, fair recruitment and the impact on the Indian health system.

- **Dr. M. Prakassama** (ANSWERS, Academy for Nursing Studies and Women's Empowerment Research Studies, Hyderabad): Determinants of out-migration of nurses from India
- **Prof. Rajan Irudaya** (International Institute for Migration and Development, India): Barriers to Health Professionals Migration
- **Prof. Margaret Walton Roberts** (Wilfrid Laurier University, Ontario, Canada): What does fair migration for nurses look like? Contrasting global nurse migration pathways
- **Prof. Ramila Bisht** (JNU)**:** Trends towards customisation of skill training in India-UK nurse migration
- **Dr. Shashi Mawar** (Ass. Prof., AIIMS, College of Nursing, New Delhi): Pull and push factors of migration of nurses from the North-Eastern region of India

The presentations were followed by a lively discussion.
The recording of the 2:15 hours session will be made available online.

Dr. Christa Wichterich, Board Member GPN

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Movement of Female Nurses from India: A Discourse on Existing Migration Theories

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Contents

Abstract 8

1 From associational migration to employment migration: Tracing the trajectory of female migration 9

2 Being woman, being migrant: Female Nursing Migration in South Asian context 10

3 Re-examining the theoretical approaches to understand female nursing migration in the South Asian context 12

4 Conclusions 18

References 20

Abstract

When the post-war welfare economy in the Global North, was replaced by the neoliberal ideology, there appeared a flexible transnational flow of not only goods, services, and financial capital, but also of people that contributed to the production and service aspect of the economy. Human migration has been an inherent element of human advancement in history. However, the cross-border movement to participate in global labor markets, had certain nuances which require detailed analysis. Although the data on migrant laborers is scarce and has been addressed time and again by researchers (Stilwell et al., 2003; King-Derjardin, 2019), the very phenomenon of migration of laborers has been internationally recognized. Even the *General Agreement on Trade in Services* (GATS) has been introduced in 1995 to regulate in and outmigration of consumers and providers across borders (Woodward, 2005).

Within this context, this review paper aims to elucidate the various stages and significant aspects of international labor migration originating from India, with a particular emphasis on the migration of females. The subsequent section of this article will examine the phenomenon of female nursing migration within the broader background of the extensive transnational movement of female care workers worldwide, particularly from developing to developed countries. To comprehend the case of South Asian nurses migrating to industrialized nations, this work will analyze current migration theories and discuss potential directions for an integrated theoretical approach.

1 From associational migration to employment migration: Tracing the trajectory of female migration

Kapur (2011) has developed a classification system for global migration pathways. The author recounts that throughout the 19th century, individuals from the global south migrated exclusively to various countries within the southern region. The author designates this phenomenon as South-South (S-S) migration, and also observes a corresponding North-North (N-N) migration pattern in the context of the Global North. In recent times, however, he has expanded his categories to include the South-North (S-N) route, noting the increasing appeal of the global north as a migration destination for individuals from the Global South. The same point is reiterated in Gulati's (2006) argument, where she illustrates how there has been a shift in direction of movement as far as Asian population is concerned. From the earlier favored routes of migration limited 'inside Asia', individuals have now moved on, for destination countries outside of Asia, preferably in the west.

Migration studies, as an interdisciplinary field, encompasses a comprehensive examination of various aspects related to migration, including immigration rules, opportunities to work in foreign countries, social-cultural impact of migration on sending and destination countries etc. However, most of the generalizations on migration behavior is based on male migration patterns. As the migration streams of male and female population are integrated and history of working female migrants is explored without downplaying and adding them inadequately in the category of associational migrants, a different picture comes in. Zlotnik (2003) illustrates in this regard, how women consisted of nearly 47–49% of international migrants even in 1960–2000 period. In the context of India, there has been a notable increase in the number of female migrants over the course of years. In 2019, female participants constituted 48.8 % of the population of foreign migrants originating from India (United Nations, 2019)

2 Being woman, being migrant: Female Nursing Migration in South Asian context

Given that women, like men, are migrating in significant numbers, and not just in associational relationships, but also in employment contexts, it is important to note that male migrants are treated differently than female migrants. The previous section posited that women from developing nations who are engaged in menial and semi-skilled jobs possess a comparative advantage in terms of migrating to developed countries, in contrast to their male counterparts. The migration of skilled women from developing countries, has been as prominent as the other migration patterns (Raghuram, 2006). The latter phenomenon in fact became a much-highlighted topic over the pandemic as while developing countries like India were suffering from an acute shortage of nurses with just 1.6 nurses per 1000 population[4] in India in contrast to the WHO norm of 3 nurses per 1000 population , the developed countries were still recruiting nurses from the former to operate their healthcare system uninterruptedly.

According to Perappadan's (2022) report in *The Hindu* India has been suffering from an acute nursing shortage. Conversely, other sources have expressed their commitment to developing a self-sustaining healthcare workforce in India by the year 2047 (FICCI, 2022). However, according to Overseas Development and Employment Promotion Consultants (ODEPC) website of Kerala government[5], India is not 'short' of nurses technically, rather it produces enough nurses by itself to even supply as per the global need of nurses[6]. Thus, the shortage happens not from non-existence but due to migration of the domestic workforces to outside (Gill 2018). On the other hand, importing nurses from outside saves the cost of producing ones for developed countries (Bhattacharjee, 2023; Tsujita, Oda & Rajan, 2023; Walton-Roberts, 2012).

Nursing institutions in India have been instrumental in the education and training of nurses since the colonial era, during when white nurses were regarded as a symbol of expertise. The nurses were commonly perceived as female individuals donning white attire, driven by an altruistic objective of providing service and care. These nurses were placed outside the confines of the occupational classification. It is essential to note that only wealthy or privileged individuals could afford to be treated under western biomedical supervision and by nurses at that time. Nonetheless, nursing as a career was not well embraced in the Indian culture due to the requirement of touching male bodies and body fluids of the sick. This

4 As per 2018 data on India, as available at OECD database. https://data.oecd.org/healthres/nurses.htm

5 ODEPC promises aspiring migrant nurses guidance and ensures to export 'most talented ones' outside

6 India now ranks second after Philippines only, in this regard (Perappadan, 2022).

portrayed nursing as a loose and dirty vocation in Hindu tradition (Gill, 2018; Walton-Roberts, 2012). The relation between Islam and nursing in India too was not very positive as opposed to Christianity (Percot and Rajan, 2007). The abandonment of nursing as a potential career opportunity by others, in fact turned to be a boon for the Keralite Christian nurses who transcending those stigmas could get educated and gain employment jobs.

In the 1970s, a significant development occurred in this context, wherein Indian nurses were presented with the prospect of migrating to the Gulf region. Many women were compelled by their families to migrate, even if they were already married and not professionally active in some instances. The majority of these migrants were Malayali Christians, as this profession has traditionally been associated with this community (Percot, 2006; Percot, 2023). However, the phenomenon of migration in the nursing profession has become widespread since then and is now associated with specific subtleties.

According to Percot (2023), nurses in the Gulf region have the potential to earn significantly higher salaries, and in the initial period of Gulf migration it was up to 10-15 times more than that of their counterparts in India. Furthermore, nurses going to the west could make much more money while enjoying greater individual freedom, the opportunity to travel with family, and a higher standard of living (Percot & Rajan, 2007). Consequently, nursing has become a more appealing career choice than in previous times.

However, while the initial burden of covering the expenses of relocation in the context of gulf migration in the 70s was assumed by the government of the host country, it has now become linked to the facilitation of recruitment agencies and subsequently, has become costly. Additionally, contrary to prior agreements, the current cost of nursing education at private training institutes has also increased. Therefore, it is important to note that the expenses associated with nursing training and migrating solely to the Gulf region, or progressing from the Gulf region to the West as a subsequent step, or even directly to the West as an initial step, have eliminated the earlier perception of nursing, as a profession predominantly pursued by individuals of lower socioeconomic status (Percot & Rajan, 2007).

On a different note, despite increasing costs, the individual or household decision for investment in nursing education, is considered profiting as per Percot and Rajan's 2007 study. One reason for that, according to them, is the future prospect of migration through nursing. Secondly, demand for nurses remains high, both domestically and internationally. Thereby, even if one stays back in the home country and receives relatively less salary as compared to outside, one never remains unemployed.

Nevertheless, this constant popularity and subsequent enrollment and supply of nursing, technically create excess nurses for the domestic hospitals, as far as the employment of nurses in India is concerned. Although government nursing jobs provide a better remuneration, they are less in number, as compared to private hospitals. Thus, the latter utilizes the surplus labor supply condition, to get an upper hand in negotiation and to keep the nursing salary at a minimum level. This in turn, while it does not necessarily curb the desirability of nursing as a career in general, it contributes to pushing the nurses to further invest in migrating and settling for better-paid options abroad.

According to Gill (2011), the nursing profession in India is characterized by a phenomenon known as step-migration. This entails individuals initially relocating to South India for training purposes, followed by seeking employment opportunities in major urban areas such as Delhi and Mumbai to acquire practical experience as nurses. Subsequently, these individuals proceed to the Gulf region by paying substantial fees to recruitment agencies. This pathway ultimately provides individuals with the opportunity to move to OECD countries after significant financial investment, relocation, and enrollment in different educational programs and examinations. Therefore, the sustained motivation and adoption of migration strategies among the aspiring and working nurses in India, will be revisited in the next section using existing theories.

3 Re-examining the theoretical approaches to understand female nursing migration in the South Asian context

Walton-Roberts (2012) employs the Global Nursing Care Chain (GNCC) model to elucidate the ongoing phenomenon of female nurse mobility. According to her, nurses hailing from developing countries, particularly those in the South Asian region, choose to migrate from their home countries mostly due to economic motivations. This migration is driven by the attractive opportunities and incentives offered by developed nations, thereby emphasizing the pull factors associated with these countries. Simultaneously, the author acknowledges the influence of push factors, such as the societal stigmatization of contact with bodily fluids within the nursing profession, which has historically contributed to the devaluation of both the occupation and its practitioners. In fact the narratives of migrant nurses from Kerala about their collective experience of stigma, hopefulness about elevated lifestyle and opportunities upon employment in the US, partially epitomize this model (Percot & Rajan, 2007; Walton-Roberts, 2012).

While such understanding throws light into the motivation aspect specific to nurse migration, the Global Nursing Care Chain (GNCC) theory has its roots in Hochschild's formulation of the idea of Global Care Chains (GCC). Hochschild (2000) argued that GCC is a unique formation being anchored in global capitalism, where it works as "*a series of personal links between people across the globe based on the paid or unpaid work of caring*" (p. 131). As she herself explained in her work, Hochschild (2000) was responding to Parrenas' then forthcoming book (2001) on Filipina domestic workers, by conceiving of the GCC model, which according to Yeates (2012) takes after the global commodity chain model.

To give a context, Parrenas' (2001) was primarily interested in the migration motivation and migrant lives of Filipino domestic workers in Rome and Los Angeles. Within this background, she explicates the nuances of globalization of mothering, where the Filipino women leave home and own children, and attends to the care of their employers' children. By doing so, they express their motherly affection, which could not be communicated to their children back home. Simultaneously, this act of replacing own sons and daughters with those of the employers at a certain level, helps them to get through the job and send their earning back at home – which acts as a materialist representative of their sincere love for their own children. This is from where Hochschild (2000) picks up her argument to claim that in a globalized labor market, the feminine duties of the first world wives and mothers, are fulfilled by the third world female migrant care workers, constituting a chain of care spanning across the globe.

Considering the increasing participation of women in the workforce, particularly in developed nations, the author's argument highlights the phenomenon of surrogate housewives. These surrogate housewives are care workers who enter the labor market of developed countries by migrating from less developed regions, thereby compensating for the lack of women in domestic roles. Nevertheless, the absence of the parents in their own home is solved by the employment of inexpensive caregivers, resulting in the establishment of a network of caregivers that transcends national lines, as observed by Hochschild. The author posits that the primary drivers behind the migration of care workers are financial incentives and wage disparities between different national economies. This migration is predominantly undertaken by women who seek to emulate a professional life trajectory traditionally associated with men.

Yeates (2012) has in fact, critiqued how Hochschild's version of Global Care Chain theory unintentionally naturalizes care work as feminine work and also how her theorization of GCC did not elucidate the skilled and unskilled varieties of care work. But simultaneously Yeates has popularized the GCC model itself by modifying it and incorporating in it the possible modes of care work, for example internal and external care work like domestic help, geriatric carer, non-profit and for-profit care-giver and so on. Moreover, Yeates (2012) and Walton-Roberts (2012) problematize the GCC and GNCC as they argue how women placed in care chains are subject to exploitations at intersectional level due to sexual, racial and stigmatized responses to them on an everyday basis.

However, we in this paper, would like to point out how both the modified GCC and GNCC models despite their inclusiveness of both skilled and unskilled work and problematization of care work as a gendered construction itself, fall back on the same shortcomings as of Hochschild's endeavor. Hochschild (2000) proposes an integrative theorization on migration. She looks at how individuals consider the money-making aspect, pull factors of development and rely on household decision making while undertaking their migration related decisions. She is also precise in mapping out the macro structures operating behind those decisions as she refers to the dual labor market theory of Piore[7] who argues that to motivate highly skilled workers to perform, it is essential to keep the income hierarchy intact nation-wise, and to the World System Theory's[8] (WST) migration variation through considering the politics of development under which land, labor and even care workers are absorbed into the first world.

However, it is exactly this model of incorporation with modification of existing migration theories, that lies at the heart of the limitations of GCC and GNCC theories. Massey and his colleagues' article (1993) was written on the background of the explicit rise in migration flows towards global north from south, unlike its previous N-N, S-S direction (as even Kapur, 2010 argued), where they were not considering specific cases of female migration rising out of contexts specific to South Asia, for example nurse migration in the Gulf. Still, it is their integrative approach that has been consulted for explaining these cases, as has been observed in Percot's multiple works mentioned previously.

Massey et al. (1993) in their paper although claim to consider both economic and social contexts of initiation and perpetuation of migration, however, the weight given to the first is far greater. In their argument, they acknowledge the differential development positions of countries and the S-N migration streams but place the pull factor of development as the explanatory tool. The endeavor of GCC and GNCC models to revamp this existing integrative model, henceforth, passes on the rational-individualist and economically deterministic elements of the latter to itself.

7 Piore argues, under any circumstances, to motivate the highly skilled workers in joining and performing, it is essential to keep the income hierarchy intact. This rule applies to both developing and developed countries, where with the hierarchy remaining constant, values of income for each occupation may differ.

8 World System Theory (WST) according to Wallerstein, analyzes how the development status of a country is negotiated within global capitalism, based on whether it is situated in the core, periphery or the semi-periphery of an existing world system. The original theory proposes that it is the core that absorbs resources from the peripheries, to retain its advancement in the development process. The WST approach for migration, follows this theoretical position, as it assumes migration to be a 'consequence' of global capitalism, following which the capable human resources of developing countries are acquired by the developed countries, for a cheaper and more efficient solution to skilled labor shortage (Massey, 1994). Thus, migration is not a problem that can be solved by ensuring income equity across countries. Rather migration is inherent to the survival of capitalism itself

It is in this scenario, that we would suggest rephrasing that migration is not even a 'consequence' but a condition to be fulfilled repetitively for the treadmill of capitalist economy to keep moving forward, where a hierarchy of cities is created with labor-importing global cities and labor-exporting urban centers in peripheries. Posing migration as a result of unequal development (the pull factor) would mean, labelling migration as an economic repercussion as the World System Theory (WST) under its Marxist influence, give too much importance to economic factors of structural inequality. As Kline (2003) opines on the possibilities of a push factor in nursing migration to be personal safety, that can be violated due to stigmatization and sexualization of nursing in South Asian context, it becomes evident how the push-pull theoretical framework can be worked out to transcend the economic determinism for the broader social and gender specific discussion.

The fact that WST missed out on micro aspects despite its promising macro approach, also meant micro theories available to explain migration would be appropriated in the integrated theory. Thus, the household strategy strands of new economics of migration became popular. But the question that we would like to add here is: who takes the decision in a South Asian household set-up? As GNCC theorists problematize the feminization of care work, it also needs to be part of the discourse why in societies where traditionally men as rational individuals have left home to earn, now women left to earn? Who took that decision on her behalf? As is in fact evident from Percot (2023), female nurses in the1970s not engaged in work in India, were forced to go to the Gulf by their family so that extra income could be added to the household and how the network they created or supported to help the community members move were out of the thinking that this might add a positive note to their character; they were afraid of being suspected back at home and in fact reinforced traditional feminine role to uphold their image. Thus, female migration unlike male ones was negotiated at the intersection of economic motivation and social sanctions, where decision-making power regarding whether to go and whether to specifically join care work. Some even de-skilled and worked as care worker despite having a degree of nursing to wait and gain residency status in a more developed country. The unitary household model of Gary Becker, which has been used for formulating public policies in many countries including India, assumes that a household is a single agent in production and consumption and has a single set of preferences. Even if the wages of the family members are not equal, the income and the resources like capital, labour, land are pooled together (Becker 1988).

Therefore, simply commenting on how countries of the Global South being discriminatory towards women more and how through GCC, women are further implicated due to the hierarchy of the developed and developing world, is inadequate. As in case of India or any other nurse-exporting country, the developed-underdeveloped binary lack explanation power. Nurses are skilled workers, whose employment and demand in abroad, show their train-

ing meets international standards. Thus, an underdeveloped country would not be able to produce such skilled workers co-incidentally. Walton-Roberts (2015) uses a Global Political Economy (GPE) approach in this regard, to convey that the migration of Human Resources for Health (HRH) can no longer be explained using a nation-state format. For her individuals with health education and training of international standard and fluency in English, are provided with both the opportunity and aspirations to join the transnational health industry. Moreover, individuals from countries like India and Philippines that has a long history of sending nurses abroad, get a competitive edge as opposed to other in enrolling and training for nursing courses. Walton-Roberts (2019) mentions that in India, the nursing council has compromised with the previous restrictions on opening private nursing schools, to battle the shortage of nurses in the home-country. But in reality this has contributed to the generation of more nurses preparing to move abroad and not to attainment of *Sustainable Development Goals* (SDG) related to balanced and safe migration and equal access to healthcare.

The latter problem mainly emerges from unwillingness of human resources for health to move to rural areas in their home country as they prefer abroad employment over such low-paid and remotely placed jobs. Walton-Roberts and Hennebry's (2012) found in their study that more Filipina nurses are intending to stay behind and seek citizenship in the West than Indian nurses. The Philippines have in this case a more explicit position, as a nation-state actively supplying nurses abroad which was earlier not the case with India though it facilitated candidates eyeing abroad opportunities. However, the aspirations and life conditions of Kerala nurses, as per study, direct to a clearer position vis-à-vis seeking abroad citizenship of these women. Percot and Rajan's (2007) work documented how Keralite nurses abroad often de-skilled voluntarily to seek resident status there and then work as nurses. Re-iteration of this tendency has been marked even in the 2012 study by Walton-Roberts and Hennebry as both Indian and Filipina nurses are likely to either seek education abroad or join as caregivers in a western care system to ensure employment and slowly prepare for citizenship there. This strategy to remain abroad and to in fact return from the home country time and again to work abroad, however is to be traced in expensive health education. Assured employment scope in the home country or abroad instills in one the confidence to get a loan and invest in nursing education (Percot & Rajan, 2007). Nowadays, there are many institutes which are coming up with collaborative nursing degrees wherein the nurses are given opportunity to complete one or two semesters abroad. Also, there are cells in the hospitals which provide training to nurses for international migration purposes. At the same time, it is because of this very loan, that one is trapped in the cycle of moving to west, getting a relatively high-paid job in either nursing or in care-giving and returning home only to go back to abroad (Walton-Roberts, 2013).

On the other hand, parallel rise in number of private nursing training institutions and number of migrating nurses has also been encountered in the state of Punjab, India (Walton-Roberts, Bhutani & Kaur, 2017). This in turn highlights Walton-Roberts' GPE perspective.

In transnational health care markets characterized by multinational corporations opening up hospital chains and institutes, the global demand and constant job opportunity of nurses, rise of health education cost and burden of loan are cyclically connected in a way, that pushes for nursing migration. Countries like India and Philippines, with early exposure to comprehensive English and health education, thus, get a competitive edge. However, a question remains. Is it solely the cross-border global political economy (GPE) that is controlling this cycle and the nursing migration? And if not, where to situate the role of family and its negotiation with GPE in the present scenario. Is it because families want their daughters to follow traditional gender roles while working and moving abroad, so that daughters don't turn into men like Hochschild imagined happening in western countries, or is it just that OECD countries have been able to afford to hire nurses from other countries?

On a different note, while nursing as a career is not going out of fashion anytime soon, with internationally educated nurses (IEN) sustaining a pool of choices for employment in developed countries, the number of male nurses enrolling and joining workforce, simultaneously keeps rising. This special mention of male nurses in fact, becomes necessary as in commonsensical assumption nursing has always been associated with feminine work in a naturalized logic. Unlike the western context, where nursing has gradually been decontextualized from the trope of altruistic female duty to emphasize a gender-neutral professional scope of nursing, the South Asian countries retain a gendered view of care work. Now that the western demand for skilled healthcare workers especially nurses, are getting fulfilled through nurses imported from these Asian countries in great numbers, this cultural tendency of feminizing care work surviving in exporting countries, travel through and continue to exist in the West too. This argument can be explained in fact, using Appadurai's conceptualization on globalization.

In his renowned article, *Disjunction and Difference in the Global Cultural Economy*, Appadurai (1990) refutes the oversimplified narrative of globalization leading to homogenization. The author contends that when cultural influences from one region reach another, the former does not immediately gain dominance of the latter. Neither do the imaginations of the individuals instantaneously coincide with those of their respective imagined communities. This disjunction as prevailing in the cultural forces in a globalized political economy, is addressed by Appadurai (1990) as he conceives of five 'dimensions of cultural flow' resembling 'fluid, irregular shapes of the landscapes' namely the ethnoscapes, technoscapes, finanscapes, mediascapes and ideoscapes (p. 296, p. 297). He understands ethnoscapes as presenting the moving population worldwide. For him, ideoscapes represent the post-enlightenment Euro-American ideas on liberalized politics and economy, which are accepted but not without

localized revisions, and reinterpretations in the non-European contexts. Thus, as the migrants from their host countries move to the destination countries for employment purposes, they subscribe to or at least participate in the globalized economy. But at the same time, the gendered ideas of work as inherent to their imagined communities (in South Asia) condition their career decisions of care work or nursing. With these seemingly diverging ideas interacting in the globalization context, the care workers move and so do the overlapping ideas of work, although not in conjunction but in relation. Thus, it can be stated that the Western 'idea' of nursing while liberated from feminization, the imported nursing 'workforce' of West, still is produced in home countries under a gendered imagination of division of labor.

4 Conclusion

The phenomenon of nursing migration from India began since the 1970s as majority of Keralite nurses left for the Gulf (Percot, 2023). The sustained flow of nurses from India to the Gulf and later to the Western nation-states through step-migration, however, cannot be understood in an isolated manner, without contextualizing it into the global nursing migration. Therefore, emerges the Global Nurse Care Chain (GNCC) model to explain how nurses move globally for better income, greater lifestyle and social dignity available in developed countries (Walton Roberts, 2012). Placing the nurses in the greater population of skilled and unskilled care workers, the modified Global Care Chains (GCC) theory on the other hand, illustrates the chains of care and dependency, weaved by third world care workers seeking a job in the OECD world, in a globalized labor market (Yeates 2012). This cheap and convenient Global North solution to their shortage of human resources for health (HRH) through utilizing Global South surrogate HRH, rather than building own health workforce, has been critiqued time and again (Tsujita, Oda & Rajan, 2023).

Nurses form a significant section of both health workers' migration and the stock of women migrants. Nursing migration illustrates the role and importance of socio-political and institutional factors in shaping the pace, direction and impact of international migration. The nature of global interdependencies of nursing care and inequalities that nursing migration entails elucidate issues regarding the regulation and governance of international migration of nurses in global context.

This perpetuating pattern of transnational movement of female nurses has been analyzed with the existing theories in migration studies, that explicitly revolve around the micro-economic rationale of decision making or macro-economic background. Even the GCC and GNCC models that were carefully laid out to cover the intersectional experiences of migrant female care workers, adopted the integrative model of Massey and colleagues, which provides more of a masculinist generalization of every migration case out there. Within this context, this paper attempted to look for a theoretical alternative that would incorporate the economic motivations for individual and household decisions for migration as well as the unique conditions under which women are motivated to migrate as professionals.

The global migration of nurses is a multi-actored, multi-locational and differentiated process. Thus, a multi-faceted and integrated approach is required to understand international nursing migration. The global dynamics acts as the central force behind international migration of nurses. Movement of nurses is a coalescence of different factors and forces. It is not just an occurrence rising from global equation of supply and demand of nurses as the spaces of globalization are multiple, intersecting, socially and politically constructed.

Gender is 'a fundamental organizing principle of society' and it plays a crucial role in the decision-making process for choosing the migrant and the non-migrant in a family, or the sort of jobs a migrant has access to - considering that domestic service, care work and sex work have been traditionally the gender specific niches of the labour market (United Nations 2006: p. 14). It can be accepted that not only gender is a vital factor in organizing migration but also that gender relations facilitate and constrain the migratory practices of women and men, thereby influencing their migration experiences.

Migration theories fail to adequately address the role of gender in the international migration processes, even though gender adds a crucial dimension to them. Therefore, this paper is an attempt to understand the phenomenon of 'female' nursing migration. Unlike their male counterparts, women's decisions to migrate for more money, as influenced by familial suggestions, are subject to an additional weight imposed by patriarchal mechanisms. Hence, the inquiry arises as to the determining factors behind the decision-making process regarding women's migration. How is the selection process for selecting the occupation of a prospective female migrant conducted? What is the typical response of women when faced with such pressures placed upon them? This research aims to investigate these concerns in order to address the current theoretical gaps regarding female migration. The paper, henceforth, proposes to explore these questions on an empirical level in future, and to further contribute to the existing gaps as far as female independent migration is concerned.

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Literature Review: **International Migration of Nurses from India**

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Contents

Introduction 24

1 Conceptualizing Global Nurse Migrations 25

2 Contextualising Nurse Migrations from India 27

2.1 Historical and cultural evolution of nursing as a profession in India 28

2.2 Individual, community aspirations and gender dynamics in the sending countries 28

2.3 Historical and current migration patterns 30

3 Structural Factors in Migration 31

3.1 International immigration policies 31

3.2 India's approach to migration of nurses 32

3.3 Migration Industry in India 33

3.4 Education Institutions 35

4 Research Gaps directions for future research 37

5 Conclusion 38

References 39

Appendix 40

Introduction

India has been one of the largest suppliers of health workers since the 1950s. Beginning in the 1950s and 1960s, the immigration of nurses from India to other nations has increased dramatically. Both doctors and nurses are drawn to working abroad for a variety of reasons, and estimates show that recently between 20 and 50 percent of Indian health care employees planned to look for a job abroad (Walton-Roberts et al., 2017). The World Health Organisation (WHO) guideline stipulates 22.8 doctors, nurses, and midwives per 10,000 people; however, in India, it is well below the expected numbers with 3.3 certified allopathic physicians and 3.1 nurses and midwives (Walton-Roberts & Rajan, 2022). In most countries under the Organization for Economic Cooperation and Development (OECD), there were 3–4 nurses per doctor (WHO, 2022, p. 13). The majority (81 %) of nurses in the world were concentrated in America, Europe, and the Western Pacific regions, where the density of nurses per 1000 population was 8.34, 7.93, and 3.60 respectively. In contrast, the density of nurses per 1000 population in the South-East Asia Region was only 1.65, which is less than half of the world average (3.69)(WHO, 2022). This situation was a result of the significant migration of nurses from developing countries, particularly the Philippines and India, before the COVID-19 pandemic (WHO, 2022). This mobility of nurses often from the Global South to the Global North has significant impact on these societies and involves several actors and agents that shape it.

This review of literature is a content analysis and will focus on arguments and questions that shape current research about nursing migration from India. A total of 12 academic writings published after 2010, including articles and books and reports were selected for this literature review. This paper attempts to present the shifting focuses in the study of nurse migrations from India. The first section follows the arguments around the conceptualizations of the phenomenon of nursing migration and how these theorizations have shifted over time in these studies. The second section follows how these studies have contextualized nurse migrations from India. The final section attempts to map how the emerging literatures delineates the structural factors that shape patterns of migration from India to international destinations. The review aims at bringing forward gaps in existing literature as well as emerging questions to shape further research in the area.

Conceptualizing Global Nurse Migrations

International healthcare workers migration has been studied through the lens of various frameworks of migration. According to a review of literature by Garner et all, the push and pull theory of migration looked at factors in the sending countries such as limited opportunity for professional development and adverse working conditions, while pull factors are conditions in the migration destination (Garner et al., 2015). However, this theory has been critiqued by Prescott and Nitcher (2014), as cited in Garner et al., for its reliance on individual decision making and not focusing adequately on the broader global context of this migration (Garner et al., 2015).

Walton-Roberts (2012) argues that the Global Care Chains (GCC) framework shows how care deficits are filled through the migration of workers from lesser income countries to higher income regions. This framework according to Walton-Roberts, focusses on feminized global migratory flow of care labour especially in domestic care work. The GCC framework has been critiqued for not taking into consideration formal care labour sector, as well as the regional patterns of migration. Walton-Roberts proposes the concept of Global Nursing Care Chains (GNCCs). This framework understands the crisis of labour in the Global North as precipitated by multiple factors including decline in welfare states, changing demographical trends, as well as health education institutions, and inability of these states to retain trained nurses (Walton-Roberts, 2012). This crisis has led to a commodification of care labour in both formal and informal care provision. This has led to the increased use of 'Internationally Educated Nurses' often from the Global South as a 'quick-fix' to 'structural deficiencies of the global health system'(Walton-Roberts, 2012, p. 176). This approach looks at the migration of skilled labour as an institutionalized process that is facilitated by different agencies and states.

Walton- Roberts (2012) uses this framework to understand nurse migration and status of nurses in Indian society vis-à-vis caste and gender structures. Within this framework several other analytical categories are being used by various studies, for example, the feminist critique that points out to the international division of reproductive labour that 'nurse production industries' (Hillmann et al., 2022, p. 2295) operate through. Hillmann's et. al. study points out further, to the formation of urban 'glocal' structures that 'operate as infrastructure shaping, facilitating, directing and perpetuating international flows under different modalities of control and regulation' (Hillmann et al., 2022, p. 2298). This approach views urban-centred 'glocal[2]' assemblages as part of the migration industry[3] that facilitates this mobility, having impacts on structures both market and governmental in both the sending countries as well as the host countries.

2 "Glocalization can be seen in 'the strategies of global localisation of key forms of industrial, service and financial capital' (Swyngedouw, 2004: 37), in the outcomes of exclusion (Sassen, 2015: 99) and in the way processes become structured (McFarlane, 2011: 222)"(Hillmann et al., 2022, p. 2298).

3 Nyberg-Sørensen and Gammeltoft- Hansen define the "migration industry as the array of non-state actors who provide services that facilitate, constrain or assist international migration' with the adherent subcategories of facilitation, control and rescue. Migration industries are about control, selection and management on behalf of employers and state institutions, comprising policies and practices of governments to regulate and manage migration." (Hillmann et al., 2022, p. 2298) The migration industry, as it pertains to the mobility of nursing care labour, involves a wide array of non-state and market actors, often working in collaboration with state agencies. These would include recruitment and travel agencies, government training centres, educational institutions, medical services, advertisers and migration brokers, amongst others, connecting countries of origin, destination and transit and supporting the perpetuation of care-sector flows(Hillmann et al., 2022, p. 2298)

2 Contextualising Nurse Migrations from India

This section provides an overview of how the literature contextualizes nurse migrations from India. The sub-themes provided are historical and cultural evolution of nursing as a profession in India and changes in migration destinations of nurses from India. Literature also points at the role of individual and families' aspirations for upward social and economic mobility in migration patterns.

2.1 Historical and cultural evolution of nursing as a profession in India

A number of authors – Reddy, Gill, Walton-Roberts and Kodoth & Jacobs - highlight the colonial origin and socio-cultural implication of nursing as a profession. Nursing as a profession in India was shaped by colonial institutions like the British Medical Services, later known as the Indian Medical Services (Gill, 2011) as well as missionaries and international funding organizations such as Rockefeller Foundation and Dufferin Fund (Walton-Roberts, 2015) (Reddy, 2015) (Walton-Roberts, 2017). According to Reddy (2015), during the colonial period much of the health and public health infrastructure of India was shaped by American protestant missions to India and their institutions. These institutions were later secularized and became a significant contributor to the public health system of colonial India. Reddy calls this network of institutions American 'network of knowledge systems' consisting of its hospitals, education institutions and public health research institutions. Post-independent India looked more towards these American public health organizations and education institutions to professionalize nursing and to train more nurses to meet its needs.

Touching and dealing with bodily fluids is seen as polluting in South Asian cultures. Nursing involves 'body work' and requires a level of intimacy that is considered taboo. Nursing has been perceived as a low status profession in India, as it was associated with caste-based pollution (Gill, 2011) (Walton-Roberts, 2012). Studies point out that initial work force in Indian nursing came mostly from lower caste communities as well as Christian converts from those communities (Gill, 2011) (Walton-Roberts, 2012). The Syrian Christian women from Kerala, who were however from a privileged minority community, also began to enter the nursing workforce, often due to socio-economic reasons as well as the religious affiliations of nursing as a profession (Kodoth & Jacob, 2013). Religious orders and colonial forces helped create the profession, which was feminised and subjugated within the medical hierarchy (Walton-Roberts, 2012). The status of nursing improved according to Walton-Roberts (2012) however, the same study points out to the discourse around nursing which shifted to sexual pollution rather than caste purity, as autonomy and mobility of women increase (Walton-Roberts, 2012).

2.2 Individual, community aspirations and gender dynamics in the sending countries

Walton-Roberts is as well a leading author when it comes to analyzing the factors which fuel the outmigration of nurses and include a gender perspective. There is an increased desire to migrate among nursing students: more than three-fourth students were therefore ready to seek opportunities abroad by the time they graduated (WHO, 2022). Immigration aspirations are fueled by a number of factors like financial gain, status and autonomy along with the motivation for social mobility for themselves and their families (Walton-Roberts et al., 2017). The adverse working conditions as well as the low status of the profession in the country's health system often pushes nurses to migrate to countries where they receive higher professional status, career progression, working conditions and renumerations (Walton-Roberts & Rajan, 2022). Sometimes immigration is fueled as a means to ensure permanent residencies in these countries that increases the chances for their families' social mobility (Walton-Roberts et al., 2017). This trend is seen more in newer generations of nurses in Punjab, as compared to Kerala where the gulf states remain the prominent destination despite not being able to settle in these countries.

In India, the nursing field has long been undervalued and seen as of low value by the medical establishment through systematic suppression (Walton-Roberts, 2012). In general, wages and working conditions are subpar, low professional status with few chances for further professional growth, particularly in the expanding private hospital sector (Walton-Roberts & Rajan, 2022). In addition to these, bureaucratic barriers in employment and subsequent professional growth along with the cultural significance of international experiences in creating a better professional status act as motivation to migration (Oda et al., 2018; Walton-Roberts & Rajan, 2022).

Families often invest in the cost of nursing education, as well as the visa and immigration process (Walton-Roberts & Rajan, 2013) because migrant nurses are able to economically contribute to their families at home due to remittances, ensure their families permanent access to the destination countries, and contribute financially to their own marriages. A recent study in Kerala by the WHO points out to motivating factors like possibility of better lifestyles in destination countries, opportunity to take the family along with availability of free education for children, free accommodation and permanent settlement in Western countries, opportunity for travelling and exploring newer places in developed countries (WHO, 2022) .

Gender is a crucial aspect in the writing of Walton-Roberts and Kodoth in understanding this process. Nursing as a care profession is highly feminised and is suitable for young women who aspire for migration. This migration may influence gender power dynamics in the context of the sending societies (Walton-Roberts et al., 2017). Among the Syrian Christian women in India there was an inversion of patriarchal gender relations of work, mobility, and sexuality (Kodoth & Jacob, 2013). Overseas employment offered them increased wealth, better work conditions, professional career prospects, and the possibility of freedom, travel, and adventure (Kodoth & Jacob, 2013). These women migrants claimed respectability and gained recognition within the sending community through remittances and sponsorships for family members. They were also able to pay for socially acceptable marriages through dowries that otherwise would have been out of reach (Kodoth & Jacob, 2013). Women in Punjab are also increasingly choosing nursing as it will secure for them an opportunity to travel abroad by themselves, unlike before, where most of women's migration occurred through matrimonial alliances with men who migrated before them. However, Walton-Roberts argues that migration practices do not necessarily undo patriarchal practices, instead they might just be reinforced and continued in a much larger scale with remittances. This reinforced patriarchy further fuels the need to migrate in order to afford patriarchal practices like dowry (Walton-Roberts, 2012). Additionally, nursing migration also allows male practitioners from India to escape the taboo attached to male caregiving and body work, and enter the profession (Walton-Roberts et al., 2022).

2.3 Historical and current migration patterns

The movement of nurses within the country and outside has happened historically, with some parts of the country like Punjab, Kerala, Tamil Nadu and Karnataka producing more nurses than the others. Literature shows women's movement from states like Kerala from 1940s to study and work in missionary nursing schools and hospitals in cities like Mumbai and Patna. These movements seemed to be motivated by opportunities in these destinations. However, this review focuses on patterns of nurses' movement outside the country. Since Kerala is one of the leading sources of migrant nurses from India, we find more literature covering this mobility. However, immigration patterns from a few other states are also outlined.

The WHO report (2022) on nurse migration from Kerala shows that movement of nurses to the Gulf and European countries began in the 1950s and 1960s. This was largely due to the influence of the British colonial presence in the middle-east in the 1930s. The willingness of Keralites to take up overseas jobs, particularly in the Gulf, was notable during this early phase of migration. Kuwait played a significant role in the 1950s by employing the first Indian women as nurses in its health infrastructure. The oil boom of the 1970s further facilitated employment opportunities for Keralites in the Middle East. This early phase of migration created social networks and disseminated information about job opportunities in the Gulf back to Kerala. Kodoth and Jacob also point out that cultural networks like the Kerala Syrian Christian community and church which supported a movement to migrate nurses from Kerala to Europe, for example, The arrival of Malayalee nurses in Germany in the 1960s led to the establishment of more associations by Indians (Kodoth & Jacob, 2013). This movement was embedded in the Catholic Church network, and provided a sense of legitimacy for migration. The church also helped shape community infrastructure and support for issues faced in the diaspora. Similarly Tamil and Punjabi nurse migrants take advantage of cultural networks created with their diaspora populations in the destination countries (Walton-Roberts et al., 2017) (Oda et al., 2018).

In the recent years according to the WHO (2022), there are fluctuations in the migration rates from Kerala, and while preferred destinations are the middle-eastern countries and UK, as well as US, Canada and other European countries. Asia and the Pacific regions attracted over 50% of nurses who migrated from Tamil Nadu, with Malaysia and Singapore being the top destinations. These countries are preferred by Tamil nurse migrants due to their geographical and cultural proximity, as well as their historical influence. Singapore is also ranked as the number one destination for Tamil Nadu migrant workers, as per Irudaya Rajan et al. (2016) as cited (Oda et al., 2018). Nursing migration from Punjab showed a shift from the traditionally preferred destinations of Canada and USA to Australia and New Zealand (Walton-Roberts et al., 2017).

3 Structural Factors in Migration

According to the State of the World's Nursing (SOWN) 2020 report, there was a global shortage of 5.9 million nurses in 2018, with a total of 27.9 million nursing personnel worldwide (WHO, 2022). The shortage was particularly significant in middle-and-low-income countries, accounting for 5.3 million nurses (WHO, 2022). High income countries too face a shortage in health care professionals. Walton-Roberts (2012) argued that this is the result of changing social and structural factors in these countries. Scholars like Walton-Roberts and Irudaya Rajan (2022) argue that various countries have shaped their policies accordingly to attract migrating nurses as well as to retain them.

3.1 International immigration policies

In this subsection focus is on the literature on outmigration policies in the sending countries with Walton-Roberts and Rajan as the most prominent authors. Countries that have a deficit in their health care resources often encourage immigration through favorable policies. The UK Fast Track Visa and Free Visa Extensions for health workers during the COVID-19 pandemic as well as Germany's new intake policies are examples (Walton-Roberts & Rajan, 2022).They also often make migration easy for the dependents of these nurses so that more nurses aspire to move to these countries. The presence of international agencies like Joint Commission of Hospitals and US Medical Licensing Body in India also encourage immigration (Walton-Roberts & Rajan, 2022). The significant movement of heath care resource has led to the evolution of intergovernmental or international guidelines to regulate this mobility. The WHO has adopted a Code of Practice of Recruitment in 2010 that aims at fostering ethical standards in recruitment ensuring the rights and obligations of both the sending as well as the destination country. The code also stresses that it is the right of individual health care workers to immigrate if they want to. The International Labour Organization's Convention on Migration for Employment and the Private Employment Agencies Convention, and the Sustainable Development Goals (SDGs) calls for better international coordination to facilitate safe immigration practices (Walton-Roberts et al., 2022). The UK Code of Practice (CoP) influenced the bilateral agreements for the migration of nurses in India.

3.2 India's approach to migration of nurses

According to the WHO (2022) report, from the time of independence India has had a deficit in nurses within the country for its expanding healthcare system (WHO, 2022). India also has unequal distribution of nurses across different states with states like Kerala, Tamil Nadu, Andhra Pradesh and Rajasthan having higher nurse ratios than other states (WHO, 2022). The post-liberalisation era of the 1990s, saw a high investment of private capital leading to the expansion of the health care sector (Walton-Roberts & Rajan, 2022). This applies to both health care systems as well as health education systems. There are several factors that emerge in the literature that will be discussed in the following sections:

3.2.1 Emigration policies

Varghese (2018) emphasises the historical development of legislation to govern emigration. The Indian government enacted a legislation, the Emigration Act of 1983 to govern emigrations and regulate recruiting agents. Varghese argues that the emergence of a robust overseas recruitment sector in response to the Gulf boom and the increasing volume of inward remittances to the country led to the re-designation of the Controller General of Emigrants to the Protector General of Emigrations (PGE), with new responsibilities and powers (Varghese, 2019). The Emigration Act of 1983 introduced the system of 'emigration clearance' to protect Indians migrating abroad for employment. ECR passport holders are eligible for protection once they receive emigration clearance. The Act also introduced a licensed recruitment regime, with the PGE issuing Registration Certificates to Registered Recruitment Agents (RAs) after detailed screening (Varghese, 2019). Varghese argues that a lack of comprehensive policy structure in India led to the proliferation of a private sector in immigration and increased exploitation by private agencies as well as by employers in the destination country (Varghese, 2019). In response to this issue the government included nursing in the list of occupations that require emigration clearance. Walton-Roberts et al. (2022) argue that increasing regulatory constraints on formal nurse migration may lead to nurses relocating through alternative channels, such as applying for visas through Indian embassies or moving overseas under different visa categories (Walton-Roberts et al., 2022). These restrictions have also been assessed as the nation's patriarchal regulation of women's mobility due to the impact of discourses around sexual purity. These policies, according to the study assumes that nursing is a female occupation, and regulates their transnational mobility, while 'further reinforcing the low status of nursing in the healthcare and immigration hierarchy' (Walton-Roberts et al., 2022).

3.3 Migration Industry in India

The migration industry has become a crucial area of focus in recent literature. 'The migration industry and agencies involve a wide array of non-state and market actors, often working in collaboration with state agencies. These would include recruitment and travel agencies, government training centres, educational institutions, medical services, advertisers and migration brokers, amongst others, connecting countries of origin, destination and transit and supporting the perpetuation of care-sector flows' (Hillmann et al., 2022, p. 2298). This session discusses the migration industry in India.

3.3.1 Private agencies

Varghese (2019) explores private recruitment agencies which have sprung up across the country to become important players in this international recruitment markets. Metropolitan areas like Delhi, Bangalore, Cochin etc have become regional hubs for recruitment. The lack of regulation has caused the uncontrolled growth of these agencies and their emergence as important stakeholders (Varghese, 2019). A study among migrating nurses from Tamil Nadu by Oda et al. (2008) shows that private sector agencies as well as individual agents, both licenced and unlicensed, control nursing recruitment as well as emigration from Tamil Nadu since recruitment by the public sector is limited. Chandigarh, the capital of Punjab, has emerged as a significant service hub for aspiring international migrants. In the study conducted by Walton-Roberts and colleagues it was found that the city has witnessed a rise in the number of agencies dedicated to facilitate the global educational mobility of nurses. Recruitment agencies in India have helped to create a path way of immigration through educational programs in destination countries such as Cannada, US, UK, Australia etc. by entering into partnerships with universities in these countries. These agencies' extensive network and the high level of enthusiasm for overseas commercial opportunities were clearly reflected in their ability to partner with educational institutions abroad (Walton-Roberts et al., 2017).

Varghese (2019) also draws attention to Indian corporate hospitals which have begun 'business process outsourcing' (BPO) to take advantage of the phenomenon of increased demand for quality and trained nurses in the developed world and the desire of Indian nurses to seek employment outside the country. They recruit and train Indian nurses in their hospitals located in the metropolitan cities of India and prepare them to take the qualifying professional and language proficiency examinations which prepare them for migration as they are working in these hospitals (Varghese, 2019).

The WHO report 2022 pointed to nurses historically migrating in a step-by-step manner, first to North Indian states, then to the Middle East and Europe or America. Finding jobs in India was easy due to numerous private sector vacancies (WHO, 2022). This experience, according to this report was useful, for further migration through recruitment agencies in metropolitan cities and tie-ups with super-speciality hospitals in the US, UK, and Middle East. Migration to Gulf countries was smooth due to more favourable responses from employing hospitals, colleagues, and agencies (WHO, 2022). The UK through NHS has started recruiting nurses directly, often reducing the need for step-by-step migration, and those successfully recruited, processed the visa and made travel arrangements, either directly by themselves or with the help of travel agencies (WHO, 2022).

3.3.2 Government bodies involvement in immigration of nurses

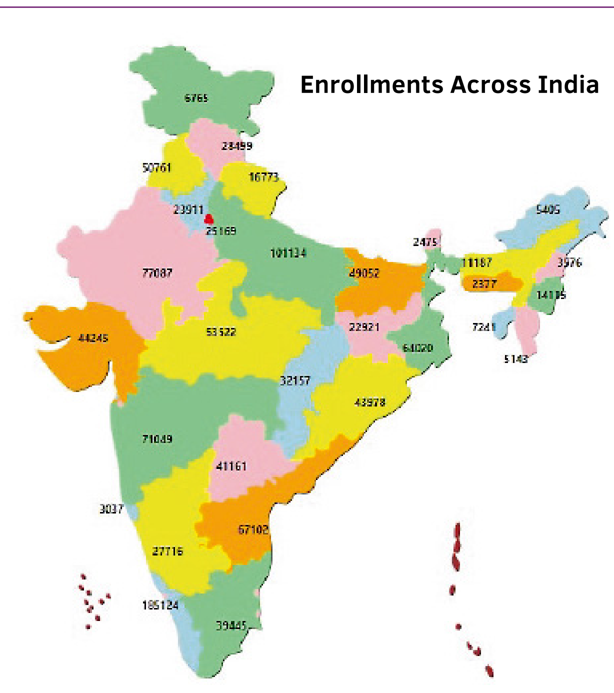

Image 4: Number of registered nurses in India state wise INC 2023

Recent studies focus on policy responses to international mobility of labour. Nurse migrations have also been studied with a focus on policies by sending countries. Walton-Roberts and Rajan (2022) point out that the policy response in India has been the setting up of regulatory bodies to mediate and regulate international recruitment of nurses at the state level (**refer to table 2 in appendix**) (Walton-Roberts & Rajan, 2022). Walton-Roberts also points out to the involvement of the state in this facilitating this mobility through the skilling of its people (Walton-Roberts, 2015).

The WHO report (2022), points out the case of Kerala, that takes an active role in enabling the migration of health care workers globally and is the largest source of migrating nurses within and outside India. As is found in some other states, the state government in Kerala has agencies Norka and ODEPC to regulate nurse migration (**see table 3 in appendix**) ODEPC also runs a travel agency which arranges air tickets for migrating nurses and provides suitable guidance in visa formalities, labour laws and travel regulations (WHO, 2022, p. 30).

The Kerala government has implemented skill development programs for nurses to aid in migration. Collaborators include KASE, NICE, ASAP, and ASEP. Professional organizations like Trained Nurses Association of India (TNAI) and United Nurses' Association (UNA) also provide continuous nursing education and skill training programs. TNAI, established in 1980, offers workshops and e-learning programs, while UNA provides state-level training for IELTS and OET (**refer to table 4 in appendix**).

The WHO study however points out to a lack of awareness about these provisions by the Kerala government to facilitate nurse's migration abroad and the skill development training to empower them (WHO, 2022). The report points out to the lack of trust in these provisions as compared to private agencies, which were perceived as customer-friendly, more informative and easily accessible with liberal feedback provisions. The report also opines that familiarity with information and communication technology enables many nurses to arrange travel tickets by themselves. This would perhaps hint at further changes to the processes of movement of nurses from India.

3.4 Education Institutions

Much of the selected literature takes up nursing education in India as well as its role in shaping migration. Gill (2011), Walton-Roberts (2012), (2017), Reddy (2015), among others point out to formal nursing education being associated with various hospital-based training schools in India. Later nursing colleges emerged across the country (Gill, 2011). Presently, nurses complete a three- and a half-year diploma in general nursing and midwifery or a four-year bachelor's degree and are registered with the council (Gill, 2011) (Walton-Roberts, 2017). Nursing and midwifery are regulated by the Indian Nursing Council and the respective state nursing councils Gill (2011) (Walton-Roberts, 2017).

Walton-Roberts argues that the structuring of nursing education was largely oriented towards a western model of care because of the influence of colonial as well as western aid (Walton-Roberts, 2012). She further argues that nursing education took the direction of increased professionalisation due to concerns about the social and professional status of nursing. Reddy (2015) argues similarly that the American nursing education sought to professionalize for a better status within the healthcare system (Reddy, 2015). They achieved this through moving nursing training out of medical institutions and organizing themselves into a structured baccalaureate course (Reddy, 2015). She further points out that in post-independence India, much of the focus was given in increasing the number of nurses (Reddy, 2015) and that despite the creation of structured baccalaureate courses in India (B. Sc Nursing) much of the nursing workforce in India were diploma holders (GNM, Post Basic etc.) (Reddy, 2015). This allowed for the B.Sc. holders to migrate since they were accepted readily in the west (Reddy, 2015).

Walton-Roberts argues that this infrastructure of nursing education facilitates migration, while at the same time devaluing it within the health system (Walton-Roberts, 2012). The Sarojini Varadappan committee report 1990 which drew attention to the serious lack of autonomy and respect of the nursing profession, commented on how physicians typically made choices and provided instructions regarding nurses and nursing care (Walton-Roberts, 2012).The committee also drew attention to the shortage of nurses, a curative approach to healthcare, the practise of using student labour, nurse shortages in hospitals, inadequately resourced schools lacking the necessary tools and infrastructure, and poor pay and working conditions.

Studies highlight that in the last three decades the nursing education systems were reformed. Walton-Roberts (2012, 2015) points to increased investments in the sector, development of curriculum by making improvements to the B.Sc. program and easy the entry to the program. The government also made plans to phase out general diploma courses in nursing as well as to introduce higher education in nursing such as a PhD programme (Walton-Roberts, 2012; Walton-Roberts, 2015). Walton-Roberts (2013) highlights the increased privatization of the nursing education system, this is in line with the increased privatization in other health education fields (Walton-Roberts, 2013). Similarly, literature points out to the concentration of nursing institutions in the southern states (Walton-Roberts, 2015). Walton-Roberts argues that this increasing number of nursing education institutions are a response to the demands in the international demand for nurses, because the training programs are aimed at meeting international standards. In line with this argument, Walton-Roberts and Rajan (2022) point to private health corporations training healthcare workers in the international systems, which enable them to work internationally and aid the commercial interests of these corporates by internationalizing these corporations and increasing medical tourism to India (Walton-Roberts & Rajan, 2022).

In the WHO 2022 study, nurses working in the UK, Ireland, and Canada reported that Kerala's nursing curriculum was more comprehensive than their work requirements. They could work in all specialties based on their education in India, but the skills required in the destination countries were slightly different. These skills were easily acquired through training provided by hospitals during the adaptation period. The main issues were communicative English and OSCE screening for licensing exams (WHO, 2022). However, computer knowledge and English language skills were recently introduced in the nursing curriculum. In the academic year 2022–23, there were 235538 seats in offer for Bachelors in Science in Nursing and General Nursing and Midwifery and other diploma courses (**see table 5 in appendix for details**), and much of these seats are in private institutions (WHO, 2022). The WHO (2022) report also makes recommendations to the government of Kerala to include foreign language training courses along with the nursing curriculum. The document also recommends that the state government embed its emigration assistance organizations within the nursing education system. These recommendations emphasize the centrality of improving migration pathways for the state and international bodies.

Research Gaps directions for future research

Nurse migration has been studied through various lenses in the last few decades as is seen in the literature review which is dominated by the works of Walton-Roberts and Rajan. Various factors that have influenced this mobility as well as the effects of these mobilities on both the destination countries and sending countries have been studied. However, trends in international migration of nurses are quick to change along with the assemblages that support these mobilities. These structures which include formal and informal agents should be studied more closely and frequently to understand the context for these changes as well as the effects of these on migration patterns. Similarly, the impact of these migrations on the hosting health systems should be studied further, so as to understand the impact of the migration on lives of the individuals and their communities. More focus should be given on intersectionality in terms of the changing class, caste and gender relationships within this quickly shifting patterns of migration while structural factors have been discussed adequately individual and cultural aspirations that fuel these mobilities should also be focused on. While migration of nurses from Kerala is more frequently studied, more focus should be given to migration patterns in other sending states. The discourses around nursing immigration in international policies and their impact on global health systems should also be explored.

5 Conclusion

The phenomenon of nursing migration is a result of complexly interwoven factors both at the global and the national context as portrayed in the literature. Most of the literature bases their arguments through contextualizing nursing as profession in India and agree that it is a result of colonial as well as religious forces which shaped the profession. There is an agreement in most of the earlier researches (Gill 2011, Kodoth and Jacob 2013, Reddy 2015, Walton-Roberts 2013, 2017) that the colonial context of the profession as well as it's shaping by western educational institutions opened the doors for international migration. These studies also stress the role of cultural and religious networks as well as the presence of diaspora in these destination countries in mobility of skilled migration. Studies like Walton-Roberts, Reddy, Gill among others also look at the effects immigration has had on the lives of the women, their families and their communities. While some studies such as Kodoth and Jacob point out to an inverting of the gender dynamics in some communities due to this migration, others such as Walton-Roberts and Reddy argue that often there is just a change in the way patriarchy controls the lives of these women. Studies have also focused on the role of institutional and policy structures that uphold and support this migration. The emerging migration industry that has come up in response to increasing demand for nurses, has also been discussed in the literature, however this requires more focus in the future. The discourse of international bodies around nurse migration seems to favor changes to the health system that accommodate the mobility of nurses. This calls to question whether the needs of high-income countries are priorities by international policies over creation of an improved global health system.

This international mobility should be understood as a result of increasing changes in the welfare states in the Global North, which decreased their healthcare spending, as well as the changing demographic nature of those societies. This has ended up in a new surge in demands for internationally educated nurses in these countries, resulting in changes in the traditional modalities of movement of nurses. New agents emerge to accommodate these increasing demands. The Covid-19 pandemic further fueled these changes and urges us to pay attention to the effects of these mobilities on the global health system.

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Appendix

Table 1: Migration of nurses from Kerala as per the ODEPC website (WHO, 2022)

COUNTRIES	PERIOD			TOTAL
	2018–2019	2019–2020	2020–2021	
KSA	222	156	70	448
Maldives	–	22	–	22
Kuwait	–	–	1	1
Oman	2	2	3	7
UAE	89	15	298	402
Ireland	1	–	–	1
UK	17	56	262	335
Total	**331**	**251**	**634**	**1216**

Table 2: Indian State-run Agencies Through Which International Nurse Recruitment Is Allowed

AGENCY	STATE
NORKA-Roots	Kerala
Overseas Development and Employment Promotion Consultants (ODEPC)	Kerala
Overseas Manpower Corporation Limited (OMCL)	Tamil Nadu
Telangana Overseas Manpower Company (TOMCOM)	Telangana
Overseas Manpower Company of Andhra Pradesh (OMCAP)	Andhra Pradesh
UP Financial Corporation	Uttar Pradesh

Source: Ministry of External Affairs, Government of India, office order dated September 9, 2016.

Table 3: Recruitment and Migration agencies approved by GoK (WHO, 2022, p. 27)

AGENCY	TYPE OF AGENCY	PURPOSE / OBJECTIVE
ODEPC	Government-approved agency	• To provide recruitment services in the domestic and international job markets
		• To process contractual agreement between the employer and candidate for the above
		• To train nursing skills and language skills to nurses
		• To assist visa processing and travel arrangements
NORKA	State-run agency	• To facilitate overseas recruitment
		• To provide skills suitable for overseas employment
		• To rehabilitate returnees

Table 4: Skill Development Agencies by GoK (WHO, 2022, p. 27)

AGENCY	TYPE OF AGENCY	PURPOSE / OBJECTIVES
KASE	Nodal Agencies of GoK under the Labour Ministry collaborating with NORKA and ODEPC	• To facilitate and coordinate skill development initiatives in Kerala • To provide accreditation to various courses under NICE, OET centre, multi-language learning institute
NICE	Skill development agency under KASE collaborates with NORKA and ODEPC	• To train nursing skills and language skills to graduate / diploma nurses • To train nurses for government licensing examinations in Middle East countries
ASAP	Government company registered in 2013 under higher education department	• To create unique demand-based, industry-led skill training ecosystem through 121 Skill Development Centers • To provide a crash course suitable for overseas employment for 10,000 qualified nurses
ASEP	Joint initiative of KSWDC, CMD and ODEPC	• To conduct a six-month programme on basic nursing skills, emergency and critical care nursing skills, infection control and patient safety, language communication, personality and soft skills

Table 5: Number of seats in Nursing education institutions in India

YEAR-WISE NUMBER OF SEATS IN NEI IN INDIA						
NAME OF NURSING QUALIFICATION	NO OF NURSING SEATS IN INDIA					
	2017–18	2018–19	2019–20	2020–21	2021–22	2022–23
General nursing and midwifery	129,926	130,676	130,182	134,949	109,758	100,329
BSc. Nursing	96,475	98,864	100,865	107,814	99,155	100,100
MSc. Nursing	12,617	12,940	13,322	13,971	12,886	12,596
Post-basic BSc. Nursing	24,415	24,520	24,310	25,485	22,460	21,100
Post-basic diploma	4,131	4,176	3,030	3,170	1,527	1,413
Total	**267,564**	**27,176**	**271,709**	**285,389**	**245,786**	**235,538**

Source: Data from Indian Nursing council website, 2023

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Exploring Fairness in International Healthcare Workers Recruitment: A Review of International and German Perspectives

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Contents

Introduction 44

Unravelling the Frameworks for Healthcare Worker Migration ... 45

1 International Labour Organization – Private Employment Agencies Convention (181) 45

2 State of the World's Nursing 2020: investing in education, jobs and leadership 46

3 WHO Global Code of Practice on the International Recruitment of Health Personnel 48

4 WHO health workforce support and safeguards list 2023 49

5 International Recruitment Integrity System Standards on Ethical Recruitment and Migration 50

6 The New German Immigration Act 53

Too Many Words, Too Little to Say – Ethical and fair to whom? 53

References 59

Introduction

In this paper, the author presents an analysis of International and German sources that outline ethics and standards for the equity of hiring healthcare workers. The paper explores the underlying interests that drive hiring processes for international health care workers. The paper reviews and summarises the standards put out by different organisation along with the notions of fairness, are elaborated upon in this paper. The paper analyses these international codes and standards on the following lines (a) for whom is the process deemed fair for, and (b) the competing interests are at play in the recruitment of healthcare workers. This essay explores the differing points of view, analyses the historical developments, and draws attention to the inconsistencies in the changing conceptions of justice in the context of hiring healthcare workers.

The first part of the paper reviews the following six sources (a) International Labour Organisation-Private Employment Agencies Convention, 1997 (No. 181), (b)State of the World's Nursing 2020: investing in education, jobs and leadership, (c) WHO Global Code of Practice on the International Recruitment of Health Personnel, (d) WHO health workforce support and safeguards list (2023), (e) IRIS Standards on Ethical Recruitment and Migration, and (f)The New German Immigration Act.

The second part presents an analysis of the all the sources and the fairness criteria and ethics described in them. It discusses the language which has been used for framing, the enforceability- which provides a lee way for developed nation to import health care workers from the developing third world nation. The phenomenon of healthcare worker migration presents a complex global challenge, marked by the migration of skilled professionals from developing to developed countries.

According to World Bank, the countries are classified as developing and developed based on Gross National Income (GNI). Those countries who have GNI of less than 1,025 dollars or less are lower income countries and those will GNI 1,026 dollars to 4,035 dollars are lower middle-income countries. Upper middle-income countries have a GNI between 4,036 dollars to 12,475 dollars and high-income countries are with a GNI of 12,476 dollars and more. Low- and middle-income economies are referred to as developing countries in this paper, and the upper-middle Income and the high Income are referred to as developed Countries.

Developed countries are hence characterized by robust economies, advanced infrastructure, and high standards of living. In this dynamic, developing countries invest resources in training healthcare professionals, only to witness their departure to developed nations in pursuit of better opportunities. The new German Immigration Act, designating nursing as a "profession in demand," exemplifies the pull factors, including attractive pay and lifestyle, drawing healthcare workers away from their countries of origin. This drain not only leads to the loss of skilled professionals but also hinders the development of healthcare systems in developing nations, perpetuating a cycle of resource depletion and hindered progress.

Unravelling the Frameworks for Healthcare Worker Migration

1 International Labour Organization – Private Employment Agencies Convention (181)

An important international labour standard created by the International Labour Organization (ILO) is ILO C181, referred to as the Private Employment Agencies Convention, 1997 (No. 181). The agreement covers the management and oversight of private employment agencies in order to guarantee just and moral hiring and placement procedures. Any individual, business, or organization that offers services for connecting job seekers and employers is considered a private employment agency according to the main clauses.

The convention acknowledges the legitimate role of private employment agencies in contributing to efficient and effective employment services. It emphasizes the need for cooperation between public employment services and private agencies.

Governments are urged in the convention to set up and keep up a system of licensing and regulation for private employment agencies in order to guarantee their accountability, transparency, and adherence to pertinent laws and rules. C181 places a strong emphasis on defending the rights and interests of employees, making sure that private employment agencies adhere to the values of fairness, non-discrimination, and equal opportunity. It also forbids charging employees fees, either directly or indirectly.

The convention emphasises on the necessity of giving employers and employees accurate and thorough information about the services offered by private employment agencies. It promotes communication between the creation and evaluation of regulations and representative groups of workers and employers. It is the responsibility of governments to set up efficient systems for observing and examining private employment agencies in order to verify adherence to pertinent rules and legislation.

It places a strong emphasis on the necessity of giving employers and employees accurate and thorough information about the services offered by private employment agencies. It promotes communication between the creation and evaluation of regulations and representative groups of workers and employers. It is the responsibility of governments to set up efficient systems for observing and examining private employment agencies to verify adherence to pertinent rules and legislation. As of 2023, 37 countries have ratified it, including Germany.

2 State of the World's Nursing 2020: investing in education, jobs and leadership

The World Health Organisation (WHO) reports that while there has been a decline in the world-wide deficit of health professionals since 2016, there was still a 15 million shortfall of healthcare professionals in 2022. The Middle East and Africa continue to have acute shortages of health personnel, and the distribution of these professionals is still wildly unequal. The countries of the Global North save their training cost by actively recruiting healthcare workers at a lower cost from the Global South. Germany is one such country- by actively recruiting healthcare workers from third-world countries, which have an underfunded healthcare system and poor working conditions. There have been various international codes, and guidelines on healthcare worker migrations that dictate criteria, and rules of conduct for fair recruitment of workers.

The State of the World's Nursing report by WHO highlights significant global differences in the distribution of the nursing workforce. It details the geographic concentration of nurses in the American, European, and Western Pacific regions, which together contain 81 % of the world's nursing workforce, despite making up only 51 % of the world's population. On the other hand, there is a severe scarcity of nurses in parts of Latin America, Africa, Southeast Asia, and the Eastern Mediterranean. These disparities are primarily caused by income, (as per the report) with low-income nations dealing with nurse densities of 9.1 per 10,000 people, compared to 107.7 in high-income nations.

There are notable differences in the distribution of nurses within the countries as well; In the surveyed 76 countries, only 36 % of nursing workforce is assigned to rural areas despite having 49 % of population share. Additionally, 75 % of nurses worldwide employment in the public sector, with the other 25 % working in the private sector. One in eight nurses, or 13 % of the nursing workforce, were not born or educated in the nation in which they presently practice. This illustrates the degree of mobility among nursing professionals, particularly in high-income nations where 15.2 % of nurses are foreign-born.

It also suggests that the WHO Global Code of Practice on the International Recruitment of Health Personnel should be strengthened. It highlights how important it is for government ministries, employers, health workforce information systems, regulatory organizations, and other stake-holders to work together to improve the governance and control of international nurse mobility.

In order to attain more self-sufficiency, the report suggests that the domestic investment in nursing education and training should be increased. It also demands that retention mechanisms be put in place in nations where emigration is significantly reducing the number of nurses in the workforce. These measures include salary increases and pay parity, improved working conditions, opportunities for professional growth, and opening up a wider range of practice that is in line with nurses' training and education. All these suggested actions can work together to guarantee fair distribution, moral leadership, and the long-term growth of the nursing workforce worldwide.

3 WHO Global Code of Practice on the International Recruitment of Health Personnel

For the purpose of addressing issues with health personnel migration and fortifying health systems, the WHO has the WHO Global Code of Practice on the International Recruitment of Health Personnel. Its multifaceted goal is to establish and promote ethical standards and procedures for international hiring while considering the rights and expectations of both the source and destination nations as well as migrant medical professionals. It also provides advice for the drafting and execution of bilateral agreements and other international legal instruments, serving as a point of reference for member states. The code is voluntary and includes participation from governments, the public and commercial sectors, and non-governmental organizations worldwide. It highlights the significance of upholding ethical norms in the international hiring of medical professionals by emphasizing ethical considerations.

The criteria for creating frameworks to fairly fortify health systems worldwide and lessen the negative consequences of health staff migration on the health systems of developing nations are complex. The demands of smaller economies, which are more susceptible to shortages, must be taken into account. In order to ensure the sustainability of health systems in developing nations, member states should give priority to the rights of the populations of source countries to ensure the best possible quality of health for them, while protecting the individual rights of health personnel to migrate.

WHO code defines ethical recruitment recruitment practices for health staff and it says that developed nation should respect the values of openness, and equity, and promote sustainability by abstaining from exploiting developing countries' healthcare systems. It is recommended in the WHO code that the member states maintain fair labour practices for all health workers, guaranteeing that no discrimination is practiced in any part of their employment or treatment. Within the confines of existing rules and regulations, the Code recognizes the freedom of health personnel to move to nations that are ready to admit and employ them, all the while protecting their rights.

To ensure moral and equitable treatment throughout the recruiting process, a number of duties, rights, and recruitment procedures are outlined in Article 4 of this WHO code. Health professionals, professional associations, and recruiters are "encouraged" to align with regulatory frameworks for the benefit of patients, health systems, and society. Collaboration with regulators and national and local authorities is "emphasized".

Employers and recruiters are “requested” to refrain from using exploitative hiring practices, ensure fair and acceptable contracts, and recognize the legal obligations that health personnel have to their home nations. The wording of the code is vague and essentially us requesting recruiters to not exploit the health professionals. Health professionals are also requested to be open and honest about any commercial commitments they may have. The ability of health professionals to make knowledgeable decisions about employment prospects is emphasized as an indicator for and a benefit of ethical recruitment practices.

Member States must ensure that equitable recruiting and contracting practices are implemented and that migrant medical personnel are not subjected to dishonest or fraudulent practices. Objective standards, such as experience and credentials, ought to guide migrant health workers’ hiring, promotion, and pay in order to ensure parity with domestically trained experts. In the code, recruiters and employers are encouraged to gives correct information about open vacancies for health personnel. Subject to applicable laws and international conventions, migrant health personnel should have the same legal rights and obligations as workers with domestic training, including the ability to pursue professional education, career advancement, and suitable orientation.

Member states are urged to put policies in place that encourage health workers to stay in underserved areas. These policies may include financial incentives, social and professional support, education, and regulatory support. The goal is to alleviate the geographical maldistribution of health workers. To maintain healthy human resource development and training, cooperation between destination and source countries is encouraged. However, destination countries are asked to abstain from aggressively hiring health workers from nations where there is a severe shortage. All these steps are envisioned to work together “to provide a just, open, and equal international hiring process for medical professionals.” This is the only time the code uses a strong word- “aggressive”- it says that the developed nation should not hire healthcare workers in bulk from developing nation (hence the word “aggressive”) but it does not stop the developed nations from hiring health care workers. It also does not define what it means by “aggressive” no definition, number of percentage (for e.g., developed nations can only hire 10% of workforce from outside) is provided. So, wording is vague and not defined, providing loopholes for exploitation.

4 WHO health workforce support and safeguards list 2023

According to the WHO Expert Advisory Group's report, nations that require health workforce assistance the most in relation to universal health care should be singled out for special protection and assistance. Leading destination nations, development partners, and other interested parties were asked by the WHO to set aside flexible funds in order to execute the WHO Global Code of Practice on the International Recruitment of Health Personnel as a global public good.

The WHO's fourth progress report on the Global Code of Practice on the International Recruitment of Health Personnel, emphasized the pandemic's adverse impacts and heightened demand for healthcare workers in high-income nations, leading to the reconsideration of safeguards against international recruitment in countries with low health workforce densities. As a result, 55 countries facing major health workforce issues in relation to universal health coverage are included in the WHO Health Workforce Support and Safeguards List 2023. In addition to having lower universal health coverage service coverage indices than the worldwide median, these nations have lower concentrations of physicians, nurses, and midwives. The COVID-19 pandemic has created significant disruptions to health services and health worker mobility.

WHO highlights the need of routinely update the list and encourages the expansion of the safeguard's method to additional low- and middle-income countries as a best practice. Updates are scheduled to occur every three years, or more frequently if needed. This methodology maintains the ongoing assessment and assistance of nations with severe shortages in the health workforce, in line with the WHO's mission to promote global health worker equity.

Health personnel development and assistance related to the health system should be prioritized for the countries identified on the WHO list in accordance with the WHO Code of Practice, specifically Articles 5 and 10. The notion of minimizing recruitment from poor countries having health workforce issues is to be aligned with the provision of safeguards to these countries that discourage active international recruitment of health personnel.

5 International Recruitment Integrity System Standards on Ethical Recruitment and Migration

An international multi-stakeholder project called IRIS encourages moral hiring practices in cross-border labour migration. It seeks to guarantee equity for migratory labourers, employers, and the nations of origin and destination.

Maintaining moral and professional behaviour during the hiring process is emphasized in the IRIS Standard's General Principle B. A labour recruiter must follow a number of indications as outlined in Criterion B.1 in order to be in compliance with the IRIS Principles. These include keeping an eye on potential risks related to the recruiter's partnerships and operations through ongoing risk assessments, using the results of these evaluations to improve business operations and reduce risk, and getting upper management support for the establishment of a strong management system compliant with the law and the IRIS Standard.

The policies, methods, and practices of the labour recruiter should also be in line with the IRIS Principles to guarantee that all migrant workers are treated with dignity and respect. Sufficient record-keeping and documentation are required to prove continuous adherence to contracts, laws, and the IRIS Standard. The labour recruiter is also responsible for making sure that its subcontractors and employees understand corporate regulations and possess the skills needed to apply them successfully.

It is essential to continuously evaluate the recruiter's and business partners' compliance with regulatory requirements and the IRIS Standard. Top management's regular evaluations of the management system are important for finding weaknesses and monitoring performance to guarantee continual compliance and development.

It is imperative that labour recruiters swiftly resolve any nonconformities that are detected by implementing appropriate corrective and preventive steps. These all steps are listed as an effort to demonstrate the employer's commitment to upholding ethical and professional standards throughout their operations.

The IRIS Standard's Criterion B.2 emphasizes how important it is for labour recruiters to continuously perform due diligence on employers and end-user employers to make sure they continue to abide by relevant laws and labour standards. Several crucial signs point to a thorough assessment of the recruiters' performance in relation to this criterion. First and foremost, labour recruiters are required to create service agreements with employers and end-user companies that precisely detail the business and operational agreements in compliance with the IRIS's requirements.

These agreements must include clauses prohibiting the charging of job seekers with recruitment fees or related charges and stresses the necessity of keeping an eye on the welfare of hired workers in the destination nation after deployment. In addition, labour recruiters are only allowed to work with employers and end-user employers who follow all applicable laws and have the necessary licences and certifications to operate their businesses. Recruiters must abstain from working with companies engaged in legal or other processes related to labour and/or human rights violations.

An essential part of the due diligence procedure is confirming, using publicly accessible sources, that the employer complies with employment laws and is not under bankruptcy protection.

Recruiters also have the responsibility of keeping a close eye on the media and other readily available sources in order to spot any warning signs of possible labour breaches or human rights abuses that require further attention.

In addition, labour recruiters have a responsibility to guarantee that migrant workers are not assigned to jobs where there is a risk of human rights or labour standards being breached. It is the recruiters' responsibility to confirm that the employment contracts of the migrant workers adhere to all relevant legal requirements. Maintaining the integrity of the hiring process requires frequent and efficient verification by the employer, the end-user employer, and related parties of compliance with the IRIS Principles.

Establishing transparent channels of communication with migrant labourers so they can offer input on their working conditions without worrying about facing backlash is considered vital. Additionally, it is expected of the recruiters to set up a responsive system to handle and respond to employee criticism. In conclusion, keeping an up-to-date list of employers and end-user employers is crucial to guaranteeing a structured and responsible hiring procedure that complies with the IRIS Standard. When taken as a whole, these procedures protect migrant workers' rights and general welfare by fostering an atmosphere of openness and responsibility in the hiring process.

The IRIS Standard's Criterion B.3 emphasises how important it is for labour recruiters to continuously perform due diligence on their recruitment business partners and subcontractors in order to guarantee strict adherence to the IRIS Principles and applicable legislation. A thorough examination of several important indicators makes it easier to assess labour recruiters' performance in relation to this criterion. First and foremost, labour recruiters should have thorough service agreements with their recruiting company partners that outline the business and operational agreements in compliance with IRIS regulations. These contracts ought to contain clauses that forbid withholding deposits from applicants and charging recruitment fees or other associated expenses. These agreements should also forbid subcontracting without consent and require the disclosure of all subcontractors.

IRIS points out that these service agreement terms will only work if the labour recruiter puts in place a strong system to check for compliance and deal with infractions as soon as they occur. This proactive strategy, if followed guarantees the upkeep of a responsible and transparent hiring procedure.

In addition, it is the labour recruiter's duty to assess the policies and practises of their subcontractors and recruiting business partners to make sure they adhere to the IRIS Principles and applicable legislation. It is essential to only work with recruitment business partners and subcontractors who adhere to the IRIS Principles and any legal requirements.

All parties participating in the recruiting process can be easily identified and information about them can be provided by keeping an up-to-date list of recruitment business partners and subcontractors. Also, it is crucial to confirm these partners' and subcontractors' compliance status using publicly accessible sources to make sure they are not involved in hiring practises that violate employment laws or filing for bankruptcy. In order to make sure that their collabourations adhere to moral and legal guidelines, labour recruiters are also expected to keep an eye out for any signs of violations of human rights in the media and other accessible sources.

Maintaining the integrity of the hiring process requires regular verification that these business partners, subcontractors, and related parties are adhering to the IRIS Principles. It also calls for establishing a feedback system that allows migrant workers to express their opinions about the conduct of business partners and subcontractors is an essential step towards ensuring accountability and openness in the hiring process. According to IRIS, this strategy protects the rights and welfare of migrant workers by guaranteeing that the labour recruiters' partners continuously adhere to moral and legal standards.

6 The New German Immigration Act

It is stated explicitly in the New German Immigration Act that Germany needs nurses. Listed among the "professions in demand" is nursing. Nursing recruitment from outside countries is overseen by the German Agency for International Healthcare Professionals (DeFa). Even profiles of competent foreign candidates who meet German labour market standards are listed on the websites for the German Immigration Act. Employers in Germany who hire competent foreign workers are subject to certain requirements specified in the Residence Act's Section 4a(5). Verifying the foreign skilled worker's residency authorization for employment in Germany is one of these duties.

Nursing professionals from other countries who want to work in Germany must fulfil certain admission requirements. First and foremost, the nurses' foreign-origin nursing degrees must be accepted in Germany. If not, they will have to wait a time of adaption or take an assessment exam. The professional recognition is valid throughout Germany and requires submission of the application to the relevant authority in the planned working state. Second, it is usually required to have German language competency, which is equal to either the B2 or B1 levels of the CEFR. Thirdly, a German doctor's certification proving the applicant's physical and mental health is required. Finally, individuals must demonstrate their personal appropriateness by presenting proof of their spotless criminal history. This can be accomplished by presenting a German certificate of conduct (Führungszeugnis) or a certificate of good conduct from their place of origin. The location of the qualification is the most important factor in determining whether or not it is recognised; nationality has no bearing on this. The bilingual "Recognition in Germany" portal provides more details about recognition, exams, transition periods, and pertinent German authorities.

Too Many Words, Too Little to Say – Ethical and fair to whom?

The movement of healthcare workers, especially from low-income to the Global North, is a result of the latter's cost-cutting measures, which entail hiring staff from outside and economically underdeveloped countries. By avoiding the need to fund substantial domestic training programs, this strategy advances the economic interests of the countries in the Global North. The nursing workforce is notably disproportionately spread around the world, with 81% of the workforce being in the high income region of Europe, North America and Western Pacific and only 19% in the rest of the world. Furthermore, one in eight nurses, or roughly 13% of them, work outside of their native nation or place of education. This worldwide trend is highlighted in high-income countries as well, where 15.2% of nursing staff are foreign-born, highlighting the substantial reliance on a foreign-born healthcare workforce.

ILO C181 has been signed by only 35 countries. ILO C181 Private Employment Agencies Convention, 1997 is a binding convention and it being signed by only 37 countries raises several concern. The limited number of signatories implies that international standards for the regulation of private recruitment agencies are not widely accepted and adopted. A greater number of ratifications would help to achieve worldwide standardisation and a more cohesive approach to tackling concerns concerning fair employment practises.

In the absence of a broader international consensus on regulating private employment agencies, workers may be more vulnerable to exploitation, and there may be a lack of standardised mechanisms to address grievances or disputes. Private employment agencies frequently operate across borders. A greater number of ratifications would allow for improved cross-border labour mobility regulation, ensuring that both sending and receiving nations comply with agreed norms. International issues like human trafficking and unfair labour practises necessitate joint solutions. A small number of ratifications hinders the establishment of a global collaborative effort to solve concerns relating to private employment agencies.

With fewer countries joining the agreement, there is a lack of international enforcement mechanisms. This leads to inconsistent and inadequate regulatory practises at the national level, creating opportunities for exploitation. C181 is intended to safeguard workers against potential exploitation by private employment agencies. The small number of countries that have signed on to this convention signals that many governments are not dedicated to developing strong regulatory frameworks that protect the rights and interests of people who work through private employment agencies.

Out of 37 countries that have signed this convention, only 15 countries are high income countries and 22 are lower and lower middle income countries. This shows the unwillingness of developed nation to commit to fair and ethical recruitment standards. While it establishes and promotes ethical standards, the World Health Organization's (WHO) Global Code of Practice on the International Recruitment of Health Personnel is more of a voluntary guide than an enforceable one.

The World Health Organisation stresses that thorough labour market studies should serve as the foundation for any agreements between governments regarding the mobility of health workers. Clauses ensuring the maintenance of a sufficient domestic healthcare worker supply in the source nations should be included in these agreements. It is believed that throughout the discussion and drafting of these agreements, the active engagement of stakeholders in the health sector – especially ministries of health – is essential. Moreover, the agreements must precisely outline the advantages that the health systems of the source countries would receive, making sure that they are commensurate with the benefits that the destination countries will receive. These agreements must be properly reported to the WHO Secretariat via the National Health Workforce Accounts and Code reporting processes in order to guarantee accountability

and transparency. While ethical issues are acknowledged as important, their scope is limited to giving underdeveloped countries' health systems priority. Although the Code states that developed countries should not take advantage of the healthcare systems in poor countries, it does not provide clear, binding rules on how to make sure this concept is followed.

The Code acknowledges healthcare workers' freedom to immigrate to other countries at the same time. Nonetheless, this acknowledgment functions within the framework of current developmental inequalities, creating a scenario in which healthcare professionals frequently relocate to richer nations. Although the WHO Code emphasizes that rich countries have a duty to support developing countries' healthcare systems, there is still a lack of practical execution of these measures. This discrepancy exacerbates the difficulties source countries face in maintaining their healthcare systems by feeding the cycle of healthcare personnel migration from poor to developed nations. The vague language of the code makes it clear that the development of the health system remains a second thought to the need of the workforce of the first world nations.

Article 4 of the WHO Code of Ethics mentions these two obligations:

"Member States and other stakeholders should recognize that ethical international recruitment practices provide health personnel with the opportunity to assess the benefits and risks associated with employment positions and to make timely and informed decisions."

4.3, Article 4 – Responsibilities, rights and recruitment practices,
WHO Global Code of Practice on the International Recruitment of Health Personnel

"Member States should, to the extent possible, under applicable laws, ensure that recruiters and employers observe fair and just recruitment and contractual practices in the employment of migrant health personnel and that migrant health personnel are not subject to illegal or fraudulent conduct."

4.4, Article 4 – Responsibilities, rights and recruitment practices,
WHO Global Code of Practice on the International Recruitment of Health Personnel

The wording used in the WHO Global Code of Practice on the International Recruitment of Health Personnel is rather flexible, especially when it comes to phrases like "should recognize" (4.3) and "ensure that". These words highlight that commitments are not strong enough to impose strict rules on recruiters from developed nations, which could lead to the exploitation of healthcare personnel. The Code places a strong emphasis on member states' obligations to guarantee moral hiring practices; despite being an international organization, the WHO does not have the power to WHO, to take direct responsibility or implement concrete mechanisms to prevent the exploitation of healthcare workers, between two nation-states or between contractors and healthcare workers.

Furthermore, the Code exhorts member states to enact laws that promote healthcare workers' continued employment in developing areas and forbid the aggressive recruitment of medical professionals from such nations. Nevertheless, it does not impose any legally enforceable regulations or responsibilities on member states, leaving a void between the WHO's recommendations and the adoption of substantive steps to address the movement of healthcare workers.

The WHO's fourth progress report on the Global Code of Practice addressed the COVID-19 pandemic's issues by highlighting the negative effects of the crisis and the increased need for healthcare personnel in high-income countries. As a result, the measures to prevent foreign hiring have been re-evaluated, particularly in nations with low healthcare worker densities. Notably, 55 countries facing major health workforce issues in the context of universal health coverage have been recognized by the WHO Health Workforce Support and Safeguards List 2023. It is acknowledged that certain nations are especially susceptible to the negative consequences of recruiting foreign healthcare workers.

These nations' placement in the WHO Health Workforce Support and Safeguards List 2023 is evidence of the urgent need for focused assistance and interventions to prevent further depletion of their healthcare systems. A step in the right direction towards tackling the complexity of healthcare worker migration may be seen in the WHO's awareness of the negative effects of healthcare worker migration and the identification of particular nations in need of assistance. To guarantee the safety and viability of healthcare systems in these fragile countries, it is crucial to convert these acknowledgments into concrete acts and legally binding regulations.

In the framework of universal healthcare guided by equity and justice, countries that need the greatest support for their health workforce should be given extra protection and aid, according to the findings of the WHO Expert Advisory Group. Leading destination countries, development partners, and other interested parties have been urged by the WHO to provide flexible financing in order to implement the Global Code of Practice on the International Recruitment of Health Personnel as a global public benefit. The report places particular emphasis on the prioritization of 55 nations for the development and support of health personnel, as well as the implementation of essential protections. It is crucial to remember that these are merely the advisory group's recommendations at this time, and specific regulations based on them have not yet been developed.

The International Organisation for Migration (IOM) has established IRIS: Ethical Recruitment, a flagship initiative, planned in partnership with a coalition of partners from the public and business sectors. IRIS is an international multi-stakeholder effort that seeks to standardize ethical hiring practices in cross-border labour migration. The IRIS rules mostly focus the onus on labour recruiters, even though they support the maintenance of moral and ethical behaviour during the hiring process, such as following due diligence, making sure contracts are correct, and protecting labour rights. Governments are also urged by the guidelines to supervise and keep an eye on these private entities' operations. However, like the WHO code of ethics, enforceability remains an issue.

This structure gives governments in affluent countries a simple option to import healthcare staff from underdeveloped countries, which ultimately results in cost savings for training. Under this dynamic, the needs of the source nations' development are subordinated to the interests of developed states and individual healthcare experts. Even while the guidelines include a number of measures that are purportedly beneficial to developing nations, their voluntary nature and lack of enforceability nonetheless place these nations at a significant disadvantage.

For poor countries, the emphasis on the freedom of individual healthcare workers to relocate in search of better prospects is a dizzying paradox. After spending money training these medical personnel, many countries now have severe shortages in their own healthcare systems as a result of their departure. The recent German Immigration Act serves as an example, as it lists nursing as a "profession in demand" and emphasizes the benefits that nurses can obtain in their new country, such as increased income and a better standard of living.

In addition to drawing qualified healthcare professionals from developing countries, the allure of a better lifestyle, as promoted by these affluent nations, also fuels the ongoing brain drain issue. As a result, the majority of the expensive expenses associated with training healthcare personnel fall on poor countries, creating a vicious cycle of low retention rates and stunted development.

Another problem is the lack of data. The World Nursing Report (WHO, 2020) emphasizes how, despite the seriousness of this problem, there is still a lack of data on the migration and movement patterns of healthcare workers. There is an urgent need to strengthen regulatory frameworks and monitoring procedures due to the ongoing absence of complete information. Even with improvements in the availability of nursing workers worldwide, it is still imperative to address the lack of accurate and trustworthy data. This disparity calls for quick action to set up thorough data collection procedures and improve openness in the dynamics of healthcare worker mobility.

The differences in the nursing workforce's distribution underscore the urgent need for international regulatory actions to guarantee the moral hiring and retention of medical professionals. The reports mention private recruiters and their obligations. Because of the large number of stakeholders in this process, with many being private recruiters who might be possibly indulging in unethical practices, there is a deficiency of sufficient data. Gathering data is essential to supporting evidence-based policies and actions meant to lessen the negative consequences of healthcare worker migration on the nations of origin and destination. In order to address the ongoing issues related to healthcare worker migration and promote a more equitable allocation of healthcare resources worldwide, the report expressly requests that the collection of solid and thorough data be given top priority.

In conclusion, there are still many facets to this complex problem of healthcare workers migrating from low-income to high-income nations, including systemic inequities and ethical difficulties. The global imbalance in the distribution of the healthcare workforce has been sustained by rich countries' prevalent practice of putting their cost-cutting initiatives ahead of the development needs of their own countries. The WHO Global Code of Practice on the International Recruitment of Health Personnel (2010) was established, but because it is voluntary and lacks legally binding provisions, it has not been able to effectively prevent the exploitation of healthcare personnel. Although the Code recognizes the ethical considerations involved, it does not offer specific rules to guarantee adherence, therefore member states will ultimately be responsible for supervising the recruitment practices. The small number of nation who have ratified ILO C181 shows the self-interest of developed income countries over health system over health systems of developing countries. Developed countries face shortages in some skilled areas, they want to prioritise immediate recruitment needs over adherence to international labour norms. Their emphasis on importing competent workers and saving training cost creates a conflict between economic goals and ethical labour practises. Developed countries with greater economic power in global labour markets exploits existing power relations. Because the treaty is binding, will not be able participate in recruitment practises that benefit their own interests without fear of sanctions, hence many developed countries have not signed it.

The WHO's efforts, such as the Health Workforce Support and Safeguards List 2023 and the focus on government-to-government agreements, highlight how critical it is to address the negative effects of healthcare worker migration, particularly in times of emergency like the COVID-19 pandemic. Nevertheless, the lack of specific policies derived from these suggestions has impeded their effectiveness in safeguarding the healthcare infrastructures of susceptible countries. The increasing awareness of the need for evidence-based policies to lessen the negative effects of healthcare worker migration on source nations is reflected in the request for extensive data collection procedures and open reporting mechanisms.

Furthermore, even if the IRIS project supports moral hiring practices, it heavily burdens labor recruiters and doesn't have strong procedures in place to guarantee compliance and responsibility. This strategy unintentionally contributes to the current discrepancies in the distribution of the healthcare workforce by allowing wealthy countries to keep drawing healthcare professionals from poor countries. The rights of healthcare professionals to migrate for better opportunities are being prioritized, which highlights the difficulties developing countries face in retaining skilled healthcare workers and maintaining their healthcare systems, especially in light of the recent German Immigration Act.

Global stakeholders, including governments, international organizations, and civil society, must work together to collaboratively build and enforce comprehensive regulatory frameworks that prioritize the ethical recruitment and retention of healthcare workers in this complex terrain. Such programs should emphasize benefits that are fair to both source and destination nations, encouraging a balanced allocation of healthcare funds. Moreover, it is imperative to establish enforceable laws and transparent methods for data collecting and reporting in order to safeguard the sustainability of healthcare systems around the world. The international community can create a more just and sustainable global healthcare workforce landscape by tackling the systemic inequalities and moral conundrums related to healthcare worker migration.

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Current Newspaper Debates on Migration of Nurses from India

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Contents

1 **Introduction** **62**

2 **Objective of the study** **63**

3 **Methodology** **64**

4 **Findings** **65**

4.1 Major Stakeholders in the Discussion 65

4.2 Pro Migration of Nurses 67

4.3 Benefits of Migration 68

4.4 Contra Migration of Nurses 69

4.5 Perceived Reasons for Migration 73

4.6 Narratives in Favour of Germany 75

4.7 Mitigation Measures in Media Reports 76

5 **Discussion** **78**

6 **Conclusions** **79**

References **80**

1 Introduction

There are 3.3 million nurses in India, according to the Indian Nursing Council (Sharma, 2023). India has less than 2 nurses per 1000 people which is lower than the WHO recommendation. Post-pandemic the demand for nurses has increased in the country but female nurses have been continuously facing several challenges at workplace such as pay disparity, sexual harassment, erratic work hours, and increased workload (Chakrapani / Your Story, 2023) resulting in out-migration of nurses overseas.

Keralite nurses have been working as care-givers in India as well in foreign countries fulfilling the increasing demand of workforce in health and care system, especially after covid-19. Started in 1960s with the future prospects of working in church-run hospitals in the Western world, Kerala has a long history of nursing migration abroad for better job opportunities and standard of living (Jacob / India Today, 2022). In each wave, the spectrum of migration from India to Western countries has been changing. As Dr Biju Peringathara, national president of the Union of *United Kingdom Malayalee Associations* (UUKMA), observes that in 1970s doctors and other professionals were migrating from India, in the 2000s nurses in large numbers were migrating and now after the pandemic students and health care professionals, including nurses and care service providers, are coming to the UK and other Western countries from India (quoted by Nair / The Times of India, 2023).

Unlike Kerala, male nurses have gained popularity in Punjab and other north Indian states where there is an opportunity of migrating overseas, especially to European countries. The male nurses composed 3 % in 2013 in India which has risen by 20 % in 2023 (Chhapia / Times of India, 2023; Johari / Scroll, 2022). Similarly, in other north Indian States like Uttar Pradesh and Maharashtra nursing profession is gaining popularity after increase demand of male nurses in private hospitals (Chhapia / Times of India, 2023).

Subramanian reports in Pulitzer Center, one of the popular international media organisations that is present in India as well, that after the pandemic and increasing demands of nurses in many Western countries, the minimum practical experience required to be qualified as nurse has been reduced from three years to none. Additionally, to work in care homes, the nurses do not have to get good score in English language proficiency (IELTS score 5.9) test in UK, this makes it easier for Indian nurses to migrate to UK (Subramanian / Pulitzer Center, 2023).

However, there are also instances of exploitation at workplace and racial discrimination of Indian nurses in the Western society and even modern forms of slavery in some of the destination countries. Moreover, there are also debates going around about the “brain drain”. According to the “brain drain” argument, developed countries attract trained skilled workforce from the lower- and middle-income countries causing a nursing shortage in the source countries like India. Some experts also support the migration of Indian nurses on the basis of better job opportunities, better pay grade and better working conditions in the Global North. The out-migration of female nurses also helps in improving their social status substantially.

2 Objective of the study

The review explores the media coverage on the topic and opinions related to migration of nurses from India with specific reference to nurses migrating to Germany.

The study aims to do a comprehensive analysis of media reports to get an idea of:

(i) Coverage of the issues of nursing migration in India
(ii) stand on the issue related to brain “drain” or brain “gain”
(iii) the stand of media coverage on shortage / out supply;
impact on health care delivery and universal health care in India
(iv) changes of opinions during Covid 19
(v) Exploring long-term benefit of this migration

This paper is a content analysis to show:

(1) How is nurse migration perceived - a brain gain, or brain drain?
(2) Is a shortage of nurses mentioned?
(3) What is the narrative about its impact on health care delivery / universal health care in India?
(4) What is the narrative about migration as beneficial?
(5) What is the narrative about needs, arguments, and advantages of nurses migration from India to Germany.

3 Methodology

At first, the key word “nurses’ migration from India” was searched in the ‘news section’ of Google search engine with a time filter of 01/01/2018 to 24/12/2023. 200 search entries were screened and all the news reports with the key word India and nurse was read to screen the relevance of the article. The articles containing the content regarding nursing migration from India were selected and reviewed. A total of 34 news reports from 24 different news agencies were selected and reviewed for the study. These news reports were read, and the narratives, opinion and data were tagged with the initial themes and later they were synthesized in the final thematic area.

Table 1. Details of media agencies discussing migration of nurses

NAME OF MEDIA AGENCY	POSITION VIS-À-VIS MIGRATION	PLACE OF PUBLISHING
The Economic Times	Pro (+1), Contra (-1)	Kerala
The Hindu	Pro (+1), Contra (+2)	Kerala
Hindustan Times	Contra (+1)	India
India Today	Neutral	Kerala
News 18	Contra (+1)	Kerala
The News Minute	Pro (+1)	Kerala
Greater Kashmir	Information	Jammu & Kashmir
The Indian Express	Contra (+1)	Kerala
Y Axis	Information	India
The Telegraph	Contra (+1)	UK
Mathrubhumi	Contra (+1)	Kerala
The Times of India	Contra (+2)	Kerala
Mint	Information	India
The Journal	Pro (+1)	Ireland
Peoples Health Dispatch	Contra (+1)	Kerala
Start News Global	Pro (+1)	India
The Daily Star	Pro (+1)	India
Business Insider	Contra (+1)	India
Your Story	Pro (+1)	India
People’s Daily Online	Pro (+1)	Kerala
BBC	Pro (+1)	India / UK
On Manorama	Pro (+1)	Kerala
Business Insider	Contra (+1)	India

4 Findings

The coverage of nurse migration in the media has been reviewed from 2018-2023. However, no news articles about nursing migration were found before the year 2021. 2021 was the year, when India was hit by the second wave of Covid-19 and the country felt a shortage of health care workers in the hospitals across country.

The coverage of nursing migration was in the newspaper and e-news portals. Almost an equal number of articles were in favor and against nursing migration. However, the opinions of the private hospital managements and doctors are always against nursing migration except in one instance.

4.1 Major Stakeholders in the Discussion

Table 2. Major stakeholders in favour of and against migration of nurses

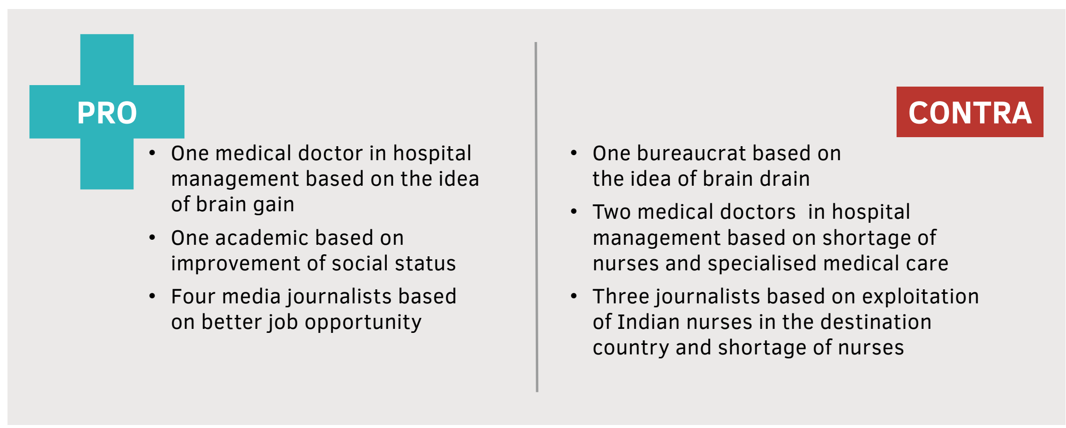
STAKEHOLDERS' CONTRA THE NURSING MIGRATION		
NAME OF THE AUTHOR	PROFESSION	CATEGORY
Aurora Almendral	Senior reporter at Quartz	Journalist
Dr. G. Shreekumar Menon	Retired IRS officer	Bureaucrat
Dr. Kishore Kumar	Founder Chairman & Neonatologist, Cloudnine Group of Hospitals	Medical doctor / hospital management
Shahid Akther	Editor, Health World, The Economic Times	Journalist
Dr. M.I. Sahadulla	Chairman and Managing Director, KIMSHEALTH	Medical doctor / hospital management
Neethu Reghukumar	Principal Correspondent at CNN-News18	Journalist
Pathikrit Sen Gupta	Senior Associate Editor with News18.com	Journalist
STAKEHOLDERS IN FAVOUR OF NURSING MIGRATION		
Dr. Vivek Desai	the Founder & MD, HOSMAC	Medical doctor / hospital management
Bindu Shajan Perappadan	Social Corresponds at The Hindu	Journalist
Vinod Gopi	On Manorama	Journalist
Miles Davis	Political Reporter, BBC Devo	Journalist
Saranya Chakrapani	Principal correspondent at The Times of India	Journalist
Marie Percot	Anthropologist, expert on migration in South Asia	Academic

A total of thirteen individuals belonging to different professions (journalist, medical doctors, hospital managements, bureaucrats, and academics) have written about the migration of nurses in various media reports. The majority of medical doctors and private hospital managements are against the migration, and they are associated with private medical care in South India. Their arguments against migration of nurses are based on the shortage of nurses in private hospitals in the post-pandemic era. They also make an argument that India needs to focus on producing specialized nurses in the field of geriatric, pediatrist, palliative and other special care (Kumar / The Times of India, 2023).

One bureaucrat, who is a retired IRS (Indian Revenue Service) and regularly writes in print media, is against the nursing migration on the basis of the idea of brain drain and an influx of uneducated and unskilled labour force in the state of Kerala. He further argues that this influx of migration from different Indian states is also polluting Kerala's culture (Menon / Mathrubhumi, 2023). Some media journalists are also against the nursing migration based on the arguments of brain drain (Akhter / The Economic Times, 2023; Almendral / The Investigations, 2023), exploitation of Indian nurses in the destination countries (Almendral / The Investigations, 2023), shortage of nurses in India (Akhter / The Economic Times, 2023; Reghukumar & Gupta / News18, 2023).

Six individuals, four journalists, one academic and one medical doctor who is also part of a private hospital management are in favour of the nursing migration from India. The medical doctor and the hospital management is in favour of nursing migration based on the idea of brain gain (Desai / The Economic Times, 2023). The academic is in favour of the nursing migration on the basis of socio-economic improvement of female nurses in the destination Western countries (Percot / The Daily Star, 2023). Media journalists are in favour of the nursing migration based on the idea of better job opportunities of Indian nurses in the destination countries in terms of salary (Gopi / On Manorama, 2023) and working conditions as well as a way for female nurses to get away from gender-based exploitation in Indian hospitals (Chakrapani / Your Story, 2023).

Figure 1. Pro vs Contra



4.2 Pro Migration of Nurses

4.2.1 Out Supply of Nurses

Kerala produces more than enough nurses to send them to other parts of the country and to other parts of the world as well. Canada, USA, UK, Germany, Italy and other developed countries are the favorite destinations for Keralite nurses (Subramanian / Pulitzer Center, 2023).

There are 145 nursing and midwifery schools in Kerala, out of which 20 are government institutions. Karnataka, Andhra Pradesh and Kerala are the largest producers of nurses and supplying its nurses to different parts of India and abroad. Other states of India are also following in the footsteps of these states by proliferation of nursing colleges, mainly private ones. Germany regulates the influx from India, especially from Kerala based on the high number of nursing graduates produced annually in Kerala (Peoples Dispatch, 2023).

India is unable to employ all the nursing graduates. Job opportunities in private sector hospitals come along with poor salaries and unfavorable working conditions. However, working in private hospitals is considered as path to achieving the minimum working experience required to work in Gulf countries and the Global North. Even though, government hospitals guarantee better job security and pay but the job vacancies in government hospitals have decreased due to privatization of health care policies resulting in growing emigration (Peoples Dispatch, 2023).

India is also in agreement with Taiwan to supply skilled workers including nurses after the agreements with Germany, Italy, Australia and other countries (Gangadharan / Start News Global, 2023). Gangadharan guesses that Taiwan can be an ideal place to work for Indian skilled workers because there are many Indians working in Taiwan but there are no reported incidents of discrimination (Gangadharan / Start News Global, 2023).

4.2.2 Nursing Migration as Brain Gain

De. Vivek Desai in The Economic Times writes that the nursing migration from India should be seen as brain gain not as brain drain because they gain forex remittances and they also gain new skills and experiences which will contribute to the healthcare system if they return to India (Desai / The Economic Times, 2023). Percot argues that nursing migration helped migrant Indian women workers to elevate their social and economic status (Percot / The Daily Star, 2023).

4.3 Benefits of Migration

(a) Nurses

Evelyn P. Kannan, secretary general, *Trained Nurses Association of India*, Delhi, has been witnessing efforts to strengthen the healthcare system across the globe after the pandemic and says, “we are definitely seeing a growing demand for trained nurses. Increased salary, healthcare benefits, family visa, etc., make the shift a lucrative deal,’’ (quoted in Perappandan / The Hindu, 2023).

The post-pandemic era has changed the preferred destination of Kerala’s nurses from Gulf countries to the European countries. There is hope of getting permanent citizenship in European countries and having a home over there. The salary per month for the nurses in UK, for example is 2.25 lakh Indian rupees per month, which is much higher than nurses in India are paid. However, the living cost is also very high which requires at least two family members to be working to sustain the household in a European country (Gopi / On Manorama, 2023). The NORKA-ROOT, a government run immigration agency, also recognizes this rising opportunity of employment of Indian trained nurses and looks at it as bright opportunity for Kerala’s nurses to improve financial conditions (Gopi / On Manorama, 2023).

A nurse who recently migrated to Dubai compares the working condition in India and overseas as “abroad we get proper respect, a much better salary and above all working conditions are far better than in India,” (Kaiwei & Jub / People’s Daily Online, 2023). Another nurse who is going to migrate to Ireland soon feels that the salary for nurses in foreign countries is much more than in India and explains, “I can make five times what I used to get here for a month in just seven days. Contrary to the practice of making us work for much longer shifts without paying extra money, in foreign countries they pay extra money for the extra hours” (Kaiwei & Jub / People’s Daily Online, 2023).

(b) Overseas country / especially Germany

After Covid, in many countries health care workers are taking early retirement and that creates demand for trained nurses in countries like Ireland, Malta, Germany, the Netherlands, Finland, the U.K. (Wales), and Belgium (Perappadan / The Hindu, 2022). Migration of nurses from a country like India is helping these countries to fulfil the gap of workforce in health sector. In UK, 46 % newly recruited overseas nurses and 20 % of the doctors are from India. The number of non-EU citizens recruitment for skilled work has been increasing since 2017, however, there was a sharp increase in 2021 and 2022 just after the pandemic (Soni / Hindustan Times, 2023).

UK has been facing a staff shortage in the health and care industry, and India is one of the largest sources of care and health service providers (Daily Excelsior, 2023). However, M. Davis in BBC reports that the new immigration policy of UK which has raised the minimum salary requirement from £26,200 to £38,700 for skilled overseas workers, including nurses, to be qualified for family visa. She raises concerns that the UK is facing a shortage of care-givers and in this situation bringing such a rule which will reduce overseas immigration to UK will affect the needy (Davis / BBC, 2023). Similarly, Finland is interested in the Indian skilled care-givers in the view of its shortage of skilled workers in the country so that Finland can be a new destination for Indian nurses (Haidar / The Hindu, 2022).

4.4 Contra Migration of Nurses

4.4.1 Brain Drain

Nursing migration is perceived as "brain drain" by some and "brain gain" by others. Brain drain generally means that trained Indian nurses are lured by the Global North with the offer of better salary and working conditions, leaving India with a shortage of nurses. Brain gain means that Indian nurses after working for some time, return to India with a diverse set of skills, and India gains better trained and experienced health care workforce. However, the offer of permanent residence after the pandemic in the Global North makes it difficult for Indian nurses to return home.

Almendral reports in The Investigation that "the increased demand for healthcare workers in the US and Europe has drained nurses from the already rickety healthcare systems of countries that can least afford to lose them" (Almendral / The Investigation, 2023).

Earlier, the Keralite nurses used to migrate to Gulf countries and the main purpose was employment, not to settle in the country due to various political and religious reasons. However, since the avenue of employment has been increasing in Western countries in the post-pandemic era has also changed the nature of migration. For example: by 2025 Germany will be needing 1.5 lakh nurses. Due to better life conditions, the nurses are not only migrating into the Western countries to work but to settle with their families. This aspiration resulted in the exodus of skilled and educated citizens of the state and influx of unskilled and uneducated workforce from other states of India. This will have a negative impact on the culture, politics, and economy of the state (Menon / Mathrubhumi, 2023). Similarly, Kishore Kumar writes in The Times of India that India needs to develop a conducive eco-system in healthcare so that nurses can work here. The country should not let drain its skilled workforce rather should learn to use them efficiently by involving theme in preventive measures as well as specializes health care services (Kumar / The Times of India, 2023).

India, especially the state of Kerala has been providing the healthcare workforce globally. The Covid-19 pandemic surged the demand of such healthcare workers, especially nurses. Unfortunately, majority of skilled health workforces leave the country and the state for the better pay and future prospects to foreign countries such as Canada, Germany, UK, which is draining our skilled work force (Akhter / The Economic Times, 2023).

4.4.2 Effect on the Health System Delivery in India

Nurses, in India, have played a crucial role in reducing maternal and child mortality as well as communicable diseases. However, Desai states in The Economic Times (2023) that Indian lacks nursing faculty, mainly in specialty care such as geriatric care, palliative care and pediatric care which is a big concern in terms of health care delivery.

Perappandan concedes in The Hindu (2023) that there is already a large shortage of nurses in India and above that, there is a private - public sector divide, and rural - urban divide. 60 % of doctors and 50 % of nurses or midwives are employed in private sector hospitals and around 66 % of population lives in rural areas but the share of nurses is only 33 % in rural India.

According to Kumar in The Times of India (2023) in India, there are three million registered nurses. Still, it is an insufficient number to deal with the growing number of diseases and the increasing number of medical care needing population in the country. The brunt of shortage of nurses has already been felt during the pandemic. There is also a need of specialist nurses in the country to react to special medical care needs.

4.4.3 Shortage of nurses

After Covid-19, the shortage of nurses has been mentioned in almost all the major newspapers. A report by the Federation of Indian Chambers of Commerce and Industry (FICCI) titled 'Strengthening Healthcare Workforce in India: The 2047 Agenda' states: "Nursing is becoming less desirable as a profession and is witnessing increased migration to foreign countries, which has left India facing one of its worst shortages of nursing staff in recent years.'' (quoted in Perappandan / The Hindu, 2023. The report further stresses that there is a greater need of nurses trained in specialised care in various fields and they should be aware of the novel medical technologies (Perappandan / The Hindu, 2023).

Perappadan stated in the Hindu (2022) that India has been facing a shortage of health care professionals since 1947. However, the country realised the dire need to health care professionals only during Covid-19. 'Strengthening Healthcare Workforce in India: The 2047 Agenda', a report by the Federation of Indian Chambers of Commerce and Industry (FICCI), states: "Nursing is becoming less desirable as a profession and is witnessing increased migration to foreign countries, which has left India facing one of its worst shortages of nursing staff in recent years.'' (quoted by Perappadan / The Hindu, 2022).

Kerala and Karnataka account for 40 % of nursing institutions in India, yet, according to the Kerala Private Hospital Association (KPHA), Kerala suffered from a 30 % shortage of nurses in the year 2022. The scarcity of nurses has been persistent in the post-pandemic era when the resignation of nurses increased in the hospitals of Kerala (Kaiwei & Jub / People's Daily Online, 2023) with the increasing demand of nurses globally. The KPHA sees the shortage of nurses in general wards as well as in intensive care units, operation theatres and emergency wards of privates hospitals as an emergency (Kaiwei & Jub / People's Opinion Online, 2023).

Sethi in Business Insider (2022), based on KPMG (Klynveld Peat Marwick Goerdeler) and FICCI (Federation of Indian Chambers of Commerce & Industry), reports on the nursing shortage of India, asserts that "the country's current capacity of allied healthcare professionals – at 57.5-58 lakh – will have to go by 8 times if the shortfall has to be filled". According to Dutt in the Indian Express (2023) the migration of Indian nurses has caused the shortage of nurses of India. Though the net number of nurses in PHC and CHC has increased in India from 2014 to 2020 but it is expected to be reduced in 2022 .

Private hospitals in Kerala are facing a shortage of nurses in the post-pandemic era of 15 to 20 %. Reghukumar & Gupta (News18, 2023) argue that the major reason for the shortage of nurses in Kerala is the out-migration of Keralite nurses to overseas especially after 2020. Many of the overseas countries realised the need to boost their health system by strengthening their care workforce and started recruiting nurses from countries like India. To do the same they have waived off experience requirement to be employed as nurses. Moreover, during Covid enrolment of nursing students also decreased and that also contributed to the present shortage of the nurses in the state.

Another reason for the shortage of nurses given by Kaiwei & Jub in the People's Daily Online (2023) is the failure of retaining trained nurses after they gain some practical experience in Indian hospitals. India produces around 200,000 nurses per year and around half of them leave the country for better prospects after gaining practical experience in India. Approximately 6.4 million Indian nurses are employed abroad.

There were 18 lakhs nurses registered in India under NCI in the year 2020. However, India is short of 10 lakhs nurses to achieve the recommendation made by WHO of a nurse-patient ratio of 1:3 nurses. India in its union budget 2023-24 has announced to establish 157 new nursing colleges to fill the urban-rural divide in healthcare (Desai / The Economic Times, 2023).

Mishra in the Times of India (2023) says that with the relaxation of the earlier required three years of work experience to no work experience required to be eligible for nursing in some European countries like Finland and Ireland and the US, there has been a sharp rise in the emigration of Indian nurses. Now, even freshers with one year of nursing experience are getting opportunities abroad according to the Kerala chapter of the United Nurses Association (UNA) which is the largest body of registered nurses in India. In 2022, Kerala witnessed 27,000 nurses migrating from the state. This is becoming the major issue in the light of the massive shortage of nurses in private hospitals. Kerala hospitals are facing a 25 % shortfall whereas Maharashtra is experiencing around a 40 % shortage of nurses (Mishra / Times of India, 2023). As 70 % of nurses and midwives work in the private sector, these numbers are really dramatic for the Indian health service system.

4.4.4 Abuse and exploitation in foreign country

There are better opportunities, pay and working condition in foreign countries for some nurses, but a year-long investigation by Quartz in partnership with Type Investigations and in association with the Pulitzer Center reports that “the migration boom is also exposing nurses to abuse and exploitation, and exacerbating imbalances in the global healthcare system” (Almendral / The Investigations, 2023). Another investigation based in UK by BBC Panorama finds that Indians employed in care services are more prone to exploitation and racial discrimination (Telegraph India, 2023). In December 2023, there was an incident of racial violence in Ireland on Indian migrant nurses. After the incidence, the Minister for Health of Ireland, issued a statement guaranteeing the safety of Indian nurses in the country (Minister, 2023).

Many Indians migrate to Gulf countries for work where Indian nurses makes one of the largest numbers. However, under the Kafala system the employers keep their passports and educational certificate for “safe keeping”, which becomes the major reason for exploitation and slavery of Indian workers in the Gulf countries. The nurses face sexual harassments by their employers. The government of India has taken cognizance of this issue and took various measures such as recruitment of nurse through the state affiliated agency to stop such exploitation overseas (Bhandare / Hindustan Times, 2023). Another issue with the migration process of nurses is that recruiting agencies overcharge Indian nurses and if they are unable to pay on time, they are threatened (Subramanian / Pulitzer Center, 2023).

4.5 Perceived Reasons for Migration

4.5.1 Salary

Sethi in Business Insider (2022) reports that to work as nurse in India is becoming less desirable, and trained nurses are migrating to foreign countries because of the poor salaries for nurses in India. Nurses in private hospitals of Kerala are paid lower salary than daily wage workers, so it's better to migrate overseas than to work in the home country (Balan / The News Minute, 2021).

Though, the nurses in public hospitals get a salary of 70.000 rupees per month plus accommodation in India which is much more than any private hospital pays in India. Dr P K Bharadwaj, secretary of the *Delhi Voluntary Health Forum* and advisor to the *Association of Healthcare Providers of India* agreed that the migration of Indian nurses to other countries has increased because of better pay abroad (quoted in Dutt / The Indian Express, 2023). Similarly, as Perappandan reports in The Hindu (2023), the nurses who are employed in the central government hospitals are also not happy with their salary and growth prospects. According to a staff nurse at a government hospital in Delhi "in India, working as a nurse is becoming challenging and less attractive with long duty hours and comparatively less pay. The growth prospects are also limited,'' (quoted by Perappandan / The Hindu, 2023).

To recruit nurses, especially from Kerala, in UK overseas nurses are offered band 5 contracts; earlier they were offered band 4 contracts until they complete UK registration. A band 5 contract has more salary than the band 4 (Mathrubhumi, 2023). "Better working conditions and handsome monthly salaries are luring them from India to work in Gulf countries and Europe. People affiliated with the sector say the prospects for nurses have multiplied especially after the COVID-19 pandemic" (Kaiwei & Jub / People's Daily Online, 2023).

Mishra reports in the Times of India the narratives of migrant nurses and nurses working in India that revolve around the pay gap and working hours in India and overseas. One nurse who is working in UK says, "I was offered £26,558 per annum which comes to around Rs 27 lakh. I wanted to work in the UK for a better future. Of course, the salary matters; but most importantly, the UK offers better working hours." (quoted by Mishra / Times of India, 2023).

4.5.2 Poor Working Conditions

The long hours of work due to scarcity of nurses are one of the major reasons which motivate Indian trained nurses to migrate overseas. Even the nurses who are employed in central government hospitals suffer from this. One nurse employed in a government hospital says, "in India, working as a nurse is becoming challenging and less attractive with long duty hours and comparatively less pay. The growth prospects are also limited.'' (quoted by Perappadan / The Hindu, 2022).

Another reason for migration given by the nurses is that in hospitals only doctors are respected, and nurses are not treated with proper dignity (Reghukumar & Gupta / News18, 2023). There were many incidences of violence against nurses during Covid in 2020 and 2021 in different parts of India, but there were not much of the actions against the perpetrators by the authority (Arora et al., 2023). Chakrapani in Your Story (2023) reports that female nurses in India face physical and sexual violence from their seniors and the patients, and lower salary than the male nurses. Furthermore long hours of work make India a not desirable place to work. These are some reasons why many of the nurses are migrating overseas, in particular in the post-pandemic era (Chakrapani / Your Story, 2023). However, the government of Indian brought policies to protect health professionals after the incidences of violence against doctors and nurses.

A nurse compares the working hours in the UK and India "Unlike in India where we used to work in a 12-hour shift for five days a week, here (in the UK), it is 37.5 hours, which means three days a week. Besides, if one opts for advanced courses, the hospital takes care of the expenses" and adds that she can have extra income for doing "double shifts" (quoted Mishra / Times of India, 2023). Abhishek, who works in the Sunderland Royal Hospital in UK, also flags meagre salary and long working hours in Indian hospitals as the two main reasons why he opted for a job in the UK (quoted by Mishra / Times of India, 2023).

Harsha and Abhishek, Indian nurses in UK, consider the respect healthcare professionals enjoy in the UK as another plus point, something which "is not there in India". They further add, "Imagine after five years, I will be a permanent citizen of the country and I will be eligible for all other benefits like free education for children, free medical treatment, etc. I can also save a lot of money which I can send to my parents." (quoted by Mishra / Times of India, 2023).

4.6 Narratives in Favour of Germany

Now the migration pattern of Keralite nurses has been changing from gulf countries to Western countries. Germany is becoming one of the most desirable destinations for Keralite nurses (Balan / The News Minute, 2021). NoRKA-Roots Chief Executive Officer K. Harikrishnan Namboothiri told *The Hindu*, “Experts predict at least 5 lakhs vacancies for nurses in Germany alone by 2030 and a demographic change will further exacerbate the shortage. This has forced many developed countries beyond West Asia to look for nurses in Kerala. As part of an agreement signed by NoRKA-Roots with the *German Federal Employment Agency* and the *German Agency for International Cooperation* under the *Triple Win Programme*, 1,100 candidates were recruited from Kerala” (quoted by Kallungal / The Hindu, 2023).

Germany like Finland, UK and Ireland has been facing a shortage of healthcare workers and employers are looking for trained nurses. Therefore, the Germany government has passed a new act for Skilled Workers Immigration in November 2023, that has increased the opportunity for skilled overseas workers in addition to the *EU Blue Card* to ease the immigration process into the country. The new act introduces flexible provisions e.g. for candidates who are taking training for 3 years in Germany to get a German qualification are now eligible for a work permit, and skilled workers can bring their family members, majorly considering spouses, small children, or parents (Singhal / Y Axis, 2023).

Recent trends have shown that around 50 % of nursing students at the early stage of their education in India are intending to migrate and by the end of their third-year majority of them want to migrate overseas. The major reason for the popularity of overseas migration is influence of peers, aspiration for recognized and well-compensated position as well as the determination of recruiting agency motivated by the growing demand of healthcare workers in the Global North. This trend in India is also beneficial for Germany because they can employ well-trained nurses without spending money in training of these nurses (Peoples Dispatch, 2023).

The NoRKA also signed agreements with the Government of Wales and various provinces in Canada for providing nurses. Further, countries like Canada, Germany, Australia, New Zealand, Singapore, Scandinavian nations, Ireland, among others, have introduced programs facilitating temporary labour migration and avenues for permanent settlement. Notably, programs like ‘Express Entry system’ and ‘Provincial Nominee Program (PNP)’ are actively seeking professionals in healthcare in Canada to manage application for permanent residence (Kallungal / The Hindu, 2023).

4.7 Mitigation Measures in Media Reports

Rajan and Menon, two academics and migration experts criticize in The Indian Express (2021) the government's policies for out-migration of nurses from India and the shortage of health care professionals in the country. They argue that the policies are based on the idea of countering brain drain. However, this idea is restrictive in nature, and it does not give long term solutions. They further argue for the policies based on brain share in which the Indian State should meet its own demand as well as share its workforce with other countries. However, they recommend improving health infrastructure along with improving overall working environment of hospitals and pay levels which will motivate health professionals to stay in the country (Rajan & Menon / The Indian Express, 2021).

Rajan and Menon propose to mitigate the issue of out-migration in The Indian Express, "The government should focus on framing policies that promote circular migration and return migration – policies that incentivise healthcare workers to return home after the completion of their training or studies. It could also work towards framing bilateral agreements that could help shape a policy of *brain-share* between the sending and receiving countries – the destination countries of the migrants would be obliged to supply healthcare workers to their country of origin in times of need, especially in times such as what we are living in now" (Rajan & Menon / The Indian Express, 2021).

Rajan and Menon further express their opinion in The Indian Express that "the low wages in private sector outfits along with reduced opportunities in the public sector plays a big role in them seeking employment opportunities outside the country. The lack of government investment in healthcare and delayed appointments to public health institutions act as a catalyst for such migration" (2021). Rajan and Menon share the experience by the nurses Berly Lawrence, working at a critical care unit in Canada, and Mithun Thampi, who works in emergency services at an Essex hospital in the UK, that in Kerala hospital environment, doctors act as God and nurses are the slaves, and that becomes the main reason for out-migration. Thampi says, "nursing in India and in the West are (as different as) chalk and cheese." Unlike India, nursing is a profession in the West and male nurses are treated equally because in some states like Karnataka, there is very limited seats for male nurses and male nurses are not preferred for female patients in the hospitals (Rajan & Menon/The Indian Express, 2021).

Akther argues in the Economic Times (2023) that enhancing the nursing education and training, and providing on-the-job training for specialized care will open more avenues for nursing careers. Based on their specialized training they should be paid adequate salary. The increased remuneration according to their skill sets will motivate them to stay in India. The work-life balance by ensuring convenient work schedule and providing job opportunities to their family members within the health care system will promote loyalty among nurses. Engaging nurses during rounds to do routine check-up of admitted patients as an integral part of care delivery, alongside doctors, has proven beneficial (Akhter/The Economic Times, 2023).

Fazili writes in Greater Kashmir, "India needs incentivising care providers working at Government hospitals to attract and retain skilled staff by enhancing the working environment, ensuring better infrastructure and processes (E filing, digital tools, QR coding), modern medical equipment, adequate resources, EBM protocols, clean and well-maintained workspace" (2023). To retain the nurses, it is crucial to empower and respect nurses. The salary should gradually increase to ensure sustainable income. Additionally, the nurses should be motivated to take management roles, like in Australia where nurses can become part of the hospital management. Diversifying their roles will create more job opportunities for them and they may not choose to migrate overseas (Akhter/The Economic Times, 2023).

Recently, with the promise of social support and better pay Germany has been succeeding in wooing trained Indian nurses. As an activist and researcher in the *People's Health Movement* (PHM) Germany, Santosh Mahindrakar says "nurses are drawn to Germany due to the promise of a stable social support network and better pay and working conditions" (Peoples Dispatch, 2023).

However, nurses from Global South countries such as Indian nurses face an extended period of accreditation upon arriving in Germany. During the accreditation period, migrant nurses cannot be employed as a regular nurse for half to one and a half years but can only work as nursing aides, which is a less stable job and they get lower a salary than a full-fledged nurse. Moreover, learning the German language is tough in the absence of any language support provided in a systematic way (Peoples Dispatch, 2023).

Even after achieving these criteria, Indian nurses essentially start from scratch because their nursing specialties done in India does not guarantee their specialized skills in Germany. So, they begin their careers with a basic salary. Mahindrakar further says, "In addition, while trying to establish themselves within the German healthcare system, these nurses often delay joining trade unions or engaging in other forms of organizing" (Peoples Dispatch, 2023).

According to the criteria of the *Indian Nursing Council* a 100 plus bedded hospital is eligible to be nursing college whereas in Kerala it should be 300 plus bedded hospital. The state government needs to reduce the bed requirement to make more hospitals eligible to be nursing colleges so that more trained nurses can be produced, and the shortage of nurses can be mitigated (quoted by Reghukumar & Gupta/News18, 2023). However, the training institutes are not the main reason for the shortage of nurses in Kerala but the migration of nurses due to poor incentives.

5 Discussion

The Kerala State's *Scheduled Tribes Development Department* (STDD), in association with the *Overseas Development & Employment Promotion Consultants* (ODEPC) has taken an initiative to send the tribal nurses to European countries after providing language proficiency training to tribal nurse for free (Jacob/India Today, 2022). Many Keralite doctors and managements of private hospitals are worried by the shortage of nurses, especially in specialist care, in the post-pandemic era (Akhter/The Economic Times, 2023; Kumar/The Times of India, 2023). The state government is also in agreement with Canada and European countries like Germany and Finland to send trained nurses to foreign countries for better opportunity of employment (Gangadharan/Start News Global, 2023; Kallungal/The Hindu, 2023).

Similarly, the Indian government is promoting medical tourism in India and easing in visa process for foreigners who are seeking medical care in India with the aim of generating revenue (Kathikeyan/The Hindu, 2023). However, there is a shortage of doctors and nurses to even cater for India's citizens and above all there is a big gap in terms of the health care workforce in public and private sectors as well as urban and rural areas (Perappandan/The Hindu, 2023). So, in one hand India is inviting more foreigners to get treatment in the country and at the same time it is helping nurses to migrate overseas, rather than providing them a decent salary and working condition in India.

6 Conclusion

The survey shows that some authors support nursing migration referring to better salary, working condition and lifestyle the destination countries offer, and brain gain for India. Other authors are against the nursing migration referring to the shortage of nurses and care service providers in India and to the gap between public and private hospitals as well as between rural and urban areas of the country. The majority of those who are against migration belong are medical doctors, hospital managers and journalists and one of them is a retired bureaucrat from Kerala. They are against nursing migration because there is a shortage of nurses, especially the specialized care nurses in private hospitals. Some journalists who are working in the destination countries are against the nursing migration due to poor working conditions and racial discrimination of Indian nurses in the destination countries.

The authors who are in favour of nursing migration are mostly nurses, and they argue by referring to the supply of a large number of trained nurses in India, especially in Kerala, as well as better wages and working conditions for Indian nurses in the destination countries, especially in the Global North.

The proposed mitigation for the Indian government is to open more numbers of nursing institutes, better treatment of nurses, gradual increment of the salaries and providing on-the-job training of nurses in specialized medical care.

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Santosh Mahindrakar[1]

Navigating the Healthcare Maze: Challenges and Issues faced by Foreign Nurses in Germany

A Position Paper

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Contents

1 **Introduction** **86**

2 **Process of adaptation and registering as a nurse in Germany** **87**

3 **Challenges faced by foreign nurses in Germany** **90**

3.1 Macro level 90

3.2 Meso level 91

3.3 Micro level 93

4 **Conclusion** **94**

References **95**

1 Introduction

The scarcity of nurses in Germany is a widely recognized reality (Reiff et al., 2020). Many political initiatives aimed at tackling this shortage primarily focus on the recruitment of nurses from foreign nations (2022). In an effort to combat the deficit of nurses, Germany launched the Triple Win project, which facilitates the recruitment of foreign nurses by government-recognized agencies. This project involves bilateral agreements overseen by the German government with an emphasis on promoting equitable recruitment practices. In 2013, Germany opened its market for nurses from South-Eastern Europe and from the Global South and thereafter continued with bilateral agreements with Bosnia & Herzegovina, Philippines, Serbia, Tunisia (2013–2016), Mexico, Brazil and India (2020 / 21) and Columbia (2022). However, within ten years, only 4747 nurses were recruited within these programmes and bilateral agreements. Additionally, nurses from the Global South came to Germany on an individual basis (Ärztezeitung 2023).

Nurses, who have migrated from non-German-speaking countries, bring diverse linguistic, cultural and professional backgrounds with them. They come with years of nursing experience from their home countries and some have even worked in international settings. Most of them are engaged in full-time nursing roles in Germany. However, their transition to a new language and culture, geographical distance from their family and the unfamiliar work environment pose a range of intricate issues and challenges during their tenure in Germany (Can et al., 2022).

- The language which they have acquired in recent years becomes their sole medium of communication and their primary working medium in life. In this entirely new environment, characterized by their newly acquired language skills, can they effectively articulate the problems, issues and challenges they encounter?
- Do they manage to grasp all the rules and regulations about their work?

From the perspective of foreign nurses, these factors can make comprehension rather complex.

- Why do nurses leave their home nations and choose to relocate to Germany?
- What is the cost of their education in their home country?
- What avenues do they utilize to reach Germany?

These are some crucial inquiries that can significantly influence the effectiveness of their work as nurses in Germany (Can et al., 2022).

This paper does not delve into the specifics of these inquiries. Instead, it focuses on the experiences of nurses after they arrive in Germany. This paper narrates the experiences of an Indian nurse and his discussions and conversations with other foreign nurses in Germany. The author attempted to compare Indian nurses' experiences working in the German and English-speaking European Union countries. An Indian nurse working in Ireland was interviewed online. He was actively involved in the nurses' union in India. He worked for more than six years and participated actively in the nurses' union in Ireland. The interview was carried out on the 15th of September 2023.

2 Process of adaptation and registering as a nurse in Germany

Understanding and comparing the registration of foreign nurses in Germany and making a comparison with other countries within the European Union (EU) is quite significant.

Nurses from non-EU states seeking to register and work as qualified nurses in Germany are required to complete an adaptation course, with the examination conducted in the German language. During this transitional phase, they are initially employed as nurse assistants at a pay scale of P5 (Euro 2950,63); whereas freshly registered nurses begin at P7 stage 2 (Euro 3304,69) when working in state-owned health institutions (Gehaltsrechner TVÖD-P 2024, 2023). The difference is 300+ Euros but it will end up for more than 500-800 Euro difference which includes payment for extra hours, night duties and so on. Additionally, it will also affect non-financial benefits. The duration of the adaptation course duration can vary from six months to a few years.

In the current context of nurse shortage in the German health systems, these foreign nurses often work on par with the registered nurses, assuming responsibilities such as administering medication and performing medical interventions. Language proficiency stands as a significant barrier, impacting their eligibility for the adaptation course and as well in the utilization of their skills and knowledge.

- Can registered nurse from non-German speaking countries effectively read their employment contracts and understand labour laws?
- Questions arise regarding whether it is equitable for a registered nurse from non-German speaking countries to perform duties equivalent to those of a registered nurse yet receive a nurse assistant's salary.

Once they complete the adaptation course, they are categorized on the pay scale as newly qualified nurses, regardless of their years of prior nursing experience. This implies that nurses with a decade of working experience receive a salary equivalent to that of a newly qualified nurse from a German nursing program. These pay scales not only affect the financial incentives but also determine the associated non-financial benefits.

Table 1: Comparison of Nursing Adaptation Courses in Ireland and Germany

	IRELAND	GERMANY
Prerequisite	IELTS and Nursing Certificate	B1–B2 language skills and Nursing certificate
Adaptation course time	1–2 Months	1–2 years
Payscale	Within two months they will be paid as per the payscale	1–2 years Nursing Assistant salary (500–700 Euro less / month)
Recognition of previous experiences	INMC recognises and mentions their potential payscale in the certificate	• No Nursing Council • An employer does not recognise experiences • Start with a basic pay scale • Employees negotiate for payscale

Source: Interview with an Indian nurse working in Ireland (15.09.2024) and https://www.nmbi.ie/Registration/Qualified-outside-Ireland

Table 1 provides a comparative brief of the adaptation courses and benefits in Ireland and Germany, both being European Union member states. In Ireland, the Indian Nursing courses are acknowledged directly and the candidates are required to qualify and pass an English proficiency test. After meeting this requirement, they are eligible to directly apply for an Objective Structured Clinical Exam (OSCE) within the first or second week of their arrival in Ireland. The Irish Nurse and Midwifery Board assesses the salary of the nurses based on their prior experiences, ensuring that the aspirants have a clear understanding of their pay scale before entering the job market.

Compared to Ireland, in Germany, even if the candidates have completed the B1/B2 proficiency level of the German language, they still need to navigate a lengthy adaptation process that can span from six months to several years. During the adaptation period, they are hired as nursing assistants, receiving salaries that are not commensurate with the role. The duration of the adaptation course can vary considerably and the candidates can get a varying number of practical and theoretical training hours. Unlike Ireland, there are no standardized, objective methods to calculate the foreign nurse's syllabus and determine the appropriate duration for the adaptation course. However, there process of evaluation is done on a case-to-case basis rather than adhering to a uniform standard.

In my experience during the adaptation course, two foreign nurses, with similar experiences underwent the adaptation courses with a significant disparity in the number of practical and theoretical adaptation course hours, exceeding 300 hours in some. Given the limited language proficiency of foreign nurses and lack of familiarity with the system, they may struggle to clarify such differences in the adaptation course duration.

Even if the candidates are aware of the duration of the adaptation course, there is still a waiting period spanning from weeks to months, before they can commence the adaptation course (Anpassungslehrgang). Some candidates have experience of waiting for more than two years for the adaptation course in one of the nursing schools in North Rhine Westphalia state. For Foreign nurses, the objective is not solely to complete the adaptation course but also to balance it with language learning, work and their family in their home country.

Challenges faced by foreign nurses in Germany

Foreign nurses encounter social, professional and cultural obstacles in their workplaces as well as in their daily lives in Germany. These challenges can be categorized into macro, meso and micro levels. This categorization is based on the author's analysis of the origins of these issues and attempts to look for probable solutions at each respective level. Macro level challenges encompass the two nations India and Germany; the Meso level encompasses challenges on the institutional levels such as the employer's policy, and the micro level relates to the working stations or departments.

Table 2: Levels of issues and challenges based on the origins of these issues and attempts to look for probable solutions

LEVELS	ISSUES AND CHALLENGES
Macro	• Non-recognition of nurses' registration within bilateral agreements • Lack of standardization of adaptation course framework and duration • Lack of availability of adaptation course choices for foreign nurses upon arrival • Oversight of private recruitment agencies • Language requirements persist as an ongoing educational requirement even after registration
Meso	• Lack of induction and orientation programmes • Working agreement in English or Other bilateral agreement countries' language • Lack of Employees Book – rights, services and entitlements • Lack of standard and transparent regular appraisal
Micro	• Lack of information on duty roster planning • Lack of mentoring • Non-regular team meetings and feedback • Lack of German native nurses' preparation to accept foreign nurses

3.1 Macro level

These challenges and issues primarily exist at the governance level. Germany has established bilateral agreements with over 10 countries for the recruitment of nurses under the Triple Win project. The project acknowledges that these partner countries have a surplus of nurses who can be potential candidates for recruitment in Germany. This arrangement benefits both the countries, the host country receives the remittance and these nurses share their knowledge and skills in their home countries. In many countries, nursing is a bachelor's degree program and adheres to the international standard. For instance, in Ireland Indian nursing courses

are recognized and the candidates are eligible to undertake the OSCE within a few weeks after arrival. In contrast, in Germany, the entire process is overseen by non-nursing experts since there is no dedicated nursing council. At this level, the major issues and challenges include non-recognition of nurses' registration within the bilateral agreements, absence of standardized adaptation course structure, limited adaptation course choices for foreign nurses upon their arrival in Germany, oversight of private recruitment agencies, and the requirement for nurses to continue German language education even after registration.

Within the framework of bilateral agreements, the participating countries could have undertaken a comprehensive comparison of their nursing syllabus and collaboratively developed a standard module of adaptation courses. This approach could replace the current practice of pursuing individual cases-based adaptation courses. Although the triple win program advocates for recruitment of the nurses through its mechanism, the number of nurses recruited via this channel is very low.

After a foreign nurse gets registered in Germany the onus of learning the German language is on them. Language is pivotal for communication and for providing quality care. The proficiency in the German language mustn't rest with the foreign nurses alone. Instead, it should be a collaborative effort shared by the German government and employers. They should collaboratively ensure that foreign nurses have access to continuing education programs to enhance their language skills. This approach will comprehensively elevate the quality of care and also foster greater acceptability within the community.

3.2 Meso level

While hospitals in each state adhere to pay scales and rules, much of the induction programs, welcome packages, and retainment are at the discretion of employers. Hospitals abide to have employee unions that resolve the issues related to the workplace. Some hospitals have larger state union units (Verdi, DGB) and some others have local representation. These larger union's membership fees are 1 % of the employee's total salary i.e. approximately 25–30 Euro / month. Foreign nurses feel this is a big amount for them so could avoid taking membership. The involvement of foreign nurses in these unions varies significantly, as the foreign nurses themselves aren't involved with the unions and show limited interest in the issue of foreign nurses.

At this level the issues and challenges can be categorized as induction and orientation; working agreements in English or in languages of the countries who are part of the bilateral agreement; employee handbooks – providing information on rights, services and entitlements; and standard and transparent regular appraisal systems.

The majority of employers do not prefer specially designed induction and orientation programs which are uniquely tailored for foreign nurses. This program could entail resources like an employee's book containing information on rights, entitlements and standardized protocols along with processes of regular appraisals and continuing nursing education. Employers argue that they are offering complimentary accommodation, food discounts and coordinator support to address the initial concerns of foreign nurses. For instance in England, approximately every 4 or 5 foreign nurses receive support from nurse managers within the same department. These nurse managers take on the responsibility of mentoring these new foreign nurses both professionally and personally until they adapt to the new environment. However, in Germany, there is a notable absence of minimum standards for nursing organograms. Recently, the post of a deputy station/team leader was abolished at one of the government tertiary hospitals without prior notice resulting in only one team leader overseeing more than 15-20 general nurses. In Germany, the nurse educators (practical instructors) who guide the adaptation process are registered nurses and may be working in the same station or independently. The responsibility of the nurse educators usually ends with the completion of the adaptation program. These nurse educators are expected to dedicate additional time beyond their duties to guide and mentor the students and foreign nurses.

The absence of nursing councils and a lack of standardized nursing organograms as well as a lack of regulatory bodies pose challenges in providing mentoring and supervision facilities for foreign nurses. In contrast, the states of Ireland and England have structurally designed modules for mentoring and supervision through their respective nursing and midwifery councils. Consequently, it falls upon the employer or the institution's interest to establish a supportive and enabling environment for foreign nurses.

3.3 Micro level

The micro-level issues pertain to the aspects of the immediate workplace of the foreign nurses. It involves interaction with fellow nursing colleagues, team leaders and other health team members like doctors, physiotherapists and housekeeping staff among others. The health teams in the hospitals are often characterized by multicultural and multi-linguistic backgrounds. Approximately a minuscule 20–30 % of them are native German speakers and more than half are of foreign origin and have learned the German language and speak it with the influence of their mother tongue. Nurses assume the vital role of intermediaries necessitating communication with patients, their families, doctors, social workers, geriatric care homes, and mobile nurse clinics. The hospital stations usually buzzing with phone calls and rings. Thus, the nurse's pivotal responsibility revolves around communication with teams, patients and other associates. No wonder that foreign nurses often encounter language barriers during their duties.

At this level the issues and challenges may entail aspects like duty roster, mentorship, regular team meetings and feedback sessions, preparing German native nurses and team members to be receptive to foreign nurses. At the micro level, foreign nurses have direct interactions with their colleagues and patients. The interventions at the macro and mesolevels discussed earlier will facilitate the building of a conducive environment for the entire team with particular benefits for foreign nurses.

It is pertinent to highlight an example here related to language barriers and constant efforts from both employers and employees to enhance language proficiency and facilitate effective communication. For instance, a foreign nurse requested a German native nurse to speak slowly, to which the German nurse responded "I am speaking normally but you need to improve your language". The response of the German nurse may seem to be quite rude on the surface, however, in reality, it was a conscious statement, and it can be explained as a nurse, you have to take care of more than 15 patients during night duty and you need to respond to emergencies and communicate effectively. Therefore, you need to improve your language skills. This interaction stresses the need for continuous dialogue between both employers and employees to improve the language proficiency of foreign nurses. This mutual effort not only benefits the team but also enhances the quality of care and reduces the conflict due to misunderstandings.

The duty roster is a significant tool to determine the satisfaction level of the nurses. Nurses work in three different shifts and these shifts offer various financial and non-financial incentives. It is the individual responsibility of the nurse to monitor their duty roster and ensure its accuracy to avail of those incentives. Several factors come into play including the distribution of morning, evening and night shifts as well as duties assigned on weekends and holidays. As an illustration, we shall consider a situation where foreign nurses are not posted in night duties or more morning shifts where basic body care is needed than medical interventions. It might appear as standard to external observers, but it's essential to note that the majority of them want to have a good time in the summer and prefer morning shifts.

4 Conclusion

The health worker shortage particularly that of nurses poses a major challenge for the German health system. Germany's ageing baby boomer population will further increase the healthcare demand. It is worth noting that a significant portion of this population works as nurses, contributing to the ageing demographic of the nursing workforce.

In addition to the ageing nurses, the dropout rate among nursing students is around 30 per cent quite high compared to other skill training (Pflegenot Deutschland). To address these issues of ageing nurses and high dropout rates of nursing students, Germany has been actively hiring foreign nurses. However, it is essential to reevaluate the current social image of the nursing profession and develop innovative nursing governance strategies to attract younger individuals to the nursing profession and retain foreign nurses for extended periods.

The issues and challenges highlighted at the three levels including state, institutional and direct workplace levels are interconnected and interrelated. To address these challenges effectively, there is a need for the state to take the initiative, establish state nursing councils and provide strong leadership to shape the future of the healthcare system. These include aspects like restructuring the health care system to accommodate the skills and knowledge of advanced nurses and developing transparent, fair and objectives-based policies for foreign nurses.

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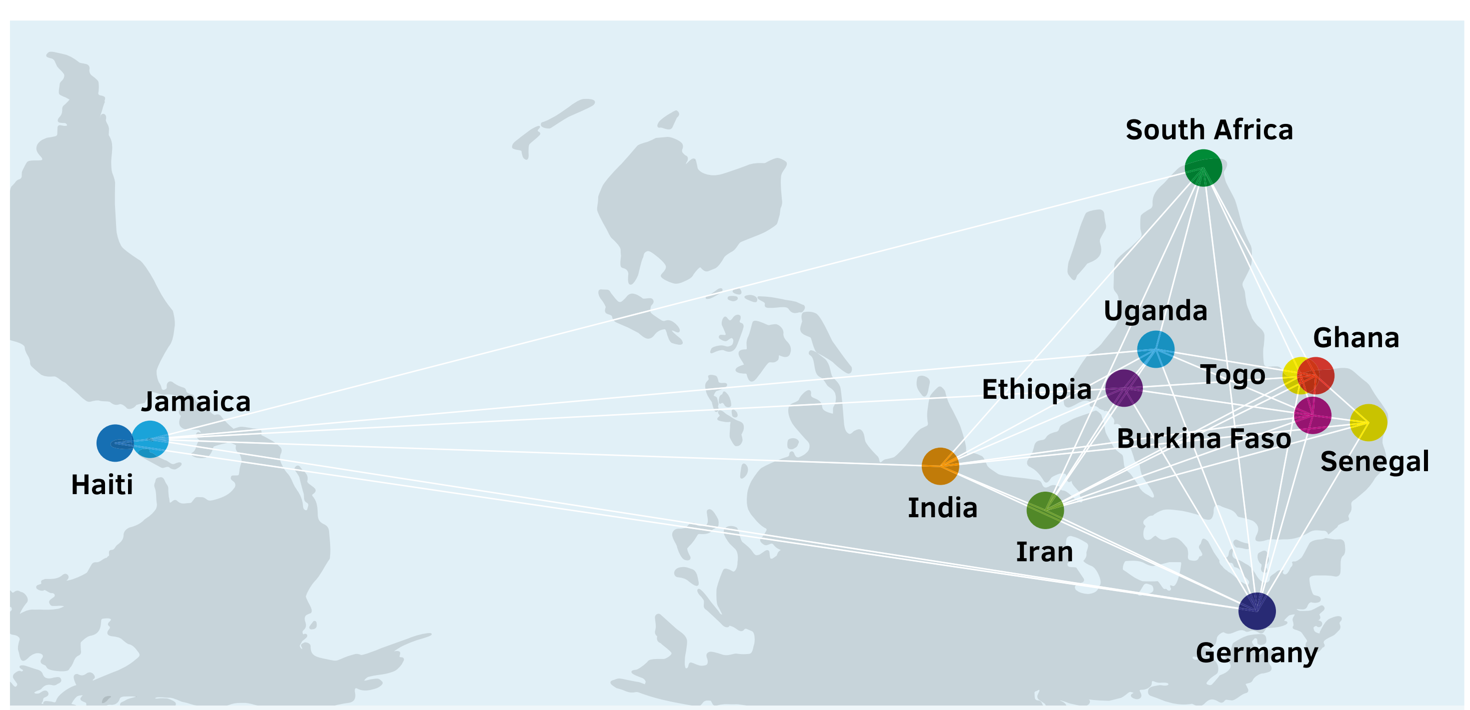

The Global Partnership Network

This world map displays all countries in which GPN partner institutions are located. The South-Up projection draws attention to overcome Eurocentrism and to take a multitude of perspectives and knowledges into account.

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