

# Hiding in Plain Sight: The Absence of Consideration of the Gendered Dimensions in 'Source' Country Perspectives of Health Worker Migration

Ivy Lynn Bourgeault (✉ [ivy.bourgeault@uottawa.ca](mailto:ivy.bourgeault@uottawa.ca))

University of Ottawa <https://orcid.org/0000-0002-5113-9243>

**Vivien Runnels**

University of Ottawa

**Jelena Atanackovic**

University of Ottawa

**Denise Spitzer**

University of Alberta School of Public Health

**Margaret Walton Roberts**

Wilfrid Laurier University

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## Research

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# Abstract

**Background:** Gender roles and relations affect both the drivers and experiences of health worker migration, yet policy responses rarely consider these gender dimensions. This lack of explicit attention from source country perspectives can lead to inadequate policy responses.

**Methods:** A Canadian-led research team with co-investigators in the Philippines, South Africa, and India examined the causes, consequences and policy responses to the international migration of health workers from these 'source' countries through documentary, interview and survey data with workers and country-based stakeholders. Here we undertake an explicit gender-based analysis highlighting the gender-related influences and implications that emerged from the published literature and policy documents from the decade 2005 to 2015; in-depth interviews with 117 stakeholders; and surveys conducted with 3,580 health workers.

**Results:** The literature on health worker migration from South Africa, India and the Philippines reveal that gender can mediate access and participation in health worker training, employment, and migration. Our analysis of survey data from nurses, physicians and other health workers in South Africa, India and the Philippines and interviews with policy stakeholders, however, reveals a curious absence of how gender might mediate health worker migration. Stakeholders in South Africa described female health workers as "preferred" for "innate" personal characteristics and cultural reasons, and in India that men are directed away from nursing roles particularly because they are considered only for women. That inadequate remuneration was identified as a key migration driver amongst survey respondents in India and the Philippines, where nurses predominated in our sample, may be linked to the impact of underlying gender-based pay inequity. The literature suggests that migration may improve social status of women nurses, but it may also expose them to deskilling, as a result of intersecting racism and sexism in their destination country. Regardless of these underlying influences in migration decision-making, 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 could offer useful insights for health and social policy responses and emphasize the importance of equity considerations to their decisions in these 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 implementation. Although there has been a visible growth in knowledge that gender roles and relations affect health workers' reasons for migrating and their migration experiences (George, 2007; Piper, 2005; Spitzer, 2016a, 2016b; Walton-Roberts 2019a; Yeoh, 2014), there is little acknowledgement that gender is an important consideration in health worker migration policies. This lack of explicit attention from source country perspectives to these important gender dimensions can lead to inadequate and potentially inappropriate policy responses.

This paper builds on growing evidence of a *feminisation of migration* (Camlin, et al, 2014) 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), increasingly women migrants are moving independently of partners or families (Kofman, 2004; Timur, 2000). Migration is thus becoming better understood as highly gendered in that it impacts men's and women's roles and experiences of migration differently (Spitzer, 2020; Spitzer and Piper, 2014; Walton-Roberts, 2019a). Although migration studies have generally become more gender analytic in nature (Donato et al, 2006; Spitzer, 2016a, 2016b), the literature however remains modest on certain issues pertaining to gender and migration policy.

The feminization of migration is particularly striking for health workers who are themselves disproportionately female, and with female nurses encompassing the dominant health worker migrant group (Brush and Sochalski, 2007; Walton-Roberts, 2015b). Indeed, women migrants are over-represented globally in health and care sectors in which care-work has typically been undervalued because of its gendered female nature (Folbre, 2012). Nurses and other female health workers are disproportionately impacted by government austerity and cutbacks to healthcare investment given their predominance in the sector (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 poorly understood.

Undertaking an explicit gender-based analysis starting with sex disaggregation of data (female versus male)<sup>i</sup> 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 (training and employment) and policy level (Bourgeault et al., 2016a). 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 of the Philippines (Castro-Palaganas et al., 2015); India (Walton-Roberts et al., 2015); and South Africa (Labonté et al., 2015), we found many indications of how gender plays an important yet unexplored role in the causes, consequences and policy responses. In this paper, we explicitly draw out the gendered dimensions of health worker migration from the three key data sources – country-based documents, health worker surveys, and interviews with key stakeholders.

### Gender and health worker migration

#### Gendering push-pull factors influencing health workers decision to migration

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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., 2016a). 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; Pan American Health Organization (PAHO), 2001; Robinson and Carey, 2000; Thompson et al., 2017; 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; Davda et al., 2018; WHO, 2006).

The push and pull factors approach to migration is intuitively appealing but it provides little distinction of their relative importance, nor analytic attention to root causes at a more structural level including the role of state and non-state intermediaries. This approach neglects the historical nature of colonial and post-colonial relations between countries influencing individual and collective decisions to migration (Hagopian et al., 2005). It also fails to fully account for the interactions of gender with factors in the broader political economy and the subsequent implications of those intersections at the household level where decision-making around migration and labour (paid and unpaid) are often carried out (Bourgeault et al., 2016a, Kingma 2006; Walton-Roberts, 2015a).

Gender is intricately implicated in the migration decision of health workers through the gender-based discrimination and inequality experienced at home and abroad, and is 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 particularly amongst occupations where women predominate, 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—a 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 are beset in a number of ways. Foremost, structural health sector reforms have a disproportionate negative effect on women health workers, who are subject to inequitably low wages and violence in the workplace, while at the same time they are often old enough to hold full responsibility for the care and support of their families (Pillinger, 2011, 2012). It is, as Susan Reverby (1987) described, a caring dilemma – being forced to care in a context that does not value that care. All these factors can converge to compel women to migrate often leaving families behind, yet bearing the responsibility for their economic livelihood through remittances.

The gendered nature of transnational social networks, which increase female health workers' awareness of migration opportunities, also have a unique 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, for instance, reveals 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 investment being remittances. Scholars are increasingly recognizing how gender intersects with various drivers of migration decisions of health workers.

### **Gendered impacts of health worker migration on source countries**

Migration can have both positive and negative 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). When confronted with situations of under- and unemployment, endemic in the female dominated health care sector, migration offers significant opportunities for health workers to apply their training in an international context (Jones et al., 2009).<sup>ii</sup> Families 'at home' can also benefit from the significant contribution that remittances make to source country household incomes.

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; Castro-Palaganas et al., 2015; Tomblin Murphy et al., 2015; Walton-Roberts et al., 2015). The emigration of healthcare workers can mean that source 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., 2005). How gender impacts these shortages is less specific: that nurses are the largest group of health professionals and that the majority of nurses are women 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., 2009; PAHO, 2001).

Migration may improve social status of some women nurses (George, 2005), but it exposes others to different degrees of deskilling, in part as a result of intersecting racism and sexism in destination countries (e.g., Pratt, 2004). Although likely to be migrating for their own economic purposes, female migrant health workers are vulnerable to certain experiences that male migrants do not experience, including increasing risks to their own health (Hennebry & Walton-Roberts, 2019). 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).

Women's decisions to migrate, particularly if viewed as self-interested, are not without criticism. Female nurses can receive gender specific condemnation from others for abandoning or neglecting family in their pursuit of financial gain (Hull, 2010). When female health workers emigrate, there are consequences for

Women's gendered care 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 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 (Eckenwiler, 2011, Jones et al. 2009). 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 carers abroad, the care deficit left to be filled by women back home to whom their care responsibilities are transferred.

### ***Gendered Nature of Source Country Emigration Policies***

Studies of labour migration have often treated source countries 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. 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 of the importance of examining gender influence explicitly. 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 their job class/profession. Emigration restrictions on women from Asian countries have included: banning of 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 is granted (Oishi, 2002; Walton-Roberts and Rajan, 2020).

Little of this literature focuses on the specific case of source country policy responses to the migration of health workers, regardless of the utilization of an explicit gender lens or not. Even international guidance for both source and destination countries from the World Health Organization (2010) in the form of its global code of practice on the international recruitment of health personnel fails to make visible sex and gender-based analyses (Bourgeault et al., 2016b; Brughha & Crowe, 2015). Invisible in particular are the perspectives in sending countries, 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.

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 with respect to whether gender is evident in policy responses.

## **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., 2015; Walton-Roberts et al., 2017). The primary focus of the larger study was on the causes, consequences and policy responses to health worker migration, from which a key emergent theme was on how gender influenced the migration of highly skilled health personnel.

Data were collected in three phases: 1) scoping reviews of the published literature and policy documents from the decade 2005 to 2015 to assess what was known/not known before we proceeded with collecting empirical data; 2) in-depth interviews with a total of 117 health worker stakeholders, senior policy officers and health care systems specialists [42 India; 38 Philippines and 37 South Africa]; and 3) on-line and household surveys conducted 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 (%)	
<b>India</b>	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)	
<b>The Philippines</b>	150	467	38
MD	17 (11.3)	28 (6.0)	
NRS	119 (79.3)	349 (74.7)	
Other	14 (9.4)	90 (19.3)	
<b>South Africa</b>	703	541	37
MD	568 (80.8)	272 (50.3)	
NRS	6 (0.9)	166 (30.7)	
Other	129 (18.3)	103 (19.0)	
<b>Total</b>	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 analysed thematically with a common coding scheme developed in partnership between Canadian principal investigators and the country-based teams. Using a subset of gender-related keywords, we analyzed the documentary and interview data for any explicit comments or details that related to gender and gender differences in behaviour or experiences, but also that spoke to gender roles and relations (Johnson et al., 2009). We examined any differences that related to the influence of gender on individual health workers through a sex-based disaggregation of the survey data, and to its influence on the questions posed to stakeholders that were sensitive to the issues of gender roles, relations and experiences.

Health worker surveys included a binary<sup>iii</sup> demographic question for female/male which was used to categorize responses to content questions.) 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 their interviews as well as those with stakeholders.

## Results

### South Africa

The literature on health worker migration from South Africa reveals a number of gender-based insights. Hull (2010), for example, found that the career decisions of female nurses are influenced by “opportunities or constraints” created through their personal relationships and networks. In short, female nurses’ choices to migrate or to migrate and return are often fraught with moral decision-making related to family and community responsibilities (Brock, 2017; Dunne, 2019; Hull, 2010). The cultural capital or status that comes with economic security from migration also helps improve women’s status outside of South Africa (Hull, 2010).

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 facilitates nurse migration from South Africa 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).

The findings from our survey of South African health workers’ views of the importance of key push and pull factors did not reveal significant differences by male and female health workers (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 push factors by close to 90% of all respondents. Ratings of living condition push factors revealed 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. 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. Caution must be exercised in comparing these findings, given the higher predominance of male physicians than nurses (male or female) in our sample.

**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 (%)**
<b>Working conditions</b>		
Poor infrastructure	636 (90.5)	474 (87.6)
Personal security at work	627 (89.2)	483 (89.3)
Lack of respect from government	618 (87.9)	470 (86.8)
<b>Living conditions</b>		
Level of corruption	673 (95.7)	512 (94.7)
Lack of personal/family safety	675 (96.0)	511 (94.5)
Poor future for children	642 (91.3)	475 (87.8)

\* Percentage of all male respondents \*\* Percentage of all female respondents

The stakeholder interviews recognized gender as an important factor which suffused aspects of career choice and professional development but how this impacted migration intentions and decisions was more complex. First, gender discrimination was generally understood by a number of stakeholders as a generator of inequality in the workplace, with 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 (the) 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)*

Nevertheless, our interviewees also recognized the gendered nature of health worker career choice. One South African stakeholder 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."* (SA KI 14) Lower numbers of men involved in nursing, was acknowledged, for example, but equality within the profession was assumed:

*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. (SA KI 4).*

In the case of physicians, one stakeholder commented on the assumed suitability of women for certain positions as registrar doctors (ie., those who train to become a specialist or sub-specialist):

*(in) the surgical specialities only one specialist can take three 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 battle with those kind of things, so they rather ... they prefer to do the soft things. (SA KI 5)*

Despite some insight into the gender differences in the division of labour in the South African health care system, the stakeholders we interviewed 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. (SA KI 6)*

However, another stakeholder offered a different opinion: *"since nursing is populated by ladies then mostly it is females. But way back I know that even males have migrated to other countries."* (SA KI 13). Another argued that women were reportedly more 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."* (SA KI 14).

Another interviewee pointed out the preference in destination countries for female health workers. 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."* (SA\_KI 15)

Regardless of some recognition of the importance of gender on migration push and pull factors, 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 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 those in the OECD and the Middle East. 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

Tables 3 and 4 outline the gender breakdown in views of the push and pull factors of migration of health workers from two different regions in India, Punjab and Kerala, which we studied. 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. 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%) but this was lower among female health worker respondents (42.5%). Female health workers responded similarly 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 (%)**
<b>Working conditions</b>		
Poor income	27 (20.1)	92 (37.1)
Poor working conditions	22 (16.4)	32 (12.9)
Poor education opportunities	21 (15.7)	45 (18.1)
<b>Living conditions</b>		
Future of your children in India Personal safety	57 (42.5)	103 (41.6)
High living costs	21 (15.7)	97 (39.1)
	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 (%)**
<b>Working conditions</b>		
Poor income	190 (76.3)	378 (42.5)
Poor working conditions	125 (28.0)	213 (24.0)
Poor education opportunities	124 (27.8)	190 (21.3)
<b>Living conditions</b>		
High living costs	228 (51.0)	439 (49.3)
Future of your children in India Personal safety	95 (21.3)	133 (14.9)
	76 (17.0)	128 (14.4)

\* 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 also 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 but also to later return to India. These intentions may be based on the 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. 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 (e.g., Percot and Rajan 2007) 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.

Female nurses' intentions to migrate and actual migration can be explained in part 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."And, "None of the private colleges are appointing male nurses.

This also reflects informants' comments that nurses in general have low status and receive little respect in relation to their work.

## The Philippines

Female health workers, and nurses in particular, 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 (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 the sustainability and improvement of their family and community, which is reflected in their ability to send remittances, plays an important role in women's decisions to migrate from the 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 express pride in being responsible for their families back home, as Filipino culture places responsibility to care for their natal families on them (e.g., culturally, it is prescribed 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, certain incentive schemes to retain health workers in the country have been employed, some of which have included 'gender sensitive considerations' (Henderson and Tulloch, 2008). It has, for example, 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. This includes flexible and/or part-time working hours, flexible leave/vacation time, and access to childcare and schools (Henderson & Tulloch, 2008).

Table 5 outlines the gender breakdown of the different push and pull factors considered by the health workers we surveyed in the Philippines, of which 78% were nurses. Similarly to some of the 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), our survey respondents see these factors as being very important in such decisions. Overall, men and women rated these factors similarly. Most important was their satisfaction with 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 (19.7% of men and 17.2% of women). Men seemed 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 (%)**
<b>Working Conditions</b>		
Job satisfaction	49 (72.1)	128 (74.4)
Poor advancement opportunities	15 (22.4)	35 (20.7)
Easy to find health job overseas	13 (19.7)	29 (17.2)
<b>Living Conditions</b>		
Lack of employment	36 (50.0)	93 (50.8)
Poor living conditions	30 (41.1)	61 (33.9)
High living costs	24 (32.9)	59 (32.4)

\* 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 the 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 of the phenomenon, and these views are often related to gender.

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 the 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.

Despite the daily departure of over 75,000 Filipino migrant workers (Spitzer & Piper, 2014), stakeholders also did not often reflect on the normalization of migration which some consider to be one of the main push factors for migration of health workers at the macro level (Dimaya et al., 2012). The Philippine government's labour export policy that has been sustained over decades, reinforced by the rhetoric that overseas Filipino workers are 'heroes' of the nation, and facilitated by a well-established state infrastructure that supports out-migration, and the complemented by the seemingly unremitting demand for care-workers across the globe, has contributed to the development of dominant discourse that comfortably accommodates the idea of migration of Filipino health workers (Rodriguez, 2010; Spitzer & Piper, 2014). The majority of which are nurses, now view foreign labour markets as natural extensions of the domestic labour market (Engman, 2010). Clearly, migration from the 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 often their female surrogates—stay home and take care of children (Oishi, 2002; Parreñas, 2005).

## Discussion

Our analysis of survey data from nurses, physicians and other health workers in South Africa, India and the Philippines and interviews with policy stakeholders reveals a curious absence of how gender might mediate health workers' access to and participation in migration. This contrasts with its noted importance in

the published literature on these three countries. Perhaps it is more difficult for individual health workers to see the influence of gender on their personal decisions, and perhaps equally so for those working at the level of policy.

This absence may also be due to the influence of gender being masked by the impact of profession. That is, although some push factors influencing health workers' decision might carry more weight depending on their gender, it also intersects with the profession and their country's policy and cultural context. 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.

For example, the fact that many health workers are women might explain inadequate remuneration levels and the generally low social status ascribed to the work of women health workers overall (Shannon et al 2019). In South Africa, where female health workers were described as "preferred" for "innate" personal characteristics and cultural reasons, and in India where males are directed away from these roles considered only for women, may be linked to the general devaluing of this work reflected in the pay inequity of nursing vis-à-vis other workers' roles such as medicine, where men have traditionally predominated. Indeed, the negative employment conditions for nurses in India are directly linked to gendered hierarchies and patriarchal norms where nursing, a feminine occupation, is deemed subservient to medicine, a masculine occupation (Walton-Roberts, 2019b). The identity of inadequate remuneration being a key driver of immigration may reflect the underlying gendered nature of the differences in remuneration levels across health workers. The fact that these issues figured more prominently in India and the Philippines, where nurses predominated in our sample, more so than in South Africa where physicians predominated our sample, reveals the importance of examining not just the gender of the worker but the predominant gender of the profession in more nuanced analyses.

Regardless of the transparency of gender differences and implications in migration decision-making and experiences for female and male health workers, gender has rarely been considered either as an important contextual influence or analytic category in policy responses. When it is, it is largely equated with the situation of women or 'inherent' feminine traits of health workers rather than a more balanced analysis that includes the influence of masculinity. Hiding in plain sight, making gender visible to health worker migration and associated health and social policies may be necessary. Raising awareness of both the surface and deep level influences of gender 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. Policy makers will need to receive evidence of the influence of gender on health worker migration, and can then understand that a gender-based analysis can be an important tool for health workforce planning and health system sustainability.

Increased international recognition and policies to implement gender-based analysis in health-related research sides with the arguments for explicit consideration of gendering of health workforce policies at all levels. Gender-based 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 Council of Europe (nd) 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, an intersectional gender-based analysis plus is written into the mandate letters of each federal minister (Status of Women Canada 2020).

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 across the whole migratory trajectory; from the household to the global context.

## 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 and what is visible and not visible about gender in health worker migration. Policy makers will need to receive evidence of the impacts of gender on skilled health worker migration, in order to understand that gender-based analysis is an important tool for health workforce planning and sustainability.

## List Of Abbreviations

GBA - Gender Based Analysis

KIKI - Kerala India Key Informant

ILO - International Labour Organization

OECD - Organization for Economic Co-operation and Development

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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.

### 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 and contributed to the text.

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## End Note

[i] We are fully aware that sex and gender are not dichotomous categories; however, they are treated as such (in this instance) in policies and documentation, etc.

[ii] As a side benefit of migration, improvements in child health and infant mortality in some developing countries have been traced to the health education that migrant women obtain in destination countries (Association of Women's Rights in Development, 2004, as cited in Jones et al., 2009).

[iii] We recognise 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 for this study.