



Exploring the migration decisions of health workers and trainees from Africa: A meta-ethnographic synthesis



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ABSTRACT

The migration of healthcare workers from Africa depletes countries already suffering from substantial staffing shortages and considerable disease burdens. The recruitment of such individuals by high income countries has been condemned by the World Health Organisation. However, understanding the reasons why healthcare workers migrate is essential, in order to attempt to alter migration decisions. We aimed to systematically analyse factors influencing healthcare workers' decisions to migrate from Africa. We systematically searched CINAHL (1980–Nov 2010), Embase (1980–Nov 2010), Global Health (1973–Nov 2010) and Medline (1950–Nov 2010) for qualitative studies of healthcare workers from Africa which specifically explored views about migration. Two reviewers identified articles, extracted data and assessed quality of included studies. Meta-ethnography was used to synthesise new lines of understanding and meaning from the data. The search identified 1203 articles from which we included six studies of healthcare workers trained in seven African countries, namely doctors or medical students (two studies), nurses (three), and pharmacy students (one study). Using meta-ethnographic synthesis we produced six lines of argument relating to the migration decisions of healthcare workers: 1) Struggle to realise unmet material expectations of self, family and society, 2) Strain and emotion, interpersonal discord, and insecurity in workplace, 3) Fear from threats to personal or family safety, in and out of workplace, 4) Absence of adequate professional support and development, 5) Desire for professional prestige and respect, 6) Conviction that hopes and goals for the future will be fulfilled overseas. We conclude that a complex interaction of factors contribute to the migration decisions of healthcare workers from Africa. Some of the factors identified are more amenable to change than others, and addressing these may significantly affect migration decisions of African healthcare workers in the future.

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Introduction

The migration of health workers from low- and middle-income countries to high-income countries contributes to producing and sustaining the human resources crisis in global health care (Arah, 2007; Eastwood, Conroy, Naicker, West, & Tutt, 2005; Pond & McPake, 2006). Such migration has been dubbed 'the brain drain' (Mullan, 2005). Despite investment in training of new healthcare professionals, low- and middle-income countries frequently lose new graduates to high-income countries (Mills et al., 2008; Robinson & Clark, 2008). It is known that childhood and maternal mortality is inversely related to access to health workers – populations in sub-Saharan Africa have proportionally just 10% of the doctors and nurses of European populations (Chen et al., 2004) –

yet underserved populations host a large share of the global disease burden (World Health Report, 2008). Since the loss of healthcare professionals to high-income countries diminishes an already strained workforce (Mills et al., 2008) and training such individuals is costly (Gutenstein, 2000) the World Health Organisation published a Code of Practice for the International Recruitment of Health Personnel in 2010, which provides ethical guidelines for the recruitment of international health personnel to strengthen health systems in developing countries, those in economic transition and small island states (WHO, 2010a).

The decision of an individual to migrate can be influenced by many different factors, including those specific to the country they are leaving. These factors have often been described in terms of 'push' and 'pull'; specific factors can act to 'push' or drive an individual away from one specific country, or to 'pull' or draw an individual to a different country, and interact with additional personal factors in the migration decision (Dorigo, 1983; Lee, 1966). Studies have identified a variety of factors contributing to 'push'

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and 'pull', such as lifestyle and family, working conditions, professional development and salary (Akl et al., 2007; Astor et al., 2005; Bezuidenhout, Joubert, Hiemstra, & Struwig, 2009; Cheng, 2009; Kingma, 2007). However, to date there has been no collective qualitative synthesis of primary data relating to the reasons for migration of health workers from Africa; the closest to such a synthesis has been a systematic review and narrative synthesis of interventions to improve motivation amongst healthcare workers in developing countries, with the aim to identify and prioritise the motivational factors affecting these healthcare workers (Willis-Shattuck et al., 2008).

Qualitative data has specific advantages over quantitative when examining reasons for healthcare worker migration: it allows a much deeper understanding of the personal experiences and reasons for migration which quantitative studies, by their nature, can only imply. Synthesis of qualitative data is an emerging methodology, recognised by Cochrane and the Health Technology Assessment programme (Cochrane, 2011; Ring, Richie, Mandava, & Jepson, 2011). As part of the synthesis process, critical appraisal of qualitative research has been the subject of debate, and several appraisal checklists are available (Mays & Pope, 2000). Different methodologies have been proposed for synthesis (Barnett-Page & Thomas, 2009; Ring et al., 2011), of which meta-ethnography is the most frequently used (Barnett-Page & Thomas, 2009; Noblit & Hare, 1988; Ring et al., 2011). Examples of data synthesis using this methodology now exist, and have developed its practical application (Campbell et al., 2003; Pound et al., 2005). An advantage of meta-ethnography is that it aims to bring new understanding and interpretation by translating studies into one another and subsequently synthesising new lines of argument, rather than just comprising a collective narrative summary of findings (Barnett-Page & Thomas, 2009; Noblit & Hare, 1988; Ring et al., 2011). Lines of argument have been used by previous qualitative researchers to report theoretical constructs arising from the thematic translation process between included studies (Campbell et al., 2003; Pound et al., 2005).

In order to form a meaningful interpretation of findings from existing data, we decided to focus solely on studies which have explored the migration decisions of African healthcare workers. Africa loses significant numbers of healthcare workers to migration abroad each year (Eastwood et al., 2005; Robinson & Clark, 2008), and despite having some of the lowest densities of healthcare workers it hosts a large disease burden (Global Health Observatory, 2011; Robinson & Clark, 2008). Such an interpretation will bring further understanding of the key reasons for health worker migration and inform both African countries who are losing health workers, as well as policy stakeholders in recipient countries, and contribute further to forging solutions to the continued loss of health professionals. Therefore we aimed to determine the reasons for healthcare worker migration from African countries by a systematic review of qualitative literature using meta-ethnographic synthesis. We aimed to explore the views of African-trained healthcare workers who had migrated, those yet to migrate, and returnees.

Methods

We included studies that used qualitative collection methods such as interviews or focus groups, and which employed qualitative methods of analysis of subsequent data. We excluded studies using quantitative analysis of questionnaire data because responses were pre-defined by the study authors, with analysis focused on frequency of agreement with closed pre-defined responses, rather than on methods such as thematic analysis of transcripts. Studies were selected which: recruited health workers who had trained in

Africa (including current healthcare trainees), reported primary research findings, and stated an aim to explore views about or reasons for migration. Eligible studies included those of health workers who had already migrated, those yet to migrate, and those who had returned following a period in another country.

We searched for primary qualitative research articles using the following databases: CINAHL (1980–Nov 2010), Embase (1980–Nov 2010), Global Health (1973–Nov 2010) and Medline (1950–Nov 2010). With the assistance of a medical librarian we used a comprehensive list of search terms, including mesh terms for 'health worker', 'migration', 'views' and 'Africa' (see [Supplementary Table 1](#) for full search strategy). We used a modified search filter to capture qualitative research. We also searched reference lists of retrieved papers and identified additional relevant grey literature by internet searches.

Titles were screened to remove obviously irrelevant titles (CB). Two authors (CB, MT) then independently reviewed titles and abstracts for inclusion and identified full text articles. Disagreements were resolved by consensus. Data extraction was performed using standardised forms (CB, MT). We assessed trial quality using a modification of the CASP criteria, which has been previously used in a similar format in meta-ethnographic reviews (Campbell et al., 2003; CASP, 2001; Pound et al., 2005).

A meta-ethnographic approach was used to translate emerging 'push' and 'pull' factors between identified studies (Noblit & Hare, 1988) by two researchers (CB, MT). Firstly both researchers read and re-read all studies to gain familiarity with the data. Secondly, they extracted 'push' and 'pull' factor data from the published report for each qualitative study, from the authors' thematic discussion and conclusions, and relevant quotes given by the authors. In papers reporting both qualitative and quantitative data, the qualitative data alone was extracted. Thirdly, they then jointly undertook the process of translation of extracted data, looking for common and opposing concepts between the study findings. They hand-wrote all extracted data from each study on large sheets to facilitate translation of findings from different studies, as used in a previous synthesis (Campbell et al., 2003). All hand-written sheets of push and pull factors were typed up using a thematic framework, to view the translation process. Finally, from this process of translation between studies, the two researchers formed new interpretations of the data and lines of argument (Noblit & Hare, 1988). We verified the synthesised lines of argument by back-checking for agreement within the content of the individual studies and all authors reviewed the construction of the lines of argument.

Results

We identified 1203 articles of which, 753 articles were clearly irrelevant based on title or abstract alone. Of the remaining 450 references, 71 articles were selected for full text review, after which seven articles remained. An additional relevant article was identified by searching reference lists and internet searches ([Supplementary Fig. 1](#)).

Eight studies were initially included in the analysis, however two of these were subsequently excluded; in one study the aims did not strictly comply with the inclusion criteria (Luboga, Hagopian, Ndiiku, Bancroft, & Mcquide, 2010), and in another the results reported in the article did not include those in the study specifically relating to reasons for migration (Joudrey & Robson, 2010). The six included studies ([Table 1](#)) included healthcare workers trained in seven African countries: Uganda (Nguyen et al., 2008), Nigeria (Aboderin, 2007), Malawi (Grigulis, Prost, & Osrin, 2009), Ghana (Hagopian et al., 2005; Owusu-Daaku, Smith, & Shah, 2008), South Africa (Oberoi & Lin, 2006), Zimbabwe (Oberoi & Lin, 2006) and

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