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Lived Experience of Migrant Health Workers

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Summary

The experiences of migrant health workers and how they live their migratory journey are crucial in better understanding the drivers, consequences and overall impact of international recruitment on health systems. A two-phased review of the literature was carried out that identified 51 studies examining the lived experiences of migrant health workers (one from 2010-2017 specifically on nurses and the other from 2015-2019 on all migrant professional groups). The findings from literature review are described using Leone's (2018)[1] conceptual framework of the migration pathway, which suggests that in order to best understand the lived experiences of migrant health workers, lived experiences should be examined from two angles:

- at numerous time points along the migration journey, starting at the point a decision is made to move,
- at multiple levels to account for the of national policies and contexts, employer structures, and individual circumstances on the migration journey.

Most literature focused on nurses or doctors, examined Asian and African health professionals in Europe, and used cross-sectional designs that examined the migration journey at multiple time points (see appendix for more details of included studies). The decision to migrate was dependent on a range of 'push' and 'pull' factors located in the home and host countries, which differed in studies high- versus low-and-middle-income countries.

Examining the entire migratory trajectory provides insight into the stages of the migratory journey that have been under-accounted for in the literature (e.g. recruitment stage) as well as into the dynamics, drivers, intended and unintended consequences of migration for the health system. For example, it shed light into the drivers and consequences for employing organisations of movements and shifts between posts within and between employing organisations after arrival into a destination country.

Introduction

The WHO Global Code of Practice on the International Recruitment of Health Personnel was established to promote voluntary principles and practices for the ethical international recruitment of

1 Leone, C. EU nurse mobility to the UK: a multilevel analysis of Portuguese nurses in England. PhD dissertation, 2018.

health personnel and to facilitate the strengthening of health systems. The main aim of the WHO code was to discourage active recruitment of health personnel from developing countries facing critical shortages of health workers. After 10 years of its adoption, the 1st Meeting of the WHO Expert Advisory Group on the review of the code's relevance and effectiveness in June 2019 concluded that there is a need to capture additional evidence on lived experience of migrant health workers to continue strengthening the Code implementation and effectiveness.

The present report aims to provide a brief overview of these experiences, contextualising them at numerous time points along the migration journey. This report is organised in four sections:

1. A conceptual framework to explore and analyse the experiences of migrant health worker.
2. The findings of a rapid review on recent literature on the lived experiences of global migrant health workers conducted specifically for this report (see the appendix for more details of the search strategy and data extraction tool).
3. A case study of Portuguese nurses in England, demonstrating the continuous, interrelated and dynamic nature of the migratory experience – and draws links between the case study and the broader experiences of all migrant health workers globally described in the literature.
4. Concluding remarks and considerations for review of the implementation and effectiveness of the WHO code.

Mobility pathway framework

This framework presented in this section is based on data of a recent study on Portuguese nurses in England[2](Leone 2018). While this study specifically focused on European hospital nurses who had moved to England there is a strong rationale that this framework is applicable to all migrant health workers. The framework provides a guide to identify and collect evidence from and on structures, actors and institutions that have influence throughout the entire migrant's journey, considering how these interact with each other, potentially creating barriers and facilitators for migration and successful integration in the destination workplace. Identifying some chronological order and structure among the different experiences, facilitators, challenges and potential relationships at different levels enables the identification of targeted suggestions and recommendations for each

[2] The study is a mixed method and multilevel study on the mobility of Portuguese nurses to England. The overall aim of this study was to explore and analyse the interactions between the individual mobile nurse, the recruiting and employing organisations and the policy or macro level factors that characterise EU nurse mobility to England.

stage. In this sense, although the framework was developed from time-and-context specific data, the lens adopted can be transferable to understand the lived experiences of migrant health workers in other contexts, regardless of the policy landscape.

The five stages identified in the migratory pathway

Data from the empirical study mentioned above highlighted that migration does not occur at a single static or isolated time point, but is a process (Leone 2018). The analysis suggested that migrant workers typically go through a series of five interconnected stages that influence and mutually inform each other. The stages are: 1) the decision to move/recruit abroad; 2) the recruitment process; 3) arrival and integration in the organisation; 4) mobility within and between Trusts; and 5) the ongoing decision to continue to work in the current country of residence, migrate to another country or return home. Leone 2018[1] argued that at each stage there are number of factors and

BOX 1: AN APPROACH TO COMPREHENSIVELY EXAMINING THE MIGRATORY PATHWAY OF MIGRANT HEALTH WORKERS

1. **The decision to move/decisions or need to recruit internationally (organisations)**

The first stage of this pathway refers to the motivations, aspirations and actions (agency) that led health workers to their decision to work abroad. To comprehensively examine this stage: analysis should include reviews of individual motivations, as well as the contextual drivers and constraints that led a country/employer to recruit internationally (e.g. migration policies, national shortages, influence of social media).

2. **The recruitment process**

The second stage marks the beginning of initial formal contact between potential migrant health workers and employing and/or recruiting organisations. To comprehensively examine this stage: analysis should cover the varied recruitment routes available into the country/organisation, the presence and role of recruitment agencies as well as the job offer (including salary, benefits package, location and position offered in relation to the candidates' preferences and expectations).

3. **Arrival and integration in the employing organisation**

The third stage refers to the moment of arrival at the new organisation and the experiences of settling and integrating among other employees. To comprehensively examine this stage: analysis should include investigation of available organisational strategies used to receive and integrate migrant health workers, integration challenges and facilitators both for the workers and the organisation, as well as any relevant/outstanding efforts/experiences from any of the sides. For example, the analysis could include an analysis of the induction programmes and support offered to migrant workers among a group of different organisations to highlight variation among them to highlight any outstanding efforts or practices.

4. **Mobility within and between organisations/industries**

This stage refers to the experiences of health professionals after their arrival in the destination workplace. To comprehensively examine this stage: analysis should cover migrants' intentions to move and actual moves between employer organisations and/or industries as well as the underlying characteristics and structures that facilitate or constrain these movements.

5. **The ongoing decision to continue to work in the current country of residence, migrate to another country or return home**

The final stage of the migratory pathway considers the personal and professional costs and benefits of the move. To comprehensively examine this stage: analysis should cover how these costs relate to migrant health workers' decisions or plans to stay in the destination country, move to a third one or go back home. This stage also includes an understanding of the different retention strategies at the organisational level as well as the perceptions and overall satisfaction of recruiting organisations with migrant' health workers.

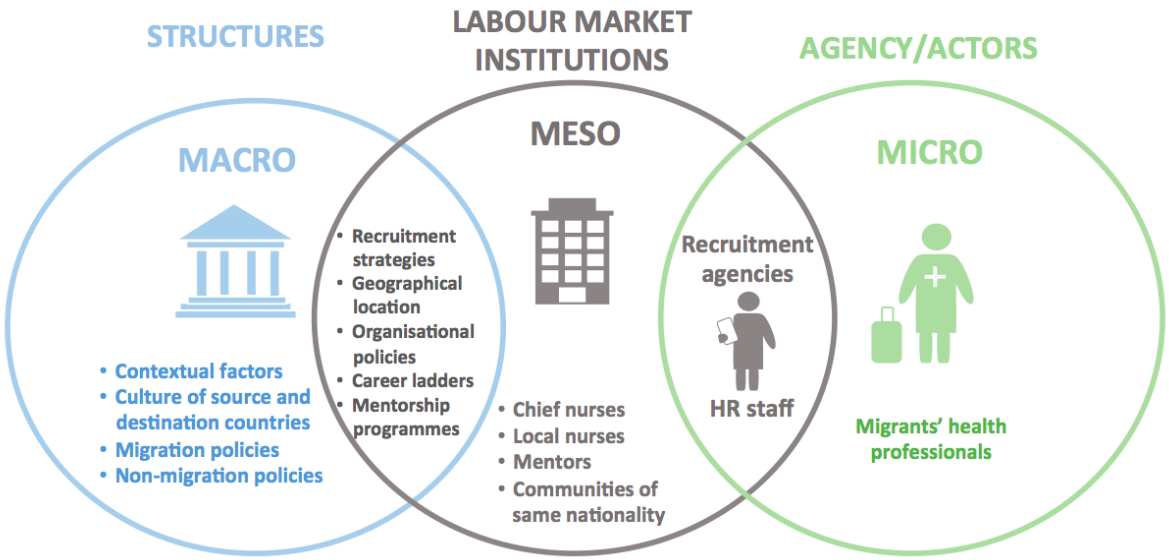
decisions that should be carefully examined when exploring the lived experiences of nurses (described in Box 1).

Source: compiled by author, adapted from Leone 2018[1].

The structures, institutions and actors involved in the migratory process

Data from the study also showed that at each of these stages, migrant health workers relate and interact with different structures (policies, institutions) and agents (actors) at different levels, affecting not only the quality and duration of their migration experience but also their future career expectations and overall identity as health professionals (i.e. what it means to be a nurse in a specific country vs. what it means to be a nurse in their home country). While factors affecting migration will vary depending on the health system, employer and health worker, Figure 1 illustrates some potentially relevant structures, institutions and actors, at the individual (micro), organisational/labour market (meso) and policy (macro) levels that influence the migratory journey. It also highlights the actors and institutions that serve as links between the different levels of analysis, such as the recruitment agencies serving as intermediaries between the individual migrants and the employing organisations or the recruitment strategies used, defined both based on the destination's country immigration policies and the employing organisations own practices.

Figure 1 – Example of key structures and actors in the mobility of health workers



Source: developed by author, based on Leone 2018[1].

Findings from rapid literature review

Characteristics of the included studies

Most studies used cross-sectional designs and focused on one or more specific point(s) in time. The most common time-points examined included the decision to leave, the arrival/integration and/or the factors associated with turnover/retention[1, 2, 3].

In the updated search conducted from 2015 to 2019 on all health professional, most of the studies focused on one professional group, the majority on nurses (n=9) and then on medical doctors (n=4). One study focused both on nurses and doctors. More often, literature on nursing covered aspects relating to their intentions and reasons to migrate as well as on activities pre-emigration, while literature on medicine focused on experiences during integration in the destination country and issues around professional recertification[4]. Only a few studies collected experiences and perspectives of participants at various levels (e.g. managers) [5, 6, 7].

The majority of the studies examined migrants leaving low/middle-income countries X country (n=9 in search conducted from 2015-2019) and entering high -income countries (n=18 in search conducted from 2015-2019). The literature highlights a gap of studies that focus on migrant health workers entering low/middle income-countries (n=1).

Stage 1: Decision to migrate

Generally, reasons to migrate, often presented in terms of 'push' and 'pull' factors, are similar among the different professions [2-4, 8-14]. Table 1 presents a list of the identified motivators to leave the home country or 'push factors' and to migrate to a specific destination or 'pull factors'.

Table 1 - Motivation to leave the home country and migrate to a specific destination

Motivations to leave home country (Push factors)	**Professional** • Lack of professional opportunities • Lack of professional ethos • Systemic deficiencies in care provision • Lack of medical resources • Poor working conditions, no job satisfaction • Low remuneration • Feeling under-valued • Difficulties reintegrating into home country's health system (for those who had returned) **Personal** • Poor quality of life for their family • Low educational opportunities for their children
Motivations to migrate to a destination country (Pull factors)	**Professional** • Better working conditions • Clear career pathway • Societal respect for profession • Highly-skilled practice environment • Perception that health professionals are in demand, facilitating immigration process

	Personal • Novel experience, adventure • Positive views of country's society and governance
Prompting/challenging the decision to leave – activating factors and barriers	**Facilitating factors** • Familiarity/fluency in country's language • Personal connections • Country's proximity to home • Presence of recruitment agencies and positive advertisements of working conditions **Barriers** • Achieving language standards at level required • Time-limited validity of language tests results, such as IELTS

Source: compiled by the author

The reasons health workers migrated were often found either embedded in other sets of findings (e.g. who migrates, where they migrate, and strategies for retention) or as part of a wider discussion on migration. However, among the identified literature, none of them explored whether their expectations of migration were later fulfilled or changed over time.

Health workers' motivations to migrate appear to vary between those from low/middle-income country compared to high-income countries. For example, economic factors, such as the possibility of sending remittances to their families back home, as well as political stability, safety, corruption and discrimination, are more closely associated with professionals from low/middle-income countries[8, 12,15-18]. Professional motivations to migrate (e.g. desires for professional advancement, societal respect and recognition, better working conditions) and personal motivations to migrate (e.g. divorce, marriage, spouse, friends working abroad or job offer abroad, desire for adventure), were more commonly observed among professionals from higher income countries.

The motivations of the migrant health worker also appeared to differ depending on the level of development in those studies focused exclusively on Europe In particular, motivations associated with nurses from low/middle-income countries in the general literature were observed among nurses from 'new' EU Member States[3] or Central and Eastern European countries, while motivations associated with high-income countries were observed among nurses from the wealthier and 'old' EU15 countries[10, 13, 19-22].

Overall, the available literature shows that factors motivating individuals to migrate vary, emphasising the complex interplay of internal, external, push and pull factors shaping the decision

[3] Members of the European Union after 2004 and 2007 enlargements. 2004: Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia, Slovenia). 2007: Romania and Bulgaria

process[2, 8, 12, 14 19, 22]. Although the reasons for migrating appear relatively similar for different professional groups, the literature suggests differences depending on the health worker's country of origin.

Stage 2: The recruitment process

There is a sizeable literature addressing the ethics of international recruitment of health professional[4]. Covell and colleagues (2016)[4] review of the literature raised that the primary concern of these literature are issues around both the conditions of employment and the recruitment from countries with health worker shortages while still recognising the health professionals' right to migrate[4]. However, the present search found that available evidence of experiences during the actual recruitment process is limited.

Experiences during recruitment varied greatly across studies, although the studies have tended to describe experiences during this stage in quite general terms. In the specific case of nurses, for example, the available information principally highlighted that the recruitment process is perceived as lengthy, complicated and costly[8, 23-25] but that the overall experiences depend greatly on the type of recruitment – i.e. active or passive.

'Agency or active recruitment' refers to nurses being recruited as part of a cohort through recruitment agencies. 'Passive or individual recruitment' refers to the self-directed process of individual migrants finding employment in the destination country on their own initiative. In the case of agency recruitment, some studies reported facilitated processes, as nurses had accommodation and travel organised by these recruitment agencies[11, 21, 26]. Other studies also reported how recruitment agencies differ in the degree to which they fulfil their contractual obligations[9], and also how this type of recruitment could imply a higher probability of being placed in lower grade vacancies[22] as well as of being 'manipulated and cheated'[9]. A study on pharmacists found that there was a general feeling among some European Economic Area pharmacists that recruitment agencies treated them unfairly and differently to local pharmacists, by placing them in busy braches with high number of managerial gaps and minimal support staff[18]. In the case of individual recruitment, literature suggests that this provided a greater sense of control of the entire process for some nurses, while for others it represented a lonelier and less supported experience. One study[9] reported nurses having experienced a poor reception or lack of support from their employers and another[27] found that nurses experienced difficulties regarding the lack of familiarity with recruitment process requirements (e.g. how to fill in an application form).

The review also found no data on the relationships between individuals and recruitment agencies or even between these agencies and the employing organisations. There were also no accessible data about the types of job offers or negotiations that take place, including the power or influence that each of the involved parties have during this process. Other than a brief description of some of the formal elements of recruitment for nurses[26] and the general perception of care workers that agency fees were poor value for money given the quality[27], the overall transactional aspects of international recruitment remain largely undocumented.

Although data about experiences during the recruitment processes were scarce, there is an overall understanding in the literature that health professionals who wish to migrate face a significant range of potential emotional and practical challenges. These include the costs of transfer and the need to learn a new language. The literature suggests that this may be true for professionals from all nationalities, all professional groups and migrating to all countries.

Stage 3: arrival and integration into the destination workplace/organisation

The experiences of migrant health workers arriving and integrating into a new workplace were described to have both positive and negative aspects[25, 29-30]. Some articles reported mostly positive lived experiences of migrant health workers (i.e. positive reception in organisation, feelings of achievement) [7, 31-32], while others identified experiences of discrimination, exploitation and unfair treatment, which in some cases extended to experiences with patients [5, 33-40]. Among the most common episodes of discrimination were nurses being asked by their superiors to cover unpopular shifts, work longer hours or look after the most challenging and difficult cases [8-9, 14-15, 16, 19, 24, 33, 35].

Other studies reported that the type of experiences depend on the country of origin of the migrant health worker. For example, one study[41] found that Indian and Pakistani nurses felt that they received more support than any of their international counterparts in the sample, while African nurses perceived more discrimination than their counterparts in their working environment.

Table 2 shows the most common barriers and facilitators for integration into the destination organisation observed in the case of nurses.

Table 2 - Barriers and facilitators in the destination workplace

Barriers to integration	Facilitators for integration
• Communication and language, including lack of fluency or understanding of the national language, problems with slang, the use of abbreviations and even hospital language. • Perceived cultural, social and professional differences (i.e. uncertainties regarding how to interact with colleagues, better informed and more active patients). • Feeling overqualified for assigned tasks and responsibilities (e.g. nurses not being able to practice some skills such as cannulation and venepuncture, not having their previous experience recognised)	• Supportive environments (e.g. colleagues, supervisors) • Good mentorship • Sense of achievement (e.g. gaining language proficiency and strong communication skills to ensure cultivation of friendship) • Greater opportunities for further education • Being able to spend more time with patients, due to lower workloads than in the home country

Source: compiled by author, adapted from Leone 2018

Beyond the identified facilitators and barriers, personal and professional relationships were reported as a determinant of the quality and overall satisfaction of all migrant health workers' experiences in their destination country[18, 25, 29-30,36, 39]. Relationships can convey support, acceptance and respect but can also foster prejudice, isolation and self-doubt[15]. In the personal sphere, feeling the loss of community and family support can exacerbate all the perceived personal costs related to migration (e.g. learning how to deal with everyday life in a new environment), in addition to homesickness [8, 14, 20, 39, 42].

In the professional environment, relationships with mentors and supervisors can strongly influence success in integration and progress as well as overall satisfaction in the new country [9,15, 24, 42,]. The importance of these professional relationships stems from the fact that is with these colleagues that migrants spend most of their initial period, which will involve learning how to navigate the overall dynamics of the organisation and making their individual development plans. Good relationships between migrant health professionals and their colleagues may have an impact on the quality of care they provide, and on their intention to stay[14].

Stage 4 and 5: internal mobility and continuation of mobility or returning home

The most common reasons cited for wanting to return home were family ties and missing home[43]. Conversely, those migrant health workers considering their job as meaningful[44], having control of work pace and with empowering leadership were more likely to have intentions to stay in their current country[45]. Overall, less satisfaction with their experience in the destination country was

associated with more likelihood to wanting to return home or migrate to a third country[46]. No particular differences were observed between professional groups.

Within the identified literature on lived experiences, there was no available data on what happens with these migrant health workers after a couple of years. “Further, only one study sought to specifically understand the experiences throughout the various stages of the migration[27]

A case study of Portuguese nurses in England

For the purpose of this report, this section highlights some of the main findings of the empirical study on Portuguese nurses in England that demonstrate the continuous, interrelated and changing nature of EU nurses’ migratory pathway and experience.

This study has a mixed method sequential multilevel design, considering the policy, organisational and individual levels for analysis. The quantitative phase consisted in a retrospective secondary analysis of data from the Portuguese branch of the FP7 funded EU RN4CAST study. Descriptive statistics, multilevel logistic regression and moderation effect analysis were undertaken. In the qualitative phase, 27 semi-structures interviews were conducted at the individual, organisational and policy levels, analysed through thematic analysis using the framework approach.

For clarification purposes, all data and analysis presented in this section focuses on Portuguese nurses in England. Additionally, it is worth noting that the term ‘mobility’ was used in the present study to refer to movements between and within organisation in the same country. The term ‘migration’ defined movements of professionals between countries.

The underlying motivations of nurses to migrate are consistent throughout their migratory journey

Data collected from Portuguese nurses in England, their employing organisations in the English NHS and several policy makers in Portugal, England and at the EU level suggest the migration experience is accomplished through a series of interconnected stages that influence and mutually inform each other. For example, data from EU nurses indicated that the main factors that led the nurses in the sample to move abroad continued to be present throughout their stay in the destination country. The main reason for Portuguese nurses seeking employment abroad was dissatisfaction with opportunities for career advancement in their home country. At the time of interview, professional achievements made these nurses evaluate their overall mobility experience as positive, even overcoming personal challenges such as homesickness or feelings of guilt and/or remorse for having taken the ‘selfish’ decision of leaving. Moreover, professional satisfaction, in the form of career growth, further training and experiences in preferred specialties, was also a key reason for these

nurses continuing to stay in the UK and in the same employing organisation. These findings are well aligned with the literature, which notes that career growth not only increases nurses' job satisfaction but also enhances their sense of commitment and loyalty toward their employer[47].

In a similar way, migrants continued to consider whether to continue working in England or return home remained throughout the entire mobility experience. Data showed that a particular event might trigger a decision to leave (e.g. a personal issue involving family in the home country), but generally the decision about whether to stay or return home was part of a continuous and ongoing assessment of the individual's entire migratory trajectory. Findings from the study suggest that the investment and effort involved in nurses leaving their family and home behind need to produce a return. As long as the balance of factors for or against staying is positive (i.e. their career expectations are met and they perceive opportunities for career advancement), remaining in a particular country continues to be worthwhile. Given the dynamic and iterative nature of these individuals' decisions, findings of the study suggest that organisations also needed to continuously satisfy these nurses with adequate working conditions, support and opportunities for career development in order to retain them. This implies a consistent and continuous effort by organisations so that they too receive a return on their investment[20, 48-49, 51]. Otherwise, as some organisations have reported, they become caught in a vicious cycle of constant recruitment and turnover, together with the added challenges and pressures that this brings to the rest of their staff (e.g. burnout, frustration and heavier workloads).

Not one migratory movement but multi-mobilities

The literature concerning migration tends to focus on the initial or subsequent factors that drive health professionals to move from one country to another. Empirical data on Portuguese nurses in England showed that migration can neither be seen as a single or 'one-off' movement that ends at the time of arrival nor as simply movements between countries. Findings from the study demonstrated that there are multiple 'mobilities' between, as well as within, organisations in the NHS (both in England and in other UK nations), which need to be accounted for when planning and devising recruitment and retention strategies.

The major driver for this internal mobility pattern identified was the level of vacancies across the entire health system and the variability between employers in retention strategies and career progression structures for, and overall attitudes toward, foreign nurses and all nurses in general. For example, Table 3 illustrates the variability observed among the retention practices in place to retain their nurses among the included employing organisations in the sample.

Table 3 - Identified retention strategies

Retention strategies mentioned	ORG1	ORG2	ORG3	ORG4	ORG5
Preceptorships	X	X	X	X	X
Career development pathways	X	X	X	X	X
Informal conversation/negotiation about ITL	X	X	X	X	X
Career clinics		X			
Focus on staff experience		X	X	X	X
Lobbying for reduction in travel costs		X			
Clinical psychologist for staff				X	
Link nurses to communities of same nationality		X		X	X
Networking and social events				X	X
Portuguese nurses as clinical facilitators					X

Source: Leone (2018)
Note: There were five organisations included in the sample. Each column represents the answers of a different organisation when asked to name and describe the strategies in place to retain their nurses.

This mobility within the NHS was observed once nurses had gained some UK experience and knowledge about how the NHS operates. However, according to data from the empirical study, the intention to move internally has a background history, beginning during recruitment, as nurses became aware of the alternative opportunities through personal networks or even through recruitment agencies.

The role that recruitment agencies have in advertising posts and in enhancing internal mobility was made clear through the interviews. According to the agencies in the sample, at the beginning of the recruitment process they would inform candidates about the possibilities of moving between specialties and hospitals if they were not satisfied after a few months. This was considered to be part of the strategy to persuade candidates to accept initial offers of employment, especially if these were not the nurses' first choice. This practice might also be associated with the tendency for RAs to respond to organisations' need to fill vacancies, and thus to find placements in areas or specialties with shortages, rather than in accordance with nurses' own preferences.

In a context of extended staff shortages and increasing competition between employers and destination countries for available nursing resources, internal mobility was an added advantage of working in the UK for these nurses. It provided them with the opportunity not only to choose where and in which specialty to work but also to move to higher pay levels and apply for promotion. What the empirical study on Portuguese nurses in England observed was that the more experienced nurses were, the better their position to negotiate the location and terms of employment.

Importance of the recruitment experience

Findings are consistent with those of other studies that individual recruitment experiences depend greatly on the type of recruitment route[2, 11-26]. Nurses who migrate through a recruitment agency have a more facilitated initial recruitment experience, due to the assistance provided with

paperwork and benefits such as accommodation and flights. This study adds that agency/active recruitment also gave these nurses easy access to the employers' human resources departments, as this contact was initiated during the interview and negotiation process. Similarly, organised cohort flights, and coordinated arrivals at the same organisation, provided nurses with opportunities to develop friendships and bond with other Portuguese nurses. This was crucial for successful nurses' adaptation and overall integration in the organisation, reducing the amount of time and resources that organisations later needed to devote to the induction, integration and retention of the nurses.

How, how is involved and what was negotiated during the recruitment process also had important repercussions, both for organisations and nurses, in the subsequent migratory pathway, including where and in which bands the nurses were initially recruited and deployed. The literature points out that, when recruited through an agency directly from their home country, most nurses were located in the lower bands of nursing [26,52]. In the current study, and as opposed to what was observed during internal movements within the NHS, this was found to be the case regardless of their level of experience. Individual accounts showed that job offers negotiated through recruitment agencies in the destination country are also mainly for regional or rural hospitals. Both situations (band 5 positions [the lowest/entry level for a registered nurse in the NHS] and regional/rural hospitals) were usually where vacancy rates were reported by participants to be higher. An analysis of data from individual nurses and employing organisations revealed that recruitment practices driven only by nursing shortages, but neglecting nurses' preferences (i.e. of specialty, location of organisations) or years of experience, triggered many nurses to move internally after a couple of months, often to more technical areas of practice and to reference hospitals in the capital, London. This trend added pressure to employing organisations' ability to retain staff, often leading them into a vicious cycle of constant recruitment and turnover.

The employer-employee relationship: interactions between migrant health workers and actors in the employing organisation

Another significant point in the analysis concerns the role of the recruiting organisations' existing staff in the overall integration and migratory experience of foreign nurses. The most common organisational practices involved in receiving and integrating foreign nurses included supervised practice, induction and mentorship programmes. However, as two studies point out [33, 52], the mere existence of these practices is not sufficient. The success of mentorship and integration of nurses in the new work environment is also related to the willingness and motivation of mentors, and their capacity and availability to dedicate sufficient time to these nurses[9,24, 33]. Empirical data from the study adds that when these nurses are not given the appropriate mentorship but are instead used as

'an extra pair of hands', this often leads to additional allocation of resources and added workloads to the rest of the staff to ensure that these nurses are ready to work independently.

The study also found that overall opportunities for career advancement, further training, professional fulfilment and overall integration were also dependent on chief nurses, 'leads of education' nurses and even managers. Members of staff have the organisational resources and information to either block or encourage nurses' access to such resources and information, thereby affecting the nurses' integration and further development (quotes in Box 2 provides an example, illustrating the role of different actors at the organisational level and relevance of their interactions with migrant nurses). The study observed that there is a tendency to ascribe the responsibility of integration to either the foreign nurses themselves or to the institution as a whole, while often overlooking the role and responsibility of local nurses, and other members of staff in more senior positions, in facilitating the process.

Box 2: Positive and negative experiences between migrant nurses and other members (superiors) in the workplace

Negative experiences

A Nurse described her first weeks as follows: *'It was horrible, horrible (...) I tell you, if I had known what I know today, I would have made a complaint (...) every day I went home, at the end of the week, I cried drool and snot (...) I had to create strategies to deal with the senior nurse who at that time made my life miserable, she told me she was going to make a complaint to the NMC'* [nurse]. She also shared the story of how, when she wanted to continue her studies and apply for a Masters degree, the lead nurse for education at the time mentioned that she had to do her training all over again as her Portuguese diploma was not going to be accepted in any UK university. She felt purposely misinformed and discouraged.

Positive experiences

A nurse shared how when she was still a band 5 [the lowest/entry level for a registered nurse in the NHS] nurse, a clinical nurse specialist began to notice her skills and competencies, encouraging her to participate in research. She mentioned that her support provided her with the confidence to persist as well as a direction for progress '*(...) she always encouraged me... I think it made a difference when she told me '[interviewee's name] you are the next me.' That person encouraged me... I want to be like her... there is where I want to go'* [nurse].

Most nurses included in the study can be characterised as nurses who felt that the only way to progress professionally was to leave their country. The combination of blocked career advancement and financial motives was strong in many cases, particularly for young and newly qualified nurses with no responsibilities in their home country. In terms of professional disadvantages, the only obvious professional disadvantage of being a nurse in the UK, about which all respondents agreed, was the public image and esteem in which the profession is held. Participants considered that nursing in the UK was not as socially valued a profession as it is in Portugal, even despite the less

favourable working conditions they refer to in their home country. However, all nurses included in the study emphasised the value of family and the inherent characteristics of Portuguese nationals as social individuals who appreciated the close contact with their loved ones. All these nurses referred to difficulties in being away from family, emphasising their feelings of remorse and even guilt for having left.

Overall, up to the point of the interviews[4], professional gains seemed to compensate for personal costs, largely due to the benefits of working in a more 'horizontal' environment and the career opportunities gained. However, there appeared to be a trade-off between the professional and personal side of migration, which was evident in the comparison between the most important factors that pushed these nurses to come to the UK (professional concerns) and those that most commonly would lead them to return (personal concerns).

Conclusions

This report seeks to offer some insights into the lived experiences of migrant health workers and provide recommendations for analysing lived experiences of migrant health workers. The findings are based on a review of existing literature. Key considerations are also highlighted by focusing, in particular, on Portuguese nurses in England. Although some of the data on Portuguese nurses should be interpreted with caution, many of the findings are likely to serve as lessons to better understand migratory experiences of other health professionals and from other nationalities.

The work presented mainly suggests that migration is accomplished through constant interaction and adjustment between structures, institutions and agents at the (policy) macro, (organisational) meso and individual (micro) levels, revealing the value in integrating different perspectives and experiences for a better understanding of the phenomenon. It argues that migrant experiences need to be contextualised in the policy context of the source and destination country, the social and organisational pressures that encourage health professionals to migrate and lead organisations to recruit internationally and the attitudes and experiences of the staff in the organisations that hire and deploy them.

The report also provides insight into some of the recruitment stages that are under-accounted for in the literature. Mainly, it shows the transactional aspects involved in the negotiation of the job offer, salary and overall benefit package during the recruitment process, emphasising how these aspects

[4] Interviews at the micro level (to migrant nurses) were conducted from November 2016 to March 2016 (before the UK referendum on leaving the EU in June 2016).

have the capacity to determine subsequent experiences and choices. This finding suggests that providing information to migrant health workers about the geographical area, position, wards and organisational culture before arrival might avoid mismatches of expectations, which may lead to frustration, demotivation and even turnover. Similarly, findings suggest that the placement in destination organisation should make an effort respond to migrant's preferred specialty and location, not only to their competencies and experiences. Considering migrants' preferences and profile might help to increases the chances of finding the right professional, with the appropriate skills and values for the post and the organisation, while increasing the chances of more effective retention.

Finally, the data presented in this report highlighted how organisational settings, conditions and, most importantly, organisational agents' attitudes and level of support influence nurses' level of commitment to their employer and their overall migratory experience. It particularly noted the impact that role and influence of actors in leading positions can have on the well-being and overall retention of these professionals. Overall, the report emphasises that the relationships that are formed in the workplace can either encourage these professionals' desire to leave the employing organisation and even health service altogether or create strong loyalty bonds and raise retention rates. Making sure that these professionals have the necessary assistance, time and support to perform their tasks ultimately avoids the employing organisation to be immersed in a constant cycle of recruitment and turnover.

In sum, this report aimed to show that there is value in understanding the implications and pressures surrounding the recruitment and retention of migrant health workers from different perspectives and throughout the entire migratory trajectory. Acknowledging the multilevel and complex nature of migration - without undermining the individual voices at each of the different levels - may help identify targeted suggestions and recommendations for each stage of the migratory pathway. Furthermore, it may also to provide valuable insight into how best to capitalise upon these migrant's contribution and experience, ultimately helping to address the sustainability of health systems. All these aspects may assist in the review of the WHO Code's implementation and effectiveness.

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Appendices

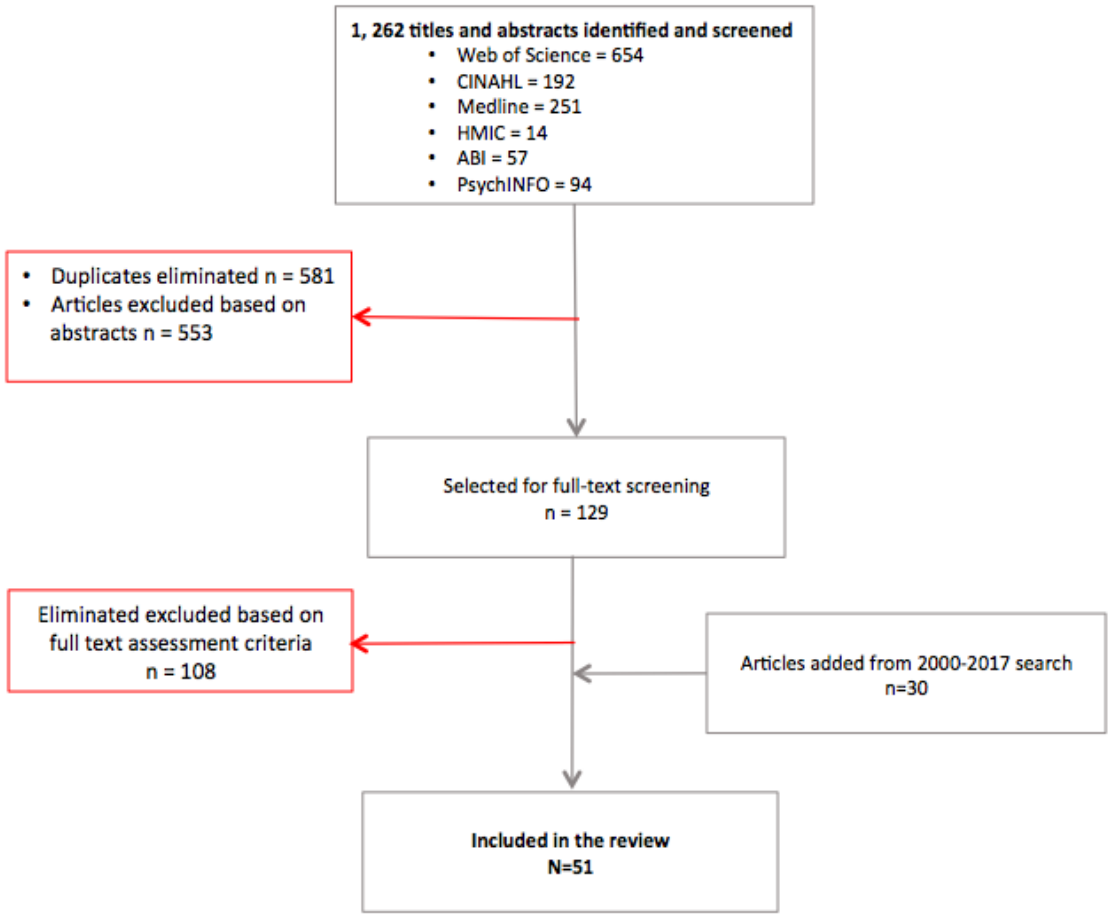
Methods of the literature review

For the purpose of this report, the rapid literature review included two approaches to data collection:

- Systematic database searches (assisted by the Birmingham Library) for international English-language studies published between 2015 and 2019 on all migrant health workers; and
- Hand searching of relevant English-language literature (between 2000 and 2017) originally systematically reviewed by Leone (2018), which focused on European migrant nurses.

In total 51 articles were included. The study selection process is shown, the search terms, inclusion/exclusion criteria and details of the included studies are presented below. Leone's (2018) mobility framework is used to describe the literature.

Study selection procedure



Inclusion and exclusion criteria

	Included	Excluded (papers exclusively about)
Topic relevance	✓ Focused on **lived experiences** of migrant health workers in destination countries	× Experiences of health professional on migrant populations, patients × Experiences of international health students × Intentions, reasons or determinants of intentions to migrate from home country among health workers
Methodology	✓ **Qualitative, quantitative or mixed methods** (including surveys, ethnographic studies and phonological studies) ✓ **Systematic literature reviews**	× **Personal reflections** (i.e. not explicitly linked to research)
Date	✓ **Published 2015 or later** (irrespective of whether it is based on pre-2015 data)	× **Pre-2015 publication date**
Language	✓ **English** ✓ **Portuguese** ✓ **Spanish**	× **Not in English, Portuguese or Spanish**

Search terms (used in the 2015-2019 search)

CINAHL	(migrant or immigrant or emigrant or transient or overseas or foreign) AND (worker or staff or personnel or work or workforce) AND health
Web of Science	(lived experience) AND (migrant or immigrant or emigrant or transient or overseas or foreign) AND (health work or healthcare work or health professional or healthcare professional or health personnel or healthcare personnel or health staff or healthcare staff) AND (recruitment or placement)
Medline	(migrant or immigrant or emigrant or transient or overseas or foreign) AND (health work or healthcare work or health professional or healthcare professional or health personnel or healthcare personnel or health staff or healthcare staff) AND (recruit$ or place$ or experience$ or attitude$ or participat$ or involve$ or reality or understand$) or “lived experience” or “life experience”

	2015-2019
HMIC	(migrant or immigrant or emigrant or transient or overseas or foreign) AND (health work or healthcare work or health professional or healthcare professional or health personnel or healthcare personnel or health staff or healthcare staff) AND (recruit$ or place$ or experience$ or attitude$ or participat$ or involve$ or reality or understand$) or “lived experience” or “life experience” 2015-2019
ABI	(migrant or immigrant or emigrant or transient or overseas or foreign) AND (health work or healthcare work or health professional or healthcare professional or health personnel or healthcare personnel or health staff or healthcare staff) AND (recruitment or placement or lived experience)
PyschInfo	(migrant or immigrant or emigrant or transient or overseas or foreign) AND (health work or healthcare work or health professional or healthcare professional or health personnel or healthcare personnel or health staff or healthcare staff) AND (recruit$ or place$ or experience$ or attitude$ or participat$ or involve$ or reality or understand$) or “lived experience” or “life experience” 2015-2019

Details of the studies included in the two-stage literature review

Record reference	Stage of the literature review	Design	Population/ sample and professional group	Destination country	Nationality of Professional Group (country of training*)
Alexis O. (2015)	2015-2019 search	Quantitative: Survey	188 Nurses in 15 NHS Trusts	England	Various, global (no EU)
Al-Hamdan ZM, Al-Nawafleh AH, Bawadi HA, James V, Matiti M, Hagerty BM. (2015)	2015-2019 search	Qualitative: 13 face to face interviews and 12 telephone interviews	25 nurses	UK	Jordania
Balasubramanian M, Brennan DS, Spencer AJ, Short SD. (2015	2015-2019 search	Qualitative: Interviews	49 dental graduates	Australia	Various, mostly from Asia and Africa.
Bobek A & Devitt C. (2017)	2015-2019 search	Qualitative	30 health professionals (foreign- and Irish-born) and with hospital managers (Irish-born).	Ireland	Various
Brugha R, McAleese S, Dicker P, Tyrrell E, Thomas S, Normand C, et al. (2016)	2015-2019 search	Quantitative: Online survey	366 non-European nationals registered as medical doctors in Ireland	Ireland	Various, global
Christensen K & Manthorpe J. (2016)	2015-2019 search	Qualitative: Interviews	31 care workers	England	Various, global
Covell CL, Neiterman E, Bourgeault IL. (2016)	2015-2019 search	Literature review	407 articles on internationally educated health professionals	Canada	Various
de Vries DH, Steinmetz S, Tijdens KG. (2016)	2015-2019 search	Quantitative: Online survey	Various 44,394	Various	Various
Efendi F, Chen C-M, Nursalam N, Indarwati R, Ulfiana E. (2016)	2015-2019 search	Qualitative: Interviews	5 nurses	Japan	Indonesia
Eneroth M, Senden MG, Gustafsson KS, Wall M, Fridner A. (2017)	2015-2019 search	Quantitative: Survey	208 Native-born and 73 foreign-born GPs	Sweden	Not specified
Gao F, Tilse C, Wilson J, Tuckett A, Newcombe P. (2015)	2015-2019 search	Qualitative: Interviews	16 (10 nursing assistants and 6 nurses)	Australia	Various (not specified), including China
Goel K, Penman J. (2015)	2015-2019 search	Qualitative: Focus groups	7 workers (5 personal carers, 1 home support worker and 1 allied health assistant)	South Australia	Philippines, India and Nigeria
Jirovsky E, Hoffmann K, Maier M, Kutalek R. (2015)	2015-2019 search	Qualitative	10 Medical doctors, nurses and midwives	Austria	Sub-Saharan Africa
Klingler C & Marckmann G. (2016)	2015-2019 search	Qualitative: Interviews	20 Medical doctors	Germany	Romania, Poland, Russian Fed., Greece, Libya, Iran, Syria
Likupe G. (2015)	2015-2019 search	Qualitative: Interviews	30 Nurses	UK	Africa
Lovelock K &Martin G. (2016)	2015-2019 search	Qualitative: Interviews	29 Care workers in the elder care sector	New Zealand	Philippines

Motala MI, & Van Wyk JM. (2019)	2015-2019 search	Literature review	20 articles (on Foreign medical graduates, international medical graduates and overseas trained graduates)	Developing or middle income countries like South Africa	Various
Rumsey M, Thiessen J, Buchan J, Daly J. (2016)	2015-2019 search	Qualitative: Interviews	14 health industry participants and 35 migrated health professionals	Australia	Various
Schilgen B, Nienhaus A, Handtke O, Schulz H, Mosko M. (2017)	2015-2019 search	Literature review	14 articles (on nurses)	Various	Various
Vesperoni P, & Masera G. (2015)	2015-2019 search	Qualitative: Interviews	12 Nurses	Italy	Morocco, Ruanda, Spain, Lithuania, Poland, Romania, Paraguay, Venezuela
Ziaei Z, Hassell K, Schafheutle EI. (2015)	2015-2019 search	Qualitative: Interviews	25 Pharmacists	UK	European Economic Area(EEA) and non-EEA
Allan H. & Larsen J.A. (2003)	2000 – 2017 search	Mixed method: focus groups and questionnaires	67 nurses in 11 focus groups	UK	Global (EU: Germany, Finland, Ukraine, Sweden)
Brewer C.S. & Kovner C.T. (2014)	2000 – 2017 search	Discussion paper	NM/NA	Global	Global
Buchan J. , Wismar W., Glinos I.A., Bremner J. (2014)	2000 – 2017 search	Mixed method: interviews, focus groups, questionnaires, etc.	NA	EU	EU
Buchan J., Jobanputra R., Gough P. (2004)	2000 – 2017 search	Mixed method: desk research, interviews and analysis of NMC data	NA	UK (London)	Global (Spain is included)
Cowan D.T., Wilson-Barnett J., Norman I.J. (2007)	2000 – 2017 search	Quantitative: questionnaires	79 nurses	UK, Greece, Spain, Germany and Belgium	UK, Greece, Spain, Germany and Belgium
Cummins T. (2009)	2000 – 2017 search	Quantitative: questionnaires with open ended questions	113 nurses	Ireland	NS
de Veer A. (2004)	2000 – 2017 search	Quantitative: questionnaires	987 nurses	The Netherlands	EU
Dywili S., Bonner A., O'Brien L. (2013)	2000 – 2017 search	Literature review	17 articles	Global	Global
Freeman M. & Baumann A. Blythe J., Fisher A. & Akhtar-Danesh N. (2012)	2000 – 2017 search	Literature review	80 documents	Global	Global
Hardill I. & MacDonald S. (2000)	2000 – 2017 search	Qualitative: interviews and observation	16 nurses	UK	Finland, Germany and other non-EU/EEA
Hongyan L., Junxin L., Wenbo N. (2014)	2000 – 2017 search	Literature review	NA	Global	Global
Kingma M. (2006)	2000 – 2017 search	Qualitative: interviews	NA	Global	Global
Magnusdottir H. (2005)	2000 – 2017 search	Qualitative: interviews	11 nurses	Iceland	7 nurses western and 4 non-western

Maier C.B., Glinos I.A., Wismar W., Bremner J., Dussault G., Figueras J. *In Wismar *et al*. (2011)	2000 – 2017 search	Mixed method: interviews and analysis of secondary data	NA	EU (17 countries)	EU (17 countries)
Newton S., Pillay J., Higginbottom G. (2012)	2000 – 2017 search	Literature review	21 articles	Global	Global
O'Brien T. (2007)	2000 – 2017 search	Qualitative: interviews	40 nurses; 8 managers; 15 HN (managers, OSN, home nurses (HN) and mentors)	UK	Philippines, India and Spain (NM how many)
O'Brien T. & Ackroyd S. (2012)	2000 – 2017 search	Qualitative: observation, semi-structured interviews, informal contacts and conversations.	63 nurses; 8 managers	UK	Philippines, India and Spain (NS how many)
Ognyanova D., Young R., Maier C.B., Busse R. *In: Buchan *et al.* (2014)	2000 – 2017 search	Qualitative: phone interviews and focus groups.	52 participants (of which 25 are nurses in 17 in interviews and 8 in focus groups).	EU, Germany	EU, Germany
Ohr S. O., Jeong S., Parker V., McMillan M. (2014)	2000 – 2017 search	Qualitative: interviews and meetings	34 interviews with managers, coordinators, researchers, and academics; 29 nurses	US, UK	Global
Palese A., Barba M., Borghi G., Mesaglio M., Brusaferro S. (2007)	2000 – 2017 search	Mixed method: questionnaires and interviews	17 nurses	Italy	Romania
Palese A., Cristea E., Mesaglio M., Stempovscaia E. (2010)	2000 – 2017 search	Longitudinal mixed method: interviews and questionnaires	110 nurses	Italy	Moldavia
Pereira C. (2015)	2000 – 2017 search	Mixed methods: questionnaires and interviews	17 interviews (in Germany) 349 questionnaires (in UK)	Germany, UK, others in EU, Asia and Africa	Portugal
Primeau M.D., Champagne F., Lavoie-Tremblay M. (2014)	2000 – 2017 search	Literature review (Integrative Review)	54 articles	Global	Global
Winkelmann-Gleed A. (2006)	2000 – 2017 search	Mixed method: questionnaires and interviews	22 interviews to nurses; 140 surveys to internationally qualified nurses; not specified number of interviews with managers and individuals involved in recruitment	UK	Global
Wismar M., Maier C.B., Glinos I.A., Dussault G., Figueras J. (2011)	2000 – 2017 search	Mixed method (not specified)	17 case studies, no specific numbers provided	EU (17 countries)	EU (17 countries)
Young R., Weir H., Buchan J. (2010)	2000 – 2017 search	Mixed method: interviews and review of documents	18 nurses; 134 documents	UK	EU

Young R., Noble J., Mahon A., Grant J., Sibbald B. (2010)	2000 – 2017 search	Mixed method: questionnaires and interviews	142 questionnaires; 74 interviews with various health professionals	UK	Philippines, India, Scandinavia, Spain and South Africa;
Young R. (2013)	2000 – 2017 search	Mixed method: questionnaires and interviews	48 semi-structured interviews with migrant staff; 74 with several stakeholders	UK	Global (EU: Spain, Greece, Czech Republic)
Young R., Humphrey C., Rafferty A.M. *In: Buchan *et al*. (2014)	2000 – 2017 search	Mixed method: interviews and questionnaires (to locate potential interviewees)	42 total (of which 13 nurses)	UK	EU
Zander B., Blumel M., Busse R. (2013)	2000 – 2017 search	Mixed method: questionnaires and interviews	1512 nurses in Germany, 27,451 nurses altogether	Germany	EU

NM = not mentioned, NA = not applicable