

Hiding in Plain Sight: Gendered Dimensions of Health Worker Migration from 'Source' Country Perspectives

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Abstract

Background: Gender roles affect health worker migration and their migration experiences, but policy responses have rarely considered the gender dimensions of health worker migration. This invisibility and lack of attention can lead to social, health and labour market inequities.

Methods: A Canadian-led research team with co-investigators in the Philippines, South Africa, and India studied the international migration of health workers from these 'source' countries through documentary, interview and survey data with workers and country-based stakeholder interviews. Our particular focus was to examine the causes, consequences and policy responses to health worker migration. Here we undertake an explicit gender-based analysis highlighting the gender-related influences and implications that emerged from the literature, policy documents and empirical data.

Results: Our data from nurses, physicians, and other health workers reveal that gender mediates health workers' access and participation in health worker training, employment, and migration, and the impact of health worker migration is gendered, depending on country context. Female migrant health workers were "preferred" for "innate" personal characteristics and cultural reasons. Female nurse migration in particular is greatly influenced and linked to personal relationships and social networks including friends in the diaspora. Remittances by female nurses to family back home may play a large role in the decision to migrate. Migration may improve social status of women nurses, but it also exposes them to deskilling, sexism and racialization. Regardless of these apparent differences in migration decision-making and experiences for women and men health workers, gender is rarely considered either as an important contextual influence or analytic category in the policy responses.

Conclusion: An explicit gender-based analysis on health worker migration offers useful insights for health workers considering migration and those that ultimately migrate, the workplaces and families they leave behind, and social and health policy of their countries.

Introduction

Who migrating health workers are, why they migrate and the consequences of their migration are important details for consideration in health workforce and migration policy design and planning. Although there has been a visible growth in knowledge that gender roles affect health workers' reasons for migrating and their migration experiences (George 2007; Piper 2005; Spitzer, 2016a, 2016b; Walton Roberts 2019; Yeoh, 2014), an acknowledgement that gender is an important consideration or factor, health worker migration-related policies and regulations show little in the way of systematic consideration or sensitivity to gender. Although gender differences are present, their invisibility and lack of attention to them can lead to social inequality, and labour market and health inequities.

In some ways, this trend of the issue being hidden but all the while in plain sight is not so surprising: classical theories of migration of the 1960s and 1970s were focused on the assumption and stereotypes that migration decisions were men's and migration experiences were universally male. Men's experiences were considered the standard: women and families who accompanied them were assumed to be passive and invisible (Piper 2005). More recently, there is evidence of the *feminisation of migration* (Camlin, et al, 2014; Ryan, 2002) where women constitute 44.3 percent of the estimated 244 million international migrants world-wide (McAuliffe and Ruhs, 2018). Although some countries have restricted women's migration as a result of patriarchal ideologies and policy (Kingma, 2006), women migrants are increasingly moving independently of partners or families (Kofman, 2004; Timur, 2000).

Migration is thus becoming better understood as highly gendered as gender impacts men's and women's roles and experiences of migration differently (Spitzer, 2020; Spitzer and Piper, 2014; Walton-Roberts 2019). Although migration studies have generally become more gender analytic in nature (Donato et al, 2006; Spitzer, 2016a, 2016b), the literature

Loading [MathJax]/jax/output/CommonHTML/fonts/TeX/fontdata.js } gender and migration policy.

The feminization of migration is particularly striking for health workers with female nurses, for example, globally forming the dominant health worker migrant group (Brush and Sochalski, 2007; Walton Roberts 2015). Indeed, women migrants are over-represented globally in health and care sectors in which care-work has typically been undervalued (Folbre, 2012). Moreover, nurses and other feminized health workers are often disproportionately impacted by health government austerity and cutback to healthcare investment (Shannon et al 2019). Yet, while the migration of women as skilled health workers contributes significantly to global labour markets and migration patterns, the “*gendered effects of migrant health workers on their personal and professional lives within the context of specific health occupations and specific recipient and source health systems*” (George 2007; p. 37) remains under explored.

Undertaking a gender-based analysis starting with sex disaggregation of data (female versus male) of migrant health workers can help in the interpretation of differences in women’s and men’s migration motivations and experiences. A more complex and nuanced view of gender does much more when it takes into consideration the social roles, relationships, behaviours, relative power and other traits that societies generally ascribe to women, men, and people of diverse gender identities (Hankivsky 2013; Schiebinger et al. 2014). Further, migration decisions are not only influenced by gender at the individual and household level, but also at the institutional and policy level (Bourgeault et al., 2016). The gendered nature of the division of labour in health care (Kuhlmann et al, 2012; Jones et al., 2009), for example, and how that is uniquely configured in both source or sending and recipient countries also has implications for understanding better the gendered nature of health worker migration and its impacts.

In the country-based empirical analyses we undertook of some of the key global health worker source or sending countries (Labonté et al., 2015; Palaganas et al., 2015; Tomblin-Murphy et al., 2015; Walton Roberts et al., 2015), we found many suggestions that gender played an important yet unnoticed role for potential migrants and migrants, the workplaces and families left behind, and social and health policies. In this paper, we explicitly analyse these gendered aspects of health worker migration from the three key data sources – country-based documentation, health worker surveys, and interviews with key stakeholders carried out for the study. We highlight the gendered aspects of health worker migration from both the literature and the findings from our country case studies of health worker migration. Theoretically, this paper’s analysis builds on the extant literature on gender-based analysis and employs the typical (although non-gendered) push/pull theories of international labour market mobility as an organizing framework. Second, we draw upon insights of the gendered impact of health worker migration on formal and informal sectors in source countries, with a particular focus on immigration and emigration policies.

Gender And Health Worker Migration

Gendering push-pull factors influencing health workers decision to migration

There is a tendency in the health worker migration literature to focus on individual level factors emphasizing how certain ‘push’ and ‘pull’ factors influence personal decisions to migrate by individuals and families (Bourgeault et al., 2016). Factors pushing health workers to migrate include poor wages, limited opportunities for professional development, heavy workloads, economic instability, poorly funded health care systems, the burdens and risks of HIV/AIDS and safety concerns (Labonte, Packer, and Klassen, 2006; PAHO, 2001; Robinson and Carey, 2000; WHO, 2006). Pull factors include better and more comfortable living and working conditions, higher wages and greater opportunities for advancement and promotion (Aiken et al., 2004; Buchan, 2002; WHO, 2006). Health workers such as doctors and nurses from source countries are considered to be highly skilled and experienced personnel (Stilwell et al., 2004). Further, migration is not necessarily a young person’s game: One older study reported that more than 40% of migrant nurses from South Africa, India, Pakistan and Mauritius were aged 40 or older (Buchan et al., 2006).

The push and pull factors approach to migration is a popular approach and useful for a descriptive means of organizing and listing factors at the individual level. However, it provides little distinction of their relative importance, nor analytic attention to root causes at a more structural level, including the influence of gender and its association with the broader political economy (Bourgeault et al., 2016, Kingma 2006; Walton-Roberts, 2015a). It can also be critiqued for neglecting the historical (and gendered) nature of colonial and post-colonial relations, and other social divisions in its analysis of the migration dynamic (Hagopian et al., 2005). Gender is intricately implicated in the migration decision of health workers through the gendered discrimination and inequality experienced at home and abroad, and perpetuated by traditional societal attitudes towards women and the care work they undertake (e.g., Adhikari, 2013; Byron, 1998; Ryan, 2008). Factors typically characterized as push, such as poor working conditions and low earnings, are often indicators of women migrants' labour market marginality (Piper, 2005). Moreover, the global demand for care-workers coupled with the expectation that women should earn for their families' well-being—discourse that is underscored by public declarations that migrant workers sustain the national family—help propel out-migration (Spitzer, 2016a).

The Public Services International's participatory research on migration and women health care workers conducted in a number of countries demonstrated that women health workers were besieged in several ways. Foremost, structural health sector reforms had negative effects on women health care workers, who are often subject to low and inequitable wages, and violence in the workplace, while they need to work to support their families, and hold full responsibility of care for them (Pillinger, 2011, 2012). All these factors can converge to cause women to migrate sometimes leaving their families behind, and/or leave work in the health sector altogether.

The gendered nature of transnational social networks, which increase female health workers' awareness of migration opportunities, also have a particular influence on their decisions (Nair, 2012; Le Espiritu, 2005; Ryan, 2008; Hagan, 1998). Ryan's (2008) work on Irish nurses who migrated to Britain in the postwar period reveals, for instance, that most of them were encouraged to migrate by female relatives, especially sisters, aunts and cousins. Adhikari (2013) similarly illustrates how female nurses in Nepal are encouraged to migrate by women in their families; their migration is seen as a collective family investment, the key return on their investment being remittances that are sent back. Scholars are increasingly recognizing how gender intersects with various push and pull factors to influence migration decisions of health workers.

Emigration policies in source countries

Studies of labour migration have often treated sending states as "unimportant auxiliaries" (Paton, 1994), merely reacting to the demands of the more powerful receiving nation-states which consume their citizens' labour. This under-theorization of what the sending state does before the migrant leaves, and the impact of sending state policies on the skills composition, geographical reach and scale of international migration, remains an important research gap in the migration field (Lee, 2017), and particularly as it relates to health workers.

Policy changes that have taken place in both source and destination countries are instrumental in precipitating and tempering women's migration (Bandita, 2015). Although International human rights' laws affirm that an individual has the right to leave and return to one's own country (United Nations General Assembly, 1948) Article 13 (2), some countries have placed gender-based limitations on emigration based on law or social norms (e.g. women from Iran are not allowed to emigrate without permission of a husband or male relative if single). As Ferrant et al. (2014) explain, "High levels of discrimination against women reduce their ability to migrate ... [and] deprive women of the resources necessary for cross-border migration." (p. 4).

Examination of states' emigration and immigration policies, cultural norms that foster international migration in some cases and prevent it in others, and the extent of women's autonomy in making decisions to emigrate, provides additional evidence that gender is excluded in push/pull considerations in the wider literature. Restrictions or guidelines on women migrating are often quite specific to their gender whereas restrictions placed on men are most likely to be targeted at the

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job class/profession. Emigration restrictions on women from Asian countries include: the banning of the recruitment of certain sectors dominated by women e.g. domestic helpers; restrictions on age of female migrants; selective bans on employment depending on destination country; and requirements of educational qualifications before exit permission would be granted. These restrictions are not equally applied to men (Oishi, 2002).

Gendered impacts of health worker migration on source countries

Migration can have positive impacts both formally on healthcare and informally in other sectors. For individual health workers, migration can bring about gains in social and professional status, and these can be accentuated for women. Indian nurses who hold visas to work overseas, and therefore have the potential to migrate, become preferred as potential wives because they can supply their own dowry, earn a wage, and buy a ticket for their future husbands (Percot, 2006; Walton-Roberts, 2012). Families 'at home' can also benefit from the significant contribution that remittances make to source country household incomes. Philippines and India for example view health worker migration positively because of the receipt of remittances. When confronted with situations of under- and unemployment, endemic in the gender dominated health care sector, migration offers significant opportunities for health workers to apply their training in an international context (Jones et al., 2009).

Reports of negative impacts of migration, gendered or otherwise, dominate the literature. Health worker shortages resulting from migration can have adverse effects on care delivery, and in turn population health and health equity in source countries (Labonté et al., 2015; Palaganas et al., 2015; Tomblin-Murphy et al., 2015; Walton Roberts et al., 2015). The emigration of healthcare workers can mean that countries lose their investments in public education and training, which are further compounded with later loss of income tax revenue from highly skilled workers (Jones et al., 2009; Hagopian et al., 2004). How gender impacts these shortages is less specific: that nurses are a very large group of health professionals and the majority of nurses are female means that migrating female nurses are lost to the sector, but filling the workload gaps that result from job vacancies and staff shortages, also falls to (predominantly) female nurses. While the levels of violence against women health workers have already been acknowledged as high in many countries (Cooper & Swanson, n.d.; Henderson & Tulloch, 2008; Needham et al., 2008), there is potential for additional harmful consequences. For example, some authors have suggested that as a result of migration, women workers face increased workload with attendant stress and low morale (Jones et al., 2005; Pan American Health Organization (PAHO), 2001).

Migration may improve social status of some women nurses, but it exposes others to deskilling, sexism and racialization in destination countries (Pratt, 2004). Although likely to be migrating for their own economic purposes, female migrant health workers are vulnerable to certain experiences that male counterparts do not experience, including increasing risks to their own health. In addition to such vulnerabilities, according to the International Labour Organization (ILO) and Public Services International (PSI), there is a clear trend of undervaluing women's work across professions (Lu-Farrer, Yeoh, & Bass, 2020; Pratt, 2004).

Women's decisions to migrate, particularly if seen for individualistic reasons, are not without criticism. Hull (2010) wrote how female nurses can receive gender specific condemnation from others for abandoning or neglecting family in their pursuit of financial gain. Outside the health sector itself, when female health workers emigrate, the knock-on effects of migration have effects on other women. Women's gendered roles are typically taken over by other women – older, younger or of lower status, who carry the burden of increased care responsibilities for sick or elderly family members in the context of weakened and under-resourced health care systems (Akintola, 2004; Eckenwiler, 2011; Jones et al., 2009; Makina, 2009; Nelson, 2002). Surrogate parenting for children is often provided by siblings and other female family members (Jones et al. 2009). Citing Nelson (2002), Eckenwiler (2011) maintains that "there is now abundant evidence to suggest that caregiving responsibilities—doled out and taken on the basis of gender norms and the social and institutional policies that exploit them—have profound effects on ... family caregivers" (Eckenwiler, 2011, p. 10). The concept of global care chains, coined by Hochschild (2000), and applied to the case of nurses by Yeates (2004, 2009) recognizes the role of female migrants as

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ack home to whom their care responsibilities are transferred.

In summary, the literature of health worker migration has begun to show and acknowledge that gender is an important determinant of migration affecting the decision to migrate, the experiences of migrants, and impacting the formal and informal sectors in source and in destination countries. The exploration of these issues is still relatively limited and remains evident in policies in which gender plays a significant role, for example codes of practice that implicate international health worker migration. (Commonwealth Secretariat, 2003; World Health Organization, 2010). Critiques of the Code have failed to make visible sex and gender-based analyses (Bourgeault et al., 2015; Brugha & Crowe, 2015). Invisible in particular are the perspectives in sending countries and experiences of health workers and the lack of knowledge of gender and gender-based analysis by stakeholder decision-makers. These gaps clearly have implications for migration policy development and health workforce planning.

Methods

The data that formed the basis of this paper are derived from the comparative research project “Source Country Perspectives on the Migration of Highly Trained Health Personnel.” Ethical approval and the methods that were employed for country-based studies have been reported in detail in the published literature to date, and they are not replicated in this paper (Castro-Palaganas et al., 2017; Labonté et al., 2015b; Walton-Roberts et al., 2017). Although the primary focus of the larger study was on the causes, consequences and policy responses to health worker migration, the key research question of this secondary analysis was on how gender influenced the migration of highly skilled health personnel from a subset of three major source countries of health workers (Buchan 2015): the Philippines, India, and South Africa.

Data were collected in three phases: 1) scoping reviews of the published literature and policy documents to assess what was known/not known before we proceeded with collecting empirical data [2005–2015]; 2) in-depth interviews with 117 health worker stakeholders, senior policy officers and health care systems specialists [42 India; 38 Philippines and 37 South Africa]; and 3) household and on-line surveys with 3,580 health workers [1719 in India, 1244 in South Africa, and 617 in the Philippines; see Table 1).

Table 1
Overview of empirical data from India, the Philippines and South Africa.

	Health Worker Surveys		Stakeholder Interviews
	Male n (%)	Female n (%)	
India	581	1 138	42
MD	297 (51.1)	235 (20.7)	
NRS	49 (8.4)	510 (44.8)	
Other	235 (40.5)	393 (34.5)	
The Philippines	150	467	38
MD	17 (11.3)	28 (6.0)	
NRS	119 (79.3)	349 (74.7)	
Other	14 (9.4)	90 (19.3)	
South Africa	703	541	37
MD	568 (80.8)	272 (50.3)	
NRS	6 (0.9)	166 (30.7)	
Other	129 (18.3)	103 (19.0)	
Total	1 434	2 146	117
MD	882 (61.5)	535 (24.9)	
NRS	174 (12.1)	1 025 (47.8)	
Other	378 (26.4)	586 (27.3)	

Gender Based Analysis

The documentary data and stakeholder interviews were originally analyzed thematically with a common coding scheme developed in partnership between Canadian principal investigators and the country-based teams. Using a number of gender-related keywords and a framework of directed questions, we analyzed the documentary and interview data for any explicit comments or details that related to gender. To answer the research question as to whether and how gender influenced the migration of highly skilled health personnel, we examined any differences that related to the influence of gender on individual health workers and the predominant gendering of the select professions on the migration questions that were posed in stakeholder interviews and health worker surveys; this augmented a sex disaggregation of data, particularly to gender sensitive questions.

Health worker surveys included a binary demographic question for female/male which was used to categorize responses to content questions. (We note that contemporary work on sex and gender-based analysis includes diverse sex and gender identities, orientations and expressions, but these concepts are more widely known in (Western) destination countries, informing a decision to focus on the binary identification.) In each country these questions included reasons for considering migration both in terms of work and living conditions, the consequences of geographical or regional impacts in relation to health worker shortages and or adequacy, and policy responses to endemic health worker migration. The data analysed here are largely descriptive, reporting frequencies of responses of the push and pull factors influencing male and female workers differently, as well as their views on impacts and possible policy responses. These analyses are complemented with the qualitative responses of workers from the interviews as well as those with stakeholders.

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Results

South Africa

The literature on health worker migration from South Africa reveals a number of gender trends. Hull (2010), for example, noted that the career decisions of female nurses are influenced by their personal relationships and networks, and the “opportunities or constraints” that are created by these. In short, female nurses’ choices to migrate or to migrate and return are often fraught with moral decision-making related family and community responsibilities (Brock, 2017; Dunne, 2019) (Hull, 2010). The cultural capital or status that comes with economic security through migration has also helped to improve women’s status which may not exist in her country of origin (Hull, 2010, p. 863).

Family and friends already located in the proposed destination country serve to ‘pull’ prospective migrants (Sanders & Lloyd, 2005). The growth of overseas nurse associations and other support networks has facilitated migration of nurses from South Africa (as well from several other source countries) to the UK (Singh, 2007). For example, Public Services International (PSI), a global federation of public sector trade unions, initiated a 16-country campaign in 2005 for ethical recruitment in international migration, and in the recruitment of female health workers specifically (Singh, 2007, p. 33).

Findings from the survey of South African health workers showed little in the way of difference by male and female health workers’ working conditions that influenced their decision to move to another country (Table 2). Lack of respect from government, workplace infrastructure such as facilities, equipment, and supplies, and their personal security in the workplace were considered important factors by close to 90% of all respondents. Regarding the living conditions as push factors, between 94% and 96% of male and female health workers rated the level of corruption as well as their personal safety and that of their family as important push factors. The future of their children in their home country was rated as less important, but 91.3% of men and 87.8% of women also considered their children’s future important factors when deciding to move to a different country.

Table 2
Push factors of migration of male and female health workers from South Africa

Perceived importance of...	Health workers from South Africa	
	Male n (%)*	Female n (%)**
Working conditions	636 (90.5)	474 (87.6)
Poor infrastructure	627 (89.2)	483 (89.3)
Personal security at work	618 (87.9)	470 (86.8)
Lack of respect from government		
Living conditions	673 (95.7)	512 (94.7)
Level of corruption	675 (96.0)	511 (94.5)
Lack of personal/family safety	642 (91.3)	475 (87.8)
Poor future for children		
* Percentage of all male respondents ** Percentage of all female respondents		

The stakeholder interviews emphasized gender as a factor which suffused aspects of career choice, professional development and migration. For example, one key South African informant suggested that women were preferred health workers because of their innate personal characteristics: “*Women tend to be more level-headed and cool-headed you know, as opposed to some of the men. They do bring a fair amount of stability within the department.*” (SAKI 14) In addition to

Loading [MathJax]/jax/output/CommonHTML/fonts/TeX/fontdata.js rs, the same respondent related this to migration: women were

reportedly interested in migration because of the stability that jobs elsewhere could offer them. *“So they are busy being recruited and the majority of them, you know because I think also because they want stability because most of them are mothers and most of them are females.”* (SAKI 14).

Respondents recognized an intersection between gender and choice of profession. For example, one male respondent commented on the suitability of females (sic) for certain positions as registrar doctors (doctors training to become a specialist or sub-specialist), and pointed out how women either select or are selected) into certain positions:

“(in) the surgical specialities only 1 specialist can take 3 registrars. So in terms of females it is also a bit of a problem because there are certain specialities that females don’t feel comfortable with like surgical because they have to raise children. You know males are a bit different because I can be working every day in the night so it might not be a problem. So females they battles with those kind of things, so they rather ... they prefer to do the soft things.” (SAKI 5)

Respondents confirmed the lower numbers of men who are involved in nursing, but also commented on the apparent equality of nursing as a profession:

For gender - there is equity in nursing - equal pay for equal work, no discrimination in salary because you are a woman or man; and you know nursing remains female dominated, but as a profession nursing is very strong. (SAKI 4).

Gender discrimination was understood as a generator of inequality in the workplace, and efforts reportedly being made to address it:

Basically, the Department of Health in South Africa as well as in the provinces are committed to achievement of targets in terms of employment equity act. So, gender discrimination ...we are not supporting that. We are trying by all means to ensure that now we are dealing with those discrepancies accordingly. (SAKI 12)

Despite some insight into the gender differences in the division of labour in the South African health care system, respondents did not consider that gender might influence migration intention. As one stated:

No. there is no difference about gender. Really, I have never heard that the ladies wanted to do it more than the gentlemen or the men or the women. There’s no definite difference between that. Definitely not so ... I’ve got single ladies interested in going, I’ve got family people, I’ve got single guys...there’s definitely no one group more than other. (SAKI 6)

However, another respondent disagreed: *“since nursing is populated by ladies then mostly it is females. But way back I know that even males have migrated to other countries.”* SAKI 13.

One respondent said that the countries to which people migrate depended on their acceptance of male and/or female health workers, echoing the earlier respondent’s reflections on women’s care work. For example, *“If it is the middle east females go to the middle east because the culture and the religious beliefs there accept females than males. But UK takes both...both females and males.”* (SAKI 15)

Regardless of some recognition of the issue of gender, there was no mention of how policy responses to health worker migration might need to take gender into consideration.

India

Much of the literature in India that has palpable bearing on gender and migration is associated with nursing. The rate of nurses emigrating from India is sizeable with estimates that range from 20% of all nurses (Hawkes et al., 2009) to as high as 50% who graduate from certain schools (Kruppa & Madhivanan, 2009). Johnson, Green and Maben (2014), for example, noted that nurses’ reasons for migration were a complex of several push and pull factors *“... migration as a short term option to satisfy career objectives - increased knowledge, skills and economic rewards - that could result in long-term*

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professional and social status gains 'back home' in India" (p. 734–735). Young unmarried nurses i.e. recently trained and with a little experience, were reported as most likely to leave India. Destination countries included OECD, Gulf/Middle East countries. According to OECD (2017) data, nearly 56,000 Indian-trained nurses work in the United States, United Kingdom, Canada, and Australia, which is equal to about 3 percent of the number of registered nurses in India (as cited in Walton-Roberts and Rajan, 2020).

Tables 3 and 4 describe the push and pull factors of migration of health workers from two different regions in India, Punjab and Kerala. The most important factor for both men (42.5%) and women respondents (41.6%) from Punjab was their dissatisfaction with the future for their children if they remained in India. In comparison, fewer health workers from Kerala (21.3% of men and 14.9% of women) shared the concern for the future of their children. Male health workers in Kerala were specifically dissatisfied with their current income (76.3%). Fewer female health worker respondents than men in Kerala: 42.5% were dissatisfied with income. Female health workers responded similarly in numbers to males with regards to the costs of living (49.3% female compared to 51% male). Female health workers from Punjab were concerned about their current income (37.1%) and the costs of living (31.9%), but in this region, fewer male health workers shared these concerns with 20.1% of men dissatisfied with their income and 14.9% with the costs of living. Women in Punjab were more worried about their personal safety (39.1%) compared to both male health workers in Punjab (15.7%) and to female health workers in Kerala (14.4%).

Table 3
Push factors of migration of male and female health workers from India (Punjab)

Dissatisfaction with current...	Health workers from India (Punjab)	
	Male n (%)*	Female n (%)**
Working conditions	27 (20.1)	92 (37.1)
Poor income	22 (16.4)	32 (12.9)
Poor working conditions	21 (15.7)	45 (18.1)
Poor education opportunities		
Living conditions	57 (42.5)	103 (41.6)
Future of your children in India	21 (15.7)	97 (39.1)
Personal safety		
High living costs	20 (14.9)	79 (31.9)
* Percentage of all male respondents ** Percentage of all female respondents		

Table 4

Push factors of migration of male and female health workers from India (Kerala)

Dissatisfaction with current...	Health workers from India (Kerala)	
	Male n (%)*	Female n (%)**
Working conditions	190 (76.3)	378 (42.5)
Poor income	125 (28.0)	213 (24.0)
Poor working conditions	124 (27.8)	190 (21.3)
Poor education opportunities		
Living conditions	228 (51.0)	439 (49.3)
High living costs	95 (21.3)	133 (14.9)
Future of your children in India	76 (17.0)	128 (14.4)
Personal safety		
* Percentage of all male respondents ** Percentage of all female respondents		

The findings from the stakeholder interviews largely supported findings in the literature, and provided more nuanced description with regard to the gender conditions and impacts on nurse migration from India. In the literature, social network factors appear to have played a critical role in Indian nurse migration, as diaspora family members in Western countries facilitate migration and retention of migrants. There is other evidence that migration can enhance single women's prospective marriage (Walton-Roberts, 2012; 2015b). One informant added that foreign-earned income, which is greater than what could be earned at home, could enhance the prospect of marriage for women. "*One reason for Kerala girls migrating in large numbers is that in Kerala the bridegroom has to be paid a huge dowry and these girls need to collect these funds.*"(KIKI #1).

Many interview participants described how female nurses stated their intentions to migrate *and* return to India. These intentions may have been based on the types of opportunities (including opportunities for citizenship) that are available in the countries to which they are migrating, and the unemployment and underemployment of nurses in the domestic context acting as push factors. Countries such as Saudi Arabia and other Middle-Eastern countries nearby to India promise good wages and have become major destination countries for Indian health workers, but they do not offer permanent residence or citizenship to migrants (Babar 2020). However, good wages allow putative migrants to consider temporary migration, earning enough money to remit and help to ensure financing for their own eventual return and retirement in India. The literature and our findings strongly suggested that Indian nurses' migration to the Gulf states was always intended to be temporary, and timed to effectively intersect with and enhance life cycle events such as marriage and child birth (Percot and Rajan 2007).

Female nurses' intentions to migrate and actual migration is in part explained by the construction and production of Indian nurses: female nurses in India are raised, prepared and educated in a culture that increasingly supports their migration, and it is a culture which also discourages the inclusion of men: "For nursing, female nurses are preferred. In a vacancy of 20 posts they only want 4 male nurses, basically for Psychiatry ward. Furthermore, male nurses were reported as badly treated in the Indian health context, "nobody wants them." "None of the private colleges are appointing male nurses."

The Philippines

Female health care professionals, particularly nurses, have come to dominate migration flows (Brush & Sochalski, 2007; Lorenzo et al., 2007). Therefore, gendered health workforce migration from the Philippines has typically referred to female nurse migration, with a majority (up to 75% depending on the year) of land-based migrants from the Philippines being educated women, resulting in a 'brain drain' for the Philippines (Ball, 2004). Le Espiritu (2005), for example, notes that while female nurses from the Philippines mentioned economic motives, "...many more cited desire to be liberated from gendered constraints: to see the world and experience untried ways of living" (p. 8), including a "...newfound freedom to make more independent choices about marriage" (p. 9).

In addition, there are some indications in the literature that seeing themselves as committed to sustainment and improvement of their family and community, which is reflected in their ability to send remittances plays an important role in women's decision to migrate from Philippines (Basa, Harcourt & Zaro, 2011). While this motive for migration might seem purely economic in nature, it seems to be partly rooted in cultural expectations and values related to gender roles. Indeed, Filipinas tend to be proud of being responsible for their families back home, as Filipino culture puts responsibility to care for their natal families on them (e.g., it prescribes that the eldest daughter should be providing for her parents and siblings (Basa et al., 2011)).

In response to an unprecedented global demand for nurses, the Philippines has experienced the phenomenon of trained male doctors retraining as nurses in order to obtain positions overseas (Choo, 2003). Although, these changes suggest a trend towards balancing female/male distribution in nurse training, and indeed our respondents across the Philippines reflected a dominance of nurses, male or female, a gender analysis of health worker migration in the Philippines tends to focus on women as nurse migrants. Certain incentive schemes to retain health workers in the country have been employed, some of which have been described, as 'gender sensitive considerations' (Henderson and Tulloch, 2008). In particular, it has been recognized that since women represent a large proportion of the health profession, the different needs of female health workers need to be considered and addressed when developing incentives to encourage workers to stay in the workforce (e.g. flexible and/or part-time working hours, flexible leave/vacation time, access to childcare and schools, etc.) (Henderson & Tulloch, 2008).

Table 5 outlines which push and pull factors were rated as important by the surveyed health workers (78 percent of which were nurses) from the Philippines when deciding if they want to move to another country for work. Similarly to some studies that emphasize the role of work and life related factors in migration decision of health workers (Lorenzo et al., 2007; Dimaya et al., 2012), Filipino survey respondents see these factors as being very important in such decision. Overall, men and women rated these the factors similarly. Most important was their satisfaction in their job for 72.1% of men and 74.4% of women. Half of both male and female respondents were dissatisfied with their current ability to find work in their chosen health profession in the Philippines. Regardless, few respondents considered it easy or very easy to find work in their health professional category overseas with 19.7% of men and 17.2% of women. Men seem to be slightly more dissatisfied with poor living conditions (41.1%) than women (33.9%).

Table 5
Push factors of migration of male and female health workers from the Philippines

Push and pull factors of migration	Health workers from the Philippines	
	Male n (%)*	Female n (%)**
Working Conditions	49 (72.1)	128 (74.4)
Job satisfaction		
Poor advancement opportunities	15 (22.4)	35 (20.7)
Easy to find health job overseas	13 (19.7)	29 (17.2)
Living Conditions	36 (50.0)	93 (50.8)
Lack of employment	30 (41.1)	61 (33.9)
Poor living conditions	24 (32.9)	59 (32.4)
High living costs		
* Percentage of all male respondents ** Percentage of all female respondents		

Our survey results suggest that social networks (family, friends and colleagues) may act as an important source of information for Filipino health workers who intend to migrate. While our study did not explore a gendered aspect of such networks and their impact on migration decision of Filipino health workers, some research suggests that gender-based transnational social networks shape migration opportunities for female nurses as they help them to move and integrate into labour market of the destination country (Le Espiritu, 2005)

Policy stakeholders in the Philippines suggest that there are differing views on migration as well as on the causes or drivers of the phenomenon, and these views are often related to gender. Some of the respondents regarded migration as a natural phenomenon: others saw it as a result of global trends, and others - social circumstances. As one Philippines informant stated it, "*migration is not just a program of the government to help address the unemployment problem in the country, but ...is also a global phenomenon*" (PKI 031813).

With regard to migration-related policy, one official reiterated that the goal of bilateral agreements should always be fairness and social justice to all health workers and professionals, which included an awareness of concerns related to gender:

"... There should be the principle of non-discrimination in employment terms and conditions; even in the issue of sex and gender, it should always be observed in the deployment of workers ..." (PKI 081213).

Given the active nature of Philippines labour export policies, it is interesting that stakeholders rarely spoke specifically of gender, suggesting in part that sex and gender-based analysis of social contributors to the Philippines' labour economy, and the impacts of women's and men's contributions in the informal sector have yet to be undertaken.

Stakeholders also did not reflect on culture of migration which some consider one of the main push factors for migration of health workers at macro level (Dimaya et al., 2012). Philippine government's labour export policy that has been sustained over decades, has contributed to the development of a culture that comfortably accommodates the idea of migration: Filipino workers, majority of which are nurses now view foreign labour markets as natural extensions of the domestic labour market (Engman, 2010). Clearly, the culture of migration in Philippines is gendered as women assume financial responsibility and as such are expected to migrate and provide for the family from afar, while men—or their female surrogates—stay home and take care of children (Oishi, 2002; Parreñas, 2005).

Discussion

Our empirical documentary, survey and interview data from nurses, physicians and other health workers indicates that gender mediates health workers' access and their participation in migration. Some push factors might carry more weight dependent on the potential migrants's gender and it appears to also be influenced by a country's cultural and policy contexts. Gender influences the choices to become educated as a health worker as well as the decision to migrate. Female migrant health workers seemed "preferred" for "innate" personal characteristics and cultural reasons, whereas in some contexts we saw examples of male health workers also being directed away from these roles considered only for women. Female nurse migration in particular is greatly influenced and linked to personal relationships and social networks including friends in the diaspora. Remittances by female nurses to family back home may play a large role in the decision to migrate. The fact that many health professions are dominated by women might also explain inadequate remuneration levels and the generally low social status ascribed to the work of women health personnel overall (Shannon et al 2019). It is difficult, however, to tease apart the individual level gender differences that emerged from this examination from those related to the predominant gender of the profession.

Regardless of apparent differences and implications in migration decision-making and experiences for women and men health workers, gender has rarely been considered either as an important contextual influence or analytic category in the policy responses. While hidden in plain sight, making gender visible to health worker migration and associated health and social policies is necessity. Policy makers need to receive evidence of the influence of gender on health worker migration, and can then understand that gender analysis can be important tool for health workforce planning and health system sustainability. Raising awareness of gender differences and consequences is a preliminary step, but carrying out a systematic sex and gender-based analysis of health worker migration deserves attention and integration into policy responses.

Increased international recognition and policies to implement gender analysis in health-related research sides with the arguments for explicit consideration of gendering of health workforce policies at all levels. Gender analysis is an approach that is now widely accepted and promoted by a wide range of bodies, including at the WHO (2019) and spearheaded by the Gender Equity hub of the Global Health Workforce Network. The European Union has also adopted a 'gender mainstreaming' approach that calls for "the integration of a gender equality perspective into every stage of policy process... with a view to promoting equality between women and men" with all EU policies to take into account the different situations of women and men. In Canada, gender-based analysis is written into the mandate letters of each federal minister. Our own work plans and papers in progress will focus on developing tools that can aid researchers and decision-makers in understanding and analyzing gender and how they might be applied to health worker migration (Runnels et al., 2014).

Our findings, which initially prompted us to pursue analyzing health worker migration from a gender lens, also presents a sufficient case for a review of theoretical approaches with respect to health worker migration and policy to include gender-based analysis. Assumptions about migration intentions and pathways tend to be premised on older migration theory and to a certain extent without a fulsome consideration of the influence of gender and its gendered implications. Our findings have raised a number of questions and challenges including how to encourage and assist researchers and decision-makers, particularly those for whom gender is not a typical lens employed, to think about and call attention to both what is known and what is not known about health worker migration from a gender lens.

Limitations And Future Research Directions

Although it would have been instructive to be able to compare across countries and professions controlling for gender, the slight variations in survey questions adopted by the country-based teams and insufficient sample sizes made it difficult to more fully integrate the quantitative analyses. We were not, for example, able to tease apart whether the gender differences

found in India were related to more male respondents being physicians and female respondents being nurses. Future research should attempt to advance an analysis that considers the gender of the professional, the gender of the profession, and the shifting gender dynamics of the professions, and how this may relate to the opportunities presented by international migration for example the feminisation of medicine and the masculinisation of nursing.

Conclusions

Our findings raise a number of questions and challenges including how to encourage and assist researchers and decision-makers, particularly those for whom gender is not a typical concern, to think about and call attention to both what is known and what is not known about gender in health worker migration. Policy makers need to receive evidence of the impacts of gender on skilled health worker migration, in order to understand that gender analysis is an important tool for health workforce planning and sustainability.

Abbreviations

GBA - Gender Based Analysis

KIKI - Kerala India Key Informant

ILO - International Labour Organization

PAHO - Pan American Health Organization

PKI – Philippines Key Informant

PSI - Public Services International

SAKI – South African Key Informant

Declarations

Ethics approval and consent to participate

The study was approved by the University of Ottawa (Ethics Approval Certificate numbers H07-10-02H and H07-10-02C).

Consent for Publication

Not applicable

Availability of data and materials

The participating countries' dataset(s) supporting the conclusions of this article are not publicly available to ensure respondents' anonymity in reporting and confidentiality in participating in the study as per the study's ethical requirements.

Competing Interests

The authors declare that they have no competing interests.

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Authors’ Contributions (Authorship)

ILB contributed to the conception and design of the paper; interpreted the data; and drafted and reviewed the article; VR contributed to the conception and design of the paper, analysed and interpreted the data, drafted and reviewed the article; JA, DS and MWR contributed to the conception and design of the research, analysed and interpreted the data and reviewed the article.

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