International Labour Organization

MIGRATION OF HEALTH WORKERS FROM NEPAL

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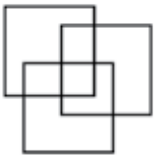

First published 2017

Migration of health workers from Nepal / International Labour Organization, ILO Country Office for Nepal. - Kathmandu: ILO, 2017.

ISBN: 9789221291060 (web pdf)

International Labour Organization; International Labour Office in Nepal.

labour migration / medical personnel / brain drain / migration policy / Nepal

14.09.1

The publication has been produced with the assistance of the European Union. The content of this publication are the sole responsibility of the International Labour Organization and can in no way be taken to represent the views of the European Union.

ILO Cataloguing in Publication Data

Printed in Nepal

Foreword

The migration of health workers is a complex and multifaceted phenomenon. While the movement of health workers is compelled by a range of pull factors, such as lucrative salaries and better working and living conditions and opportunities for career advancement, it is also driven by push factors, such as unemployment, lack of skill development options and inadequate remuneration. The migratory trends of health workers, especially from developing countries to industrialized countries, have resulted in acute shortages of health professionals as well as an unequal geographical distribution. This issue is especially contentious, given the ramifications it has on the health system of developing countries as well as on the health of their populations.

Nepal has experienced an unprecedented surge of out-migration for foreign employment in the past decade. This has included a sizeable out-migration of health personnel, especially doctors and nurses, to countries of the global North. Various studies have explored the many facets of labour migration from Nepal, but there has been scant investigation on the out-migration of health workers. Nor is there any systematic manner of collecting and analysing related data. Thus, little is known about the actual numbers of health workers leaving Nepal, the policies governing such movement and the consequent impact on the country's health care situation.

This report aimed to fill this knowledge gap by providing an overview of the current situation relating to the stock and flow of migrant Nepali health care workers. Presenting the findings of a survey with undergraduate medical and nursing students, the report discusses the factors driving Nepali health workers to seek employment opportunities abroad. To complement the analysis, the report also reviews international as well as national frameworks and mechanisms regulating the migration of health workers from Nepal.

Commissioned under the International Labour Organization's European Union-funded South Asia Labour Migration Governance project, the study was conducted by the Centre for the Study of Labour and Mobility (CESLAM) at the Social Science Baha. The authors, Bandita Sijapati, Jeevan Baniya, Neha Choudhary and Ashim Bhattarai, were supported by Dawa Tshering Sherpa, Soni Khanal, Manju Gurung and Swarna Kumar Jha. I would like to thank the entire CESLAM team involved with the report. I also thank Anna Engblom and Niyama Rai for conceptualizing the study and bringing the report into its final shape.

Richard Howard
Director
ILO Country Office for Nepal

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Abbreviations

AU$	Australian dollars
BDT	Bangladeshi taka
BN	Bachelor of Nursing
BSc Nursing	Bachelor of Science in Nursing
ICN	International Council of Nurses
ILO	International Labour Organization
INR	Indian rupees
MBBS	Bachelor of Medicine, Bachelor of Surgery
MDG	Millennium Development Goals
NHPC	Nepal Health Professional Council
NMC	Nepal Medical Council
NNC	Nepal Nursing Council
NPR	Nepali rupees
OECD	Organisation for Economic Co-operation and Development
PCL Nursing	Proficiency Certificate Level in Nursing
PSU	primary sampling unit
SSU	secondary sampling unit
WHO	World Health Organization

EXECUTIVE SUMMARY

The international migration of health workers has sparked multiple debates, particularly around the ethics of the recruitment process. It is an especially contentious topic, considering the chronic global shortage and inequitable distribution of health workers that brought about the alarming rates at which health workers are migrating from countries of the global South to countries of the global North.

Although the volume of health workers leaving Nepal has been on a steady rise and the implications seem significant, there has been no study to identify the drivers of such migration. Neither are there any policies in Nepal to govern and manage the migration of health workers. This study aimed to fill the gaps. The major findings of the study are as follows.

Nepal experiences inequitable distribution of health workers leading to critical shortage of health workers in most part of the country. This leaves the health worker-to-population ratio at 0.67 doctors and nurses per 1,000 individuals, which is significantly lower than the World Health Organization's recommendation of 2.3 doctors, nurses and midwives per 1,000 individuals.

Well-managed data on the stocks and flows of health workers has been a major challenge due to the lack of a comprehensive database, coupled with the tendency of health professionals to opt for other channels of migration, such as through student migration. Lack of data has led to the absence of effective policies to govern the migration of health workers from Nepal. There is no policy framework, act or guidelines specifically to govern the migration of health workers from Nepal, other than the laws that govern foreign employment in general. While there are separate laws governing migration and the health sector, the two areas seldom interact. The scant policy attention received by the international migration of health workers is also reflected in the absence of retentions programmes geared towards motivating health workers from migrating abroad.

A crucial aspect of human resource management in the health sector has been the overproduction of doctors and nurses due to the liberal distribution of licenses to new educational institutions (which is done to ensure the availability of health personnel in rural areas). However, few opt for service in the rural areas, leading to migration. Additionally, the culture of health worker migration has resulted in individual motivation geared towards migrating abroad.

The survey conducted for this study revealed that 50 per cent of the respondents, comprising final-year undergraduate medical and nursing students, planned to migrate abroad to pursue further studies or to work. The main drivers of out-migration were largely structural, with better quality of education, better living conditions and ease of securing job afterwards ranking high among those who wanted to migrate to study. Better salary, better living conditions and better work conditions were the top-three reasons motivating individuals to migrate for work. Some of the factors dissuading these individuals from migration included a better health policy environment, higher salary, better working conditions, better benefits and sufficient medical resources.

While the migration of health workers is governed by rules and regulations for foreign employment in general, health workers, unlike general migrants, cannot migrate and begin working. They usually must undergo a process of registration in professional organizations to practise abroad. Hence, health workers from Nepal often take the student visa route to migrate. They often go abroad to acquire postgraduate degrees and thereafter apply for registration. Additionally, the study revealed that the role of international educational consultancies, which once acted as recruitment agents, has been reduced to disseminating information on educational opportunities abroad. These international educational consultancies have been replaced by internet or personal networks as sources of information.

The study also revealed that the migration of health workers from Nepal remains a largely unexplored area. The internal migration of health workers has received far more attention than international migration, which has been recognized as an issue at the policy level but remains an "unseen phenomenon", with no records maintained on the outflow.

Other findings from the study:

■ There is lack of any comprehensive policy on migration of health personnel due to the absence of interaction between policies governing the health sector and those related to migration.

■ The human resource system for health workers in Nepal is characterized by a peculiar condition; on one hand, there seems to be an oversupply of doctors as well as nurses, particularly in terms of the numbers graduating from medical and nursing institutes each year; yet, on the other hand, the country continues to suffer from a low health worker-to-population ratio, which points to a chronic shortage of health workers, particularly in rural areas.

■ While the number of health professionals migrating for employment abroad is not numerically high, the aspirations to go abroad, whether for further studies or employment, are high among students who are currently pursuing medical and/or nursing degrees.

■ The most common migration pathway of health workers is the increasing trend of health workers opting for study in other countries as a way of facilitating their permanent settlement abroad.

Based on these findings, the study report concludes with a few recommendations:

■ A system should be established for the effective data management of human resources for the health sector and better classification of jobs and occupational categories of migrants in the Department of Foreign Employment database.

■ Tasks that health care professionals currently manage should be delegated to less specialized health workers to meet the needs of the population.

■ The strategy for retaining health workers should be reconsidered, such as comprehensive packages that include both financial and non-financial incentives rather than sanctions and control measures.

■ The production of highly skilled health professionals should be recalibration, with more focus on developing the capacity of community health workers, especially to prepare them for task shifting.

■ Stakeholders should coordinate in the drafting of guidelines to govern the migration of health workers from Nepal and to develop measures for managing such migration in order to maximize benefits for the country as well as individual migrants.

■ Further research on the various aspects of this complex phenomenon should be conducted to inform policies and programmes.

1. INTRODUCTION

Human resources are the most critical component of health care systems.[1] There are currently an estimated 60 million health workers around the world,[2] typically unevenly distributed across countries and regions but still inadequate in numbers. The dearth as well as the unequal distribution of health workers has become all the more alarming with increasing rates of international migration of health workers from countries of the global South to industrialized countries.[3]

This "brain drain", or "skills drain" as it is more commonly referred to, is driven by a combination of push factors in countries of migration outflow and pull factors in countries of destination. Specifically, studies have demonstrated that the migration of health professionals is inevitably driven by underlying structural reasons (political, social or economic conditions) in developing countries and by shifting policies conditioned to attracting professionals in the destination countries, a phenomenon that has been characterized as the "political making" of the migration of health workers.[4]

Increased demand for paid care workers (resulting from an ageing population, better medical treatment and transformed family structures), policies in countries of destination that change according to domestic needs, lucrative salaries, better working and living conditions, and opportunity for career advancement combine as pull factors. The push factors include unemployment, lack of skill development opportunities, inadequate remuneration, ineffective regulation and monitoring, and the politicization of specialized bodies related to the health sector, including the interests of recruitment agencies.[5]

Dwelling on the role of underdevelopment, Connell (2014) argued that such migration occurs within a longstanding culture of migration. Where local development opportunities are few, migration generates a source of income, and most individuals consider migration at some point of their lives. This movement occurs within a professional culture that is oriented towards superior technology and advanced skills, which is perceived to exist overseas.[6] As a result, in most developing countries, there is a predisposition among health care workers to migrate.

Whatever the reasons for migration, the outflow of health workers from developing countries for more than five decades reflect several phases but an overall growth in numbers, increasingly complex care chains and trends in active recruitment.[7]

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[1] GHongoro and McPake, 2004, pp.1451–1456.
[2] Siyam and Dal Poz, 2014.
[3] Nair and Webster, 2012, pp.157–163.
[4] Kaelin, 2011, pp. 489–498.
[5] Lofters, 2012, pp. e376–e378; WHO, 2006; Sapkota, van Teijilingen and Simkhada, 2014, pp. 57–74; Baral and Sapkota, 2015, pp. 25–29; Adhikari, 2012.
[6] Connell, 2014, pp. 73–81.
[7] Connell, 2014, pp. 73–81; James, 2007, pp. 36–43.

BOX 1.1

The spectrum of health workers

There is no single global definition of health workers or specific health worker occupations. This absence of even a broad definition has complicated data collection and cross-comparison of the health workforce across countries. The World Health Organization (WHO) defines health workers as "all people primarily engaged in actions with the primary intent of enhancing health". The ambiguity inherent in such a broad definition along with the limited availability of data have resulted in published datasets on the global health workforce generally including only paid health care professionals. Among paid health care professionals, most of the official sources, including the WHO and the European Commission, often differentiate between service providers (nurses, doctors, midwives, pharmacists and lab technicians) and health management and support workers who support the health service without directly providing health services (managers, computing professionals, trades people and clerical and service workers).

For the purpose of data collection, most sources today use the International Standard Classification of Occupations, the latest version of which categorizes health-related occupations in five broad groups:

- health professionals;
- health associate professionals;
- personal care workers in health services;
- health management and support personnel; and
- other health service providers not classified elsewhere.

Difficulties relating to the categorization and data collection persist, making it challenging to obtain an unequivocal picture of the global health workforce.

Source: Jensen, 2013.

The ramifications of health worker migration may vary country to country, but they mostly tend to have severe and longstanding effects on the health of populations, as well as the health system of developing countries. This impact has generated much debate worldwide. Arguments at a general level maintain that aggressive recruitment of overseas health workers by countries from the global North is the main reason for the unbalanced distribution of health personnel between and within countries, including in terms of understaffed hospital wards and rural health clinics.[8] Further, imbalances and shortages are considered to have become the major obstacle in the attainment of the health-related Millennium Development Goals and other health development goals in many countries, including in Nepal.[9]

The international migration of health workers has also sparked debate around the ethics of the recruiting process. This attention has resulted in national and international attempts to slow migration, regulate internal recruitment through the voluntary World Health Organization's (WHO) Global Code of Practice on the International Recruitment of Health Personnel and engage in what is called "managed migration". Critics argue that while countries of origin invest in educating their health professionals, they lose on the return of their investment when the educated workforce migrates out of the country. When health workers leave the country in large numbers, they leave behind a huge gap in the provision of health care.[10]

The debate surrounding the ethical recruitment of health workers is countered by recognition of the right of individuals to move. This argument is supported by the benefits of migration in terms of international mobility providing work for unemployed professionals and contributing towards improving their standard of living as well as in terms of the residents of sending countries gaining from migration through remittances sent home by migrant health professionals and the skills and expertise such individuals bring with them when they return home.[11]

1.1 OBJECTIVES AND OVERVIEW OF THE STUDY

Although the volume of health workers leaving Nepal has been steadily rising and the implications seem significant, there has neither been a systematic study to identify the drivers of such migration nor robust analysis to examine its effects. Accordingly, policies to govern and manage the migration of health care workers are also largely absent. To address these gaps, this study examined:
i) the major trends characterizing international migration of health personnel[12] from Nepal;
ii) international as well as national frameworks and mechanisms regulating the migration of health workers from Nepal;
iii) the main drivers involved in the migration of health workers; and
iv) international good practices relating to governance and the retention of health workers that Nepal can draw insights from.

After introducing the context and issues of the study, the report then outlines the methodological framework of the study, elaborating upon the range of quantitative and qualitative methods used to

[8] Dussault and Franceschini, 2006; Connell, 2014, pp.73–81; also see Bach, 2003; Hooper, 2008, pp. 684–687.
[9] Afzal et al., 2011, pp. 298–306; for challenges and implications for Nepal, see, MOHP and NHSSP, 2013.
[10] Hooper, 2008, pp. 684–687; see also Goenhout, 2012, pp. 1–24.
[11] Buchan, 2010, pp. 791–793; Hooper, 2008, pp. 684–687.
[12] According to ISCO-08, the definition of health workers broadly includes five categories: (i) health professionals; (ii) health associate professionals; (iii) personal health workers in health service; (iv) health management support personnel; and (v) other health service providers not classified elsewhere. Within these categories, there are further subcategories (see Annex I) that were not feasible to include in the study. The study focuses on two major categories of health workers – doctors and nurses, which were easily accessible and have been at the forefront of the debate around health worker migration (Bach, 2003).

fulfil the study objectives. After that it goes on to give a brief overview of the dynamics of migration of doctors and nurses from Nepal, presenting the dominant trends and the main drivers of such movement. This is followed by an analysis of institutional mechanisms regulating migration of health workers from Nepal in order to explore whether and how regulations governing the health sector in Nepal have interacted with those governing migration, and what impacts it has had on the effective management of health worker migration. Subsequently, the report presents the intentions, drivers and channels of migration of health workers, drawing particularly from the primary research conducted for the study. Finally, the report presents some international good practices that would be relevant for Nepal, followed by conclusion and recommendations.

1.2 METHODOLOGICAL FRAMEWORK

Data collection

The study used the following combination of quantitative and qualitative approaches.

Literature review: An examination of the existing policies, legal frameworks and mechanisms governing the migration of health workers from Nepal was conducted. The study also made use of secondary research to find good practices and strategies from around the globe for the management of the outflow as well as retention of health workers. Additionally, a policy review of major sending and destination countries with regards to recruitment of foreign health workers was carried out to determine factors that influence the mobility of health workers.

Analysis of existing data: Because data on the migration of health workers were not readily available, information was extrapolated from various sources to analyse trends and patterns relating to the migration of health workers from Nepal. Some of these sources include the Department of Foreign Employment's database on foreign labour migration, the Ministry of Education's data on registration of no-objection certificates for students pursuing medical studies abroad and information available from the Nepal Medical Council (NMC) and the Nepal Nursing Council (NNC).

Mapping of stakeholders and institutions: A mapping was done of the formal and informal institutions and organizations associated with the migration of health workers from Nepal.

Survey: Previous surveys of students in the medical field, including one in Nepal, were conducted to understand the push and pull factors driving health personnel to migrate abroad.[13] Adopting a similar framework, this study administered a survey of 294 final-year undergraduate medical and nursing students at two medical and six nursing colleges in Kathmandu Valley to understand their migration intentions[14] (see Annex III for the sampling strategy and framework used in the study). This small-scale survey aimed to go beyond the previous studies by focusing on more than one category of health workers[15] and to collect demographic profiles of prospective migrants, their destinations, channels of migration and their preferred migration pathways. Additionally, the survey included questions on what keeps health care workers from migrating abroad (see Annex IV for the survey questionnaire).

[13] Rao, Rao and Cooper, 2006, pp. 185–188; Akl et al., 2008; Sousa et al., 2007; and Huntington et al., 2012, pp. 417–428.
[14] For the sampling framework, refer to the methodology section.
[15] Previous studies solely focused on doctors (see Huntington et al., 2012, pp. 417–428) or nurses (see Baral and Sapkota, 2015, pp. 25–29; Another study (Sapkota, van Teijilingen and Simkhada, 2014, pp. 57–74) was region-specific and focused solely on health workers who had migrated to the United Kingdom.

In-depth interviews: Interviews were conducted with a variety of stakeholders to understand the management of health worker migration in Nepal (see Annex II for a listing of the people consulted). This included the dynamics behind the migration of medical personnel, with a particular focus on the patterns and trends as well as the impact of the outflows. Interviews were also conducted with returned and prospective migrants on the migration process. Group interviews were conducted with doctors working in public and private hospitals in Nepal and nurses working in private hospitals[16] for a perspective on the working conditions.

Methodological challenges

The study team encountered a number of challenges in the course of the research. The target sample of 600 persons for the survey could not be reached, for two reasons: (i) permission not forthcoming from some of the institutions that were included in the sample; and (ii) unavailability of students in certain institutions, because the collection of data overlapped with their examinations (see Annex V for sample size methodology). Among the nursing institutes sampled, students in three colleges were not available because they were on leave for examination preparations. One nursing institute rejected the research team's overtures, stating that participation in such a study was against their policy.

It was particularly challenging to access medical colleges, most of which asked for approval from the Nepal Health Research Council, despite the non-invasive nature of the research and the proposal having been approved by the Research Ethics Committee at Social Science Baha as well as the ethics review body in each college. Given that the target population in medical colleges were interns, finding a suitable time to conduct the survey was another challenge, which was further compounded by indifferent administrative support from some of the institutions. Some 20 respondents also refused to take part in the survey.[17]

Another difficulty the research team encountered was in contacting doctors and nurses who had returned from working abroad; many of the individuals contacted could not find the time to be interviewed. Additionally, it was difficult to locate returned nurses; the migration of nurses is more recent compared with doctors, and most of them are still abroad. Even among the returned doctors, most had migrated a long time back and returned to Nepal after working abroad for 10–15 years. Recent returned health care workers were rare. Although it had been proposed that focus group discussions would be conducted with doctors and nurses working in Nepal, this proved to be a huge challenge to bring a sufficient number together and was cancelled. Instead, group interviews were conducted separately with doctors and nurses.

Ethical considerations

As noted, the research design and tools were approved by the Research Ethics Committee of Social Science Baha. Prior to the administration of the survey, the research team fulfilled the requirements of individual institutions and received ethical clearance from their respective ethics review committee. All the study participants were also given an information sheet outlining the purpose of the study and their role in it. Informed consent was acquired in written form from every participant.

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[16] Despite several attempts, the research team was not able to bring together nurses working in public hospitals for a group discussion during the duration of the study.

[17] Their reasons for this are unknown because the consent form stated that participants can refuse to take part in the survey without giving any reason for non-participation.

Limitations of the study

Given the focus of the study in Kathmandu, the research findings may have an urban bias and would not be generalizable to the entire country. Due to the lack of data, inferences on the migration trends of health workers was derived from data on those seeking to migrate for further studies. According to a WHO representative, this has proven to be one of the best proxies to measure the extent of migration of this category.[18] Because the scope of the study was limited and exploratory in nature, the findings can at best only provide indicative trends relating to the migration of health workers from Nepal.

The study only addresses issues of health worker migration as they relate to Nepal and does not deal with the experiences of those already abroad. The latter have been covered by other studies, which indicate that health professionals who have migrated from Nepal and many other developing countries have experienced a high degree of deskilling and underutilization of their skills.[19] To avoid being too general, the scope of this research was limited to issues concerning health workers prior to their departure.

[18] Interview at WHO, 10 May 2016.
[19] Adhikari, 2009–10, pp. 122–138; Adhikari, 2012; Adhikari and Grigulis, 2013, pp. 1–9.

2. MIGRATION OF HEALTH PROFESSIONALS FROM NEPAL

2.1 OVERVIEW OF HUMAN RESOURCES IN THE HEALTH SECTOR

Despite the paucity of accurate and updated information on the number, characteristics and distribution of Nepal's health workforce,[20] there is no dispute about the country experiencing a critical shortage of health workers, especially in remote areas. The health worker-to-population ratio in Nepal is 0.67 doctors and nurses per 1,000 individuals, which is significantly smaller than the WHO recommendation of 2.3 doctors, nurses and midwives per 1,000 individuals.[21] Table 2.1 shows the distribution of selected categories of health workers in the public and private sectors in Nepal and their ratio to the population.

Table 2.1. Selected categories of health workers in the public and private sectors and population ratio

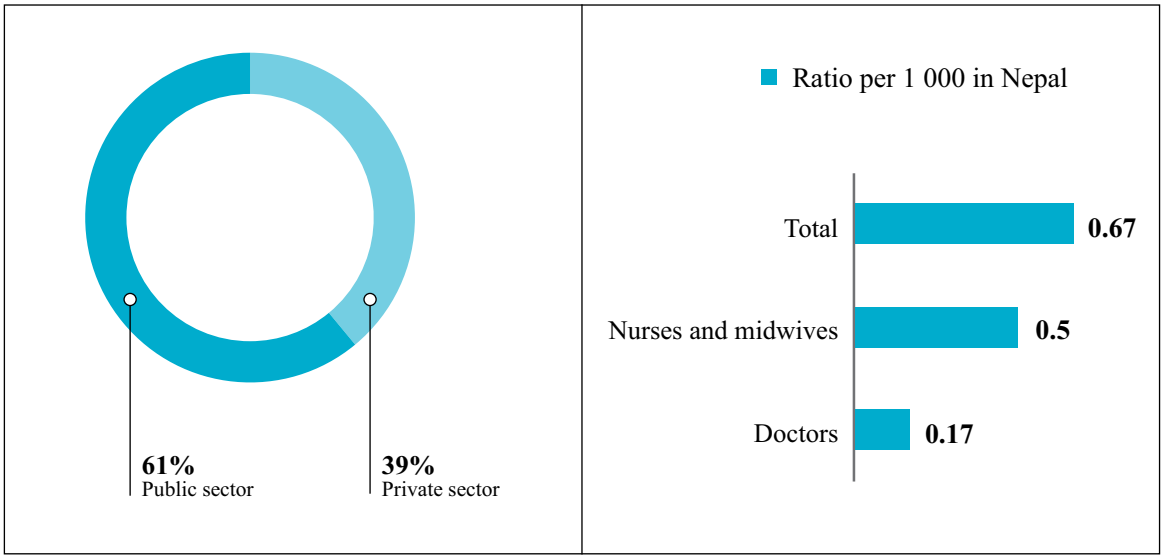
Health occupation category	Public		Private		Total		Health workers per 1 000 population
	No.	%	No.	%	No.	%	
Generalist medical practitioners	1 123	3	1 327	6	2 450	5	0.09
Specialist medical practitioners	636	2	1 315	6	1 951	4	0.07
Nursing professionals	3 371	10	3 683	17	7 054	13	0.27
Nursing associate practitioners	4 876	15	1 393	7	6 269	1	0.24

Source: HRH Assessment, 2012, cited in MOHP and NHSSP, 2013.

A 2013 assessment of Nepal's human resources for health conducted by the then Ministry of Health and Population in collaboration with the WHO and the Nepal Health Sector Support Programme counted a total of 54,177 health workers. Of them, 39 per cent were in the private sector and 61 per cent in the public sector (figure 2.1). The same assessment also indicated that only two-thirds of positions for doctors and nurses were filled.

[20] GMOHP and NHSSP, 2013.
[21] ibid.

Figure 2.1. Distribution of health workers in Nepal, 2013



Source: MOHP and NHSSP, 2013.

As in many other countries, the health profession in Nepal is quite gendered (table 2.2). Men dominate as medical practitioners – with 1,828 men working as generalist medical practitioners, compared with 622 females, and 1,576 male specialists, compared with 375 females. However, the situation is reversed among nurses. Females dominate among the nursing professionals and nursing associate professional categories. As table 2.2 reflects, only one man was identified in each category, compared with the 7,053 female nursing professionals and 6,268 nursing associate professionals.

Table 2.2. Sex distribution, by health occupation category, 2012

Health occupational category	Female	Male	Total	Proportion of females (%)
Generalist medical practitioners	622	1 828	2 450	25
Specialist medical practitioners	375	1 576	1 951	19
Nursing professionals	7 053	1	7 054	100
Nursing associate practitioners	6 268	1	6 269	100

Source: HRH Assessment, 2012 cited in MOHP and NHSSP, 2013.

The caste and ethnic distribution of health care providers is also unequally distributed (table 2.3). The top-three caste or ethnic groups predominant in the health workforce in Nepal are Hill Brahmins (at 32 per cent), Chhetri (at 18 per cent) and Newar (at 13 per cent). Compared with their actual population, these groups are overrepresented in the health sector, although only slightly in the case of Chhetris. Many of Nepal's 125 caste and ethnic groups, notably Dalits, are minimally represented, if at all, in the health sector.

Table 2.3. Distribution of health workers, by caste and ethnic group, 2012

Groups	Total No.	Total %	Percentage of total population (2011 census)
Hill Brahmin	18 031	32	12.17
Chhetri	10 311	18	16.59
Newar	7 520	13	4.98
Tharu	2 161	4	6.55
Yadav	2 081	4	3.97
Magar	1 941	3	7.12
Teli	1 426	3	1.39
Tamang	1 343	2	5.81
Gurung	1 235	2	1.97
Thakuri	1 065	2	1.60
Other	8 348	15	10.71
Unclassified	563	1	0.05

Source: HRH Assessment, 2012 cited in MOHP and NHSSP, 2013.

The dearth of health professionals persists, even though the output from health education and training institutions has been in the range of 10,000 per annum in recent years, with more than 32,000 health workers trained between 2009 and 2011 alone.[22] While the precise reasons for the chronic shortage, despite the high levels of production, is not known, the 2013 assessment of the health sector points to such factors as weak and fragmented human resource management and deployment decisions; poor staff attendance and lack of performance incentives; inability of training institutions to produce sufficient numbers of health workers in accordance with service demands; weak human resource planning systems and capacity; shortage of skilled workers in certain specializations and surplus in others; overconcentration of health workers in urban areas and outside the government sector; and mismatch between the health needs of the population and human resource development of health workers.[23]

Another factor that has often been perceived as a primary reason for the shortage of health workers is the increasing number of health personnel seeking employment abroad.[24] This form of migration involves movements of doctors and nurses moving to countries of the global North and about which no systematically collected data are available. Previous research led to an estimation that 16 per cent of registered Nepali doctors were outside the country, either studying or working.[25] The NMC records show that between 2013 and 2015, a total of 1,265 students had applied for postgraduate study abroad, with Bangladesh, China and the Philippines the most-favoured destinations.[26] The NNC records indicate that between 2002 and 2015, a total of 5,916 nurses (about 15 per cent of total membership[27]) had formally migrated out of the country.[28]

[22] MOHP and NHSSP, 2013.
[23] BNMT and EU, 2012.
[24] MOHP and NHSSP, 2012; MOHP and NHSSP, 2013; BNMT and EU, 2012.
[25] A survey of 710 doctors who had graduated from the Institute of Medicine, the oldest medical training school in Nepal, from 1983 to 2004 found 36 per cent to be outside of Nepal (Zimmerman et al., 2012); see also Shrestha and Bhandari, 2012.
[26] Nepal Medical Council Database.
[27] As of 5 July 2016, the NNC had a registered membership base of 38,759, see www.nnc.org.np (accessed 18 Aug. 2016).
[28] Nepal Nursing Council Database.

2.2 TRENDS IN INTERNATIONAL MIGRATION OF HEALTH WORKERS FROM NEPAL

As is the case in several countries,[29] well-managed data on stocks and flows of health workers has been a major challenge for Nepal. The review conducted during this study found that although each institution maintains some kind of record on the migration of specific categories of health personnel for education or work, no institution compiles all the data or information. Nor is there any comprehensive disaggregated data on destinations.

The Department of Foreign Employment is the main government body regulating the migration of individuals for foreign employment. It issues labour permits to individuals seeking to work abroad and is thus responsible for maintaining records of Nepali workers who migrate. Yet, due to the limitation of the database (such as lack of a jobs classification and collection of data in terms of jobs of migrants) and the tendency of health professionals to opt for other channels of migration, such as through student visas (as discussed in chapter 4), this database does not present accurate information on migration trends among health workers.

Although there is a general realization among officials that this situation of data management is problematic, they attribute it to the lack of financial and technical capacity. Other observers attribute it to the lack of a centralized system. According to a Ministry of Health official, "Of course, we need to keep proper data of those health workers who migrate abroad. But it is not only due to lack of resources and manpower; it is the result of the fact that there was no system from the beginning."[30]

There is also recognition that the lack of records is affecting human resource planning in the health sector. All agency officials contacted during this study noted there are plans aimed at comprehensive data gathering on the health workforce. Without reliable data, any attempt to develop policies and strategies to retain and manage health professionals is likely to be an uphill task. Meanwhile, trends can only be inferred from the available data: the NMC, NNC and the Department of Foreign Employment records.[31] Notably, data available from NMC and NNC are of individuals seeking to go abroad for further studies; but the number of health workers applying for certification of credentials by professional councils and/or other relevant government agencies serves as a proxy indicator for the number of health workers seeking to migrate for work purposes as well.

Data and record keeping on health workers' migration is further complicated by the different procedures that nurses and doctors must follow. These procedures not only differ from what other workers follow, but they differ for nurses and doctors. For instance, the NMC requires medical students seeking further studies abroad to fulfil certain criteria[32] to receive an eligibility certificate, which is necessary to obtain the no-objection certificate issued by the Ministry of Education. The no-objection certificate is a mandatory requirement for students going abroad for studies.[33] But the same requirement does not apply to students pursuing nursing education abroad. Instead, the NNC

[29] Bach, 2003.
[30] Interview with the MOH chief public health administrator, 20 Apr. 2016.
[31] Despite several visits, the Department of Foreign Employment technical officer would not provide the research team with information on the number of health professionals who had obtained a labour permit to migrate abroad for work.
[32] According to the official guidelines, students applying for an eligibility certificate for an undergraduate medical course in a foreign medical institution should have passed 10+2 or equivalent qualification recognized by universities or board with physics, chemistry and biology and having passed in each subject with a minimum of 50 per cent mark and also in aggregate (see www.nmc.org.np/downloads/d408e.pdf (accessed 17 May 2016). A student applying for an eligibility certificate for a postgraduate medical course in a foreign medical institution should have passed the MBBS or equivalent recognized by the NMC with an internship certificate. They also need to have the temporary or permanent registration certificate issued by the NMC (see www.nmc.org.np/downloads/b3247.pdf (accessed 17 May 2016)).
[33] Interview with the NMC administrative assistant, 1 Mar. 2016. For further information of criteria to obtain a no-objection certificate, see www.moe.gov.np/content/no-objection-letter.html (accessed 17 May 2016).

issues a verification letter and a letter of good standing.[34] Nursing students can apply for these letters, even from abroad.[35]

The available information shows that a total of 3,643 medical students went abroad to pursue their undergraduate education between 2008 and 2013 (table 2.4), with the top destinations consistently Bangladesh, China and the Philippines.

Table 2.4. Nepal Medical Council distribution of eligibility certificate to medical students (undergraduate)

Country	2008	2009	2010	2011	2012	2013
Bangladesh	184	385	336	216	218	271
China	136	123	284	304	199	265
Philippines	8	20	124	130	59	83
Others	0	0	0	0	0	49
Belarus	0	0	0	4	1	0
Georgia	0	0	5	1	1	0
Germany	3	2	0	0	0	0
India	6	1	5	23	13	0
Kyrgyzstan	8	3	10	2	0	0
Pakistan	20	11	34	5	7	0
Russian Federation	2	8	10	4	6	0
Ukraine	13	5	13	15	8	0
Total	**380**	**558**	**821**	**704**	**512**	**668**

Source: NMC, 2016.

As shown in table 2.5, 892 students acquired the eligibility certificate to pursue postgraduate degrees abroad in fiscal year (FY) 2013–14 and FY 2014–15, with China, the Philippines, India and Bangladesh ranking as the top destinations. Despite these four countries being favoured as destinations for education, the United Kingdom, Canada and the United States appear to be the countries where most Nepali doctors seek to register as working professionals, based on requests for verification letters from the NMC – at an average of four per day.[36]

[34] The verification letter establishes the authenticity of the degree; and the letter of good standing indicates the status of the student while pursuing the degree. According to official guidelines, students who have completed the PCL Nursing and the BSC Nursing need to pass the license exams from the NNC and obtain a certificate for registered nurses (see www.nnc.org.np/pages/credentials/licensing.php (accessed 17 May 2016)).

[35] Interview with the NNC registrar, 1 Mar. 2016.

[36] Interview with the NMC administrative officer, 1 Mar. 2016.

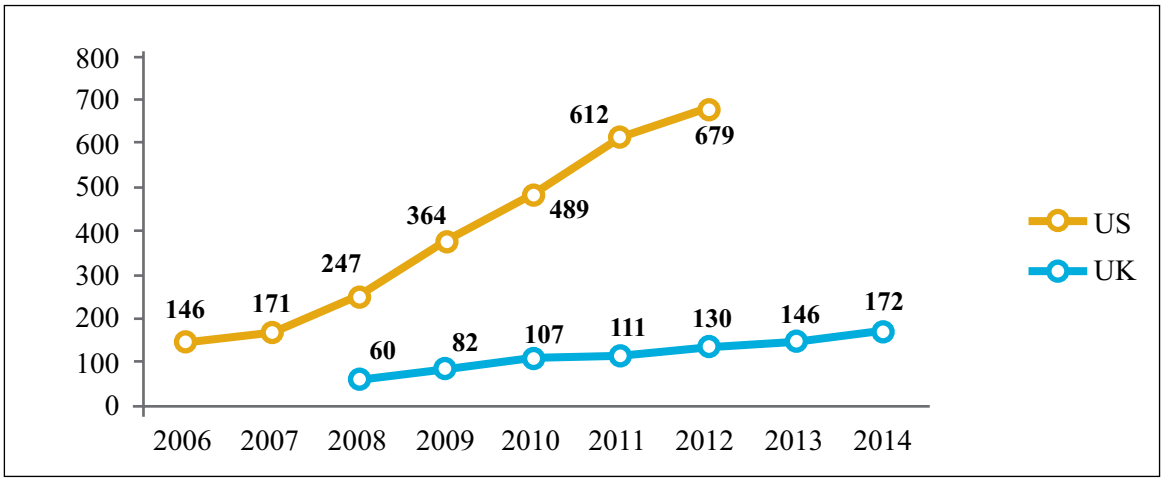
Table 2.5. Nepal Medical Council distribution of eligibility certificates (postgraduate level)

Country	FY 2013–14	FY 2014–15
China	175	285
India	17	109
Philippines	57	53
Bangladesh	37	44
United States	12	19
Pakistan	14	10
Japan	2	7
Egypt	0	5
Republic of Korea	0	3
Russian Federation	5	2
Belarus	0	2
Kyrgyzstan	6	1
Thailand	4	1
Norway	1	1
Germany	1	1
Islamic Republic of Iran	0	1
Australia	10	0
United Kingdom	2	0
Indonesia	1	0
New Zealand	1	0
Portugal	1	0
Ukraine	1	0
Israel	1	0
Belgium	0	0
Total	**348**	**544**

Source: NMC, 2016.

The NMC data is corroborated by data on the inflow of foreign-trained doctors to select Organisation for Economic Co-operation and Development (OECD) countries, such as the United Kingdom and the United States (figure 2.2).[37] This observed consistency between NMC data and that of OECD also confirms the premise that the number of medical professionals seeking certification of their credentials is closely tied with the numbers who eventually migrate abroad.

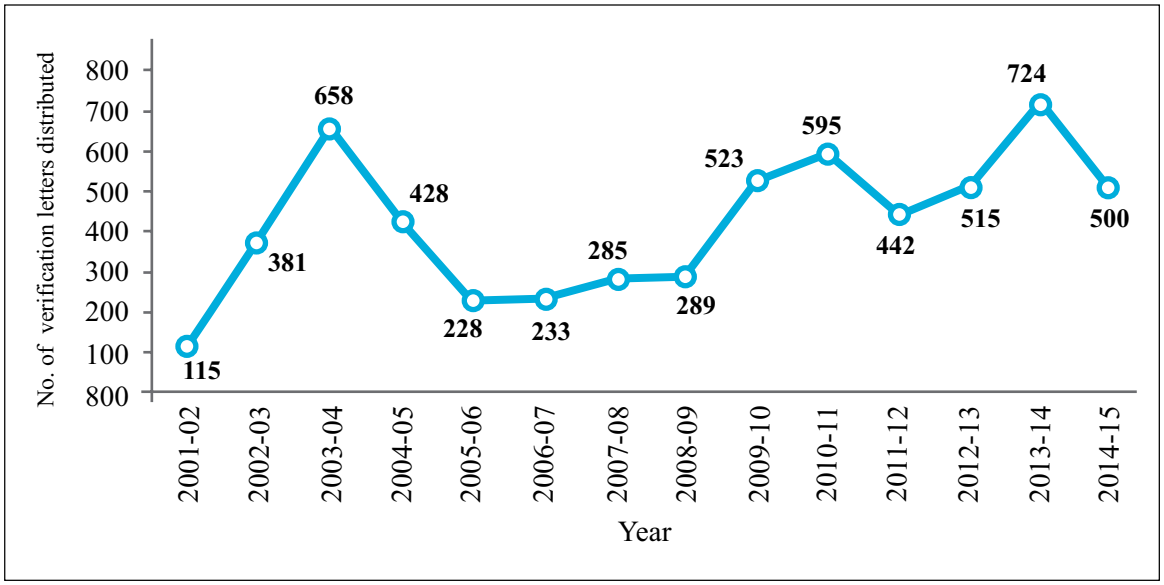
Figure 2.2. Stock inflow of Nepali doctors in the United Kingdom and United States, 2006–2014



[37] OECD, undated.

The NNC, on the other hand, has not introduced any requirement for individuals seeking to pursue nursing studies abroad. Nurses who intend to work as registered nurses abroad, however, need a verification letter, also known as a letter of good standing, which the NNC issues. NNC records on the distribution of verification letters suggest that the number of nurses from Nepal working abroad has dramatically increased since 2002, albeit with fluctuations over the years (figure 2.3).

Figure 2.3. Nepal Nursing Council distribution of verification letters, 2001–2015



The total numbers reflected in the NNC records could be an under-representation of the actual number of nurses who leave the country because many do not apply for such a letter. Sex-disaggregated data is not available for nurses migrating abroad; but given that nursing is highly gendered, most, if not all, of these migrants are likely to be female. The NNC has not maintained data on country-specific flows,[38] but the United States, Australia and, more recently, the United Arab Emirates are considered to be popular destinations for nurses.[39]

[38] During an interview, the NNC registrar said they do not maintain country-specific data due to lack of resources. They can provide the number of verification letters issued by the NNC to present to an embassy for certain years (for example, the 2002 records –which is the latest available – show that 75 letters of verification were issued and presented to the British embassy in Kathmandu).

[39] Interview with the NNC registrar, 6 Mar. 2016.

3. NATIONAL AND INTERNATIONAL LEGAL AND REGULATORY ENVIRONMENT

3.1 NATIONAL REGULATIONS RELATING TO THE MIGRATION OF HEALTH WORKERS

Nepal does not have a separate policy framework, act or guidelines specifically to govern the migration of health care workers. There is a set of policies and guidelines related to migration for foreign employment, such as the Foreign Employment Act, 2007, the Foreign Employment Rules, 2008, the Foreign Employment Policy, 2012 and a set of health sector-related regulations, such as the National Health Policy, 2014 and the Nepal Health Service Act, 1997. However, these two domains – health and migration – have seldom engaged with each other to address the issue of migration of health workers, even though the process and procedures for the migration of health care workers are defined by the laws guiding foreign employment.

With regard to the health sector and based on the constitutional commitment to effectively regulate and manage the health sector, the Government of Nepal drafted several plans and policies to guide regulations relating to human resources for health (table 3.1). The Nepal Health Service Act, 1997 broadly incorporates provisions for the management of health workers employed by the Ministry of Health in terms of their recruitment, deployment and promotion. On the other hand, the Nepal Medical Council Act, 1964, the Nepal Nursing Council Act, 1996 and the Nepal Health Professional Council Act, 1997 call for the establishment of autonomous bodies, such as the NMC, NNC and the Nepal Health Professional Council (NHPC), which are responsible for the management of the qualification standards and registration of medical practitioners,[40] nurses and health professionals, respectively. While both the NMC and NHPC require candidates planning to go abroad for education to register at the respective councils,[41] the NNC does not have any such requirements.

Thus far, the National Health Policy, 2014, which provides the general framework to guide health sector development, is the only document that explicitly recognizes the migration of health workers as an issue. The policy identifies the gap that exists between institutions producing health workers and the institutions that utilize them. The policy also includes provisions that include financial and non-financial incentives to create a better working environment for health workers in order to

[40] The Nepal Medical Council Act (1964) defines medical practitioner as "a person who has obtained a bachelor's degree from the recognized institution in the medical science under modern medical system and engaged in the concerned profession".
[41] Interview with the NMC administrative officer, 1 Mar. 2016 and the NHPC registrar, 11 Mar. 2016.

dissuade them from migrating. Likewise, although one of the aims of the ongoing Second Long-Term Health Plan, 1997–2017 is to ensure equitable distribution of technically competent health workers across the nation, it does not mention migration of health workers as an area requiring policy intervention or regulation.

Table 3.1. Current plans and policies guiding human resources for health in Nepal

Policies	Major provisions related to health services and human resources for health management
Constitution of Nepal, 2015[a]	■ Article 40 ensures the right to basic health services free of cost to every citizen. ■ Article 55 (h) calls for policies directed at: - increasing state investment in medical education while managing and regulating the private sector; - increasing state investment in the health sector; - ensuring easy and equal access to health services; - regulating and managing the private health sector; and - increasing the number of health organizations.
National Health Policy, 2014[b]	■ Provides a framework to guide health sector development. ■ Recognizes migration of health workers as a primary challenge. ■ Recognizes the lack of coordination between institutions producing health workers and institutions utilizing these health workers. ■ Identifies the necessity for the proper implementation of health-related codes, rules, policies, strategies and implementation plans. ■ Recognizes the need for reforms to be made in the transfer, promotion and career development procedures for health-related personnel at various levels, including arrangement for training in foreign countries to produce categories not available in Nepal, as well as provide financial and non-financial rewards to discourage "brain drain". ■ Ensures 23 health personnel, including 1 doctor per 10,000 people, with special consideration given to rural areas. ■ Provisions for educational opportunities, skills training and research opportunities. ■ Adopts effective measures, including financial as well as non-financial incentives, to discourage the migration of health personnel.[c] ■ Provisions for 'certain facilities and opportunities' for health workers in remote areas and their dependant family members. ■ Stipulates the formulation of a master plan with a projection and the human resource management and development to produce and supply the necessary health-related personnel.
Nepal Health Service Act, 1997[d]	■ Includes provisions for the management of health workers employed by the Ministry of Health. ■ Provides guidance on the recruitment, deployment, promotion, and discipline of health workers. ■ Provides more flexibility in the employment of health workers. ■ Provides rules on transfer, deputation and promotion. ■ Allows local contracting, partly to deal with staffing shortages and partly in line with the decentralization of management to facility level.
Nepal Medical Council Act, 1964[e]	■ Mandates the constitution and management of the Nepal Medical Council, which is responsible for managing the qualification of medical practitioners and their registration. ■ Confers upon the Nepal Medical Council the status of being autonomous, with functions that include: - providing accreditation as prescribed to medical/dental colleges engaged in teaching or training of medical education;

Policies	Major provisions related to health services and human resources for health management
	- determining policy as required for the smooth operation of the medical profession; - issuing registration licences to practise modern medicine by determining qualification of the medical practitioner and conducting prescribed licensing examinations of qualified medical practitioners; and - preparing code of conduct of medical practitioners.
Nepal Nursing Council Act, 1996[f]	■ Mandates the establishment of the Nepal Nursing Council – the body responsible for effectively managing the nursing sector and registering nurses according to their qualification. ■ Confers upon the Nepal Nursing Council the following functions, duties and powers: - prepare policies required for the smooth operation of the nursing business; - give recognition to nursing education institutes; - evaluate and review the curricula, terms of admission, examination system and other necessary terms and infrastructures of the education institute; - fix qualifications of nursing professionals, enter the name of a nursing professional having possessed the qualification in the register and issue a certificate of registration. - fix work limitation of nursing professionals; and - fix professional code of conduct of nursing professionals and take action against the nursing professional who violates such a code of conduct.
Nepal Health Professional Council Act, 1997[g]	■ Mandates and regulates the establishment of the Nepal Health Professional Council to ensure effective health service, mobilize the services of health professionals other than doctors and nurses and make provision on the registration of their names according to their qualification.
Second Long-Term Health Plan, 1997–2017[h]	■ Some of the provisions of the plan include: - improve the health status of the most vulnerable groups, particularly those whose health needs are often not met, the rural population, the underprivileged and the marginalized; - extend to all districts cost-effective public health measures and essential curative services for the appropriate treatment of common diseases and injuries; - provide the appropriate numbers, distribution and types of technically competent and socially responsible health personnel for quality health care throughout the country, particularly the underserved areas; - improve the management and organization of the public health sector and to increase the efficiency and effectiveness of the health care system; - develop appropriate roles for NGOs and the public and private sectors in providing and financing health services; and - improve inter- and intra-sector coordination and provide the necessary conditions and support for effective decentralization with full community participation.

Source: a= Government of Nepal: Constitution of Nepal 2015, www.lawcommission.gov.np/en/documents/2016/01/constitution-of-nepal-2.pdf (accessed 3 Apr. 2016); b= Government of Nepal: National Health Policy, 2071, www.mohp.gov.np/images/pdf/policy/1 per cent20National per cent20Health per cent20Policy per cent202071.pdf (in Nepali) (accessed 28 Apr. 2016); c= For specific programme, see the section on Strategies for Retention; d= Government of Nepal: Nepal Health Service Act, 2053 (1997), www.lawcommission.gov.np/en/documents/2015/08/nepal-health-service-act-2053-1997.pdf[Accessed: 3 April 2016]; e= Government of Nepal: Nepal Medical Council Act, 2020 (1963), www.lawcommission.gov.np/en/documents/2015/08/nepal-medical-council-act-2020-1964.pdf (accessed 3 Apr. 2016); f= Government of Nepal: Nepal Nursing Council Act, 2052 (1996), www.lawcommission.gov.np/en/documents/2015/08/nepal-nursing-council-act-2052-1996.pdf (accessed 3 Apr. 2016); g= Government of Nepal: Nepal Health Professional Council Act, 2053, www.lawcommission.gov.np/en/documents/2015/08/nepal-health-professional-council-act-2053-1997.pdf (accessed 3 Apr. 2016); h= MOHP, 2007.

3.2 INTERNATIONAL INSTRUMENTS RELATING TO RECRUITMENT OF HEALTH PERSONNEL

In addition to the national legislation, an important international instrument governing international recruitment of health personnel is the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010),[42] the major provisions of which are outlined in box 3.1. This document, which was formulated to address the challenges posed by the migration of health workers, does not aim to put an end to migration; rather, it is to guide member States in addressing and mitigating some of the detrimental effects of migration of health personnel, particularly in the countries of

BOX 3.1

World Health Organization's Global Code of Practice on the International Recruitment of Health Personnel (2010)

- The main objective of the Code is "to establish and promote voluntary principles and practices for the ethical international recruitment of health personnel, taking into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel" (article 1).
- The preamble of the Code states that the document is meant to be "a core component of bilateral, national, regional and global responses to the challenges of health personnel migration and health system strengthening".
- The Code presents guidelines for recruitment practices (article 4); provision for health workforce development and health system sustainability (article 5); guidelines for data gathering, research and information exchange; and instructions on the implementation of the Code and monitoring and institutional arrangements.
- The Code mandates that the international recruitment of health personnel should be in line with the aim of promoting the sustainability of health systems in developing nations (article 3.5).
- The Code also includes provisions on the effective gathering of national and international data and the sharing of information on international recruitment of health personnel (article 3.7).
- The Code also calls upon member States to adopt and implement effective measures aimed at "strengthening health systems, continuous monitoring of the health labour market, and coordination among all stakeholders in order to develop and retain a sustainable health workforce responsive to their population's health needs" (article 5.7).

[42] WHO, 2010.

origin. In particular, the Code is geared towards managing the migration of health workers more effectively by maintaining a balance between the right of an individual to move and people's right to health care, no matter the country. It encourages circular migration of health workers while discouraging active recruitment of health workers from countries that face shortages of health care personnel.[43] The effectiveness of the Code, however, has been questioned, given its non-binding nature and lack of enforcement mechanisms. There is also the need for sustainable funding required for the reforms encouraged by the Code.

Nepal is a member of the International Council of Nurses, which adopted some of the provisions outlined by the ILO Nursing Personnel Convention, 1977 (No. 149) and its accompanying Nursing

BOX 3.2

International Council of Nurses: Position statement on the ethical recruitment of nurses (2002)

- The International Council of Nurses (ICN) and its member associations believe that quality health care is directly dependent on an adequate supply of qualified and committed nursing personnel and support the evidence that links good working conditions with quality service provisions.
- ICN recognizes the right of individuals to migrate and confirms the beneficial outcomes of multicultural practice and learning opportunities supported by migration. The ICN acknowledges the adverse effect that international migration may have on health care quality in countries seriously depleted of their nurse workforce.
- ICN condemns the practice of recruiting nurses to countries where authorities have failed to implement sound human resource planning and to seriously address problems that cause nurses to leave the profession and discourage them from returning to nursing.
- ICN denounces unethical recruitment practices that exploit or mislead nurses into accepting job responsibilities and working conditions that are incompatible with their qualifications, skills and experience.
- ICN and its member national nurses' associations call for a regulated recruitment process based on ethical principles that guide informed decision-making and reinforce sound employment policies on the part of governments, employers and nurses, thus supporting fair and cost-effective recruitment and retention polices.

Source: ICN, 2002.

[43] Connell, 2010, pp. 17–20.

Personnel Recommendation, 1977 (No. 157) relating to ethical international recruitment of nursing staff. Box 3.2 outlines a framework for action that can be incorporated into policy development. Article 67 of the Nursing Personnel Recommendation states that recruitment of foreign nurses should be authorized only if: (a) there are no qualified personnel in the country of employment to fill those positions; and (b) if the employment of the nursing personnel does not cause shortage in the country of origin. The extent to which these provisions are adhered to in Nepal as well as in the country of destination remains a question.

3.3 OTHER REGULATIONS AFFECTING FLOW OF HEALTH WORKERS

Notwithstanding the importance of these policy frameworks, changes in regulations in origin and destination countries impact the flow of migrants. For instance, the Nepal Ministry of Education in 2011 issued a directive limiting the role of educational agencies from disseminating information on post-education employment opportunities;[44] this may have had a significant impact on medical and nursing students seeking to migrate abroad as they may not have had avenues for help other than relying on self-research or information received from friends and family knowledgeable about the field. Likewise, the immigration and integration policies in countries of destination directly impact the immigration and employment of foreign health workers from Nepal. As the president of the Educational Consultancy Association of Nepal explained: "If those countries are receptive, if they have greater tendency of providing visas, then many students [from Nepal] go to that country that year. If the visa policy is strict, [Nepali] students start going to other destinations. For example, prior to 2002, Australia used to give out around 230 visas [to Nepali students]. It started increasing from the year 2005 and at one point they gave visas to 11,039 [Nepali] students. Then, they gradually started becoming strict. Last year, they gave out visas to only 3,082 [Nepali] students. The Australian Government used to accept documents from 16 commercial banks, but now they have reduced that to two."

Likewise, the annual inflow of Nepali nurses into the United Kingdom[45] has experienced significant fluctuations over the years. It peaked in 2007 and 2008, when 148 and 117 nurses entered the United Kingdom, respectively, and then dipped to four nurses and three nurses in 2009 and 2010, respectively.[46] The annual inflow of Nepali doctors to the United Kingdom also peaked in 2005, with 33 doctors entering the United Kingdom that year. But this figure dropped to 16 in 2006.[47] These changes were partly triggered by a number of legislative changes in the country. Doctors in 2005 and then nurses in 2006 were removed from the professional shortage list, obliging employers to give priority to recruiting personnel from within the European Union. Since 2006, non-European doctors holding a training position were also required to have a work permit. Also in 2005, the Nursing and Midwifery Council instituted the Overseas Nurses Programme, a compulsory orientation course for nurses who wanted to practise in the United Kingdom, while the number of seats in this programme was also limited. In 2007, requirement of English language proficiency was raised from 6.5 to 7

[44] Education Consultancy Service and Language Instruction Directive, 2068.
[45] The report uses the United Kingdom as an example because it is the only country for which annual data on both doctors and nurses are available.
[46] OECD, undated.
[47] ibid.

in the International English Language Testing System and, by 2013, the procedures for foreign nurses interested in seeking employment were made more complex with the inclusion of an online theoretical exam as well as practical assessment. In 2008, the United Kingdom had introduced the points-based system immigration policy which allowed foreign doctors to come to the United Kingdom without a prior job offer but this policy was revoked in 2010.[48]

3.4 STRATEGIES FOR RETENTION OF HEALTH WORKERS

The scant policy attention to migration of health workers is reflected in the absence of effective retention programmes of the Government of Nepal. Members of the NNC, NMC and NHPC interviewed for this study stated that they were not aware of any such programme directed towards the retention of health workers from migrating abroad. The majority of retention programmes formulated have been to primarily address the challenges of rural retention. For instance, the Nepal Health Sector Programme, 2004–10 introduced a bonding scheme that mandated physicians who studied under government scholarship to complete a compulsory two-year service in rural health facilities.[49]

The effectiveness of such a measure to retain health workers for the long term has been mixed. As a Ministry of Health official noted, "Even if a student receives scholarship, he or she works for two years, gets a good opportunity and goes abroad."[50] Likewise, WHO officials stressed that compliance with the bonding scheme is fraught with questionable practices, such as paying off individuals to acquire a posting in an urban area.[51] Further, the five-year bond for those completing their postgraduate degree on government scholarship is thought to be impractical. As a medical officer explained, "In exchange for doing a three-year postgraduate degree, we need to work in a rural area for five years for NPR40,000 a month. Those five years are our peak time. If we go to the village for such duration, all will be lost. There is still no proper set-up in the rural areas. Just recently I heard about a case in Narayani where an operation was done using a torch. What will we do in such places?" Another participant added, "Plus, your skills will degrade. We won't use what we learn."

The Nepal Health Sector Programme introduced financial incentive packages to retain doctors, nurses and technicians in rural areas.[52] The second phase of the programme (2010–15) recognized the shortage of health workers, especially the deployment and retention of essential health workers in rural and remote areas, as a key challenge to human resource for health management.[53] Apart from these initiatives, there were no programmes to specifically address the retention of health workers within the country.

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[48] OECD, 2015.
[49] MOHP and NHSSP, 2013; see www.mohp.gov.np/images/pdf/guideline/Guideline-for-Mobi-of-Sch_Doctor.pdf (accessed 13 June 2016).
[50] Interview with MOH senior public health administrator, 8 Apr. 2016.
[51] Interview with WHO officials, 10 May 2016
[52] ibid. The MOH and NHSSP, 2013 report discusses various incentive schemes under consideration, but none have been endorsed to date. At the time of this study, the only intervention that was found to have been implemented is the Rural Staff Support Programme, a pilot programme implemented by the Nick Simons Institute and the Government in three government hospitals (NSI, 2010). During the course of the interviews, some medical students, as discussed in section 4.3, mentioned incentives, such as provisions for non-practising allowances, overtime stipends, pensions and yearly bonuses, as benefits they can access in government institutions.
[53] MOHP and NHSSP, 2013.

4. INTENTIONS, DRIVERS AND CHANNELS OF MIGRATION

A host of factors in countries of origin and destination help drive the out-migration of health workers. While the literature has largely attributed such out-migration to wage differentials between locations, later works have pointed to a variety of other reasons including the significance of household choice to diversify risks and distribute human capital across several markets.[54] The following sections present findings from the survey conducted as part of this study to understand the migration intentions among final-year students from two medical and six nursing colleges in the Kathmandu Valley. It is important to emphasize here that the findings are merely based on declared migration intentions and do not reflect the actual migration outcomes.

4.1 PROFILE OF PARTICIPANTS

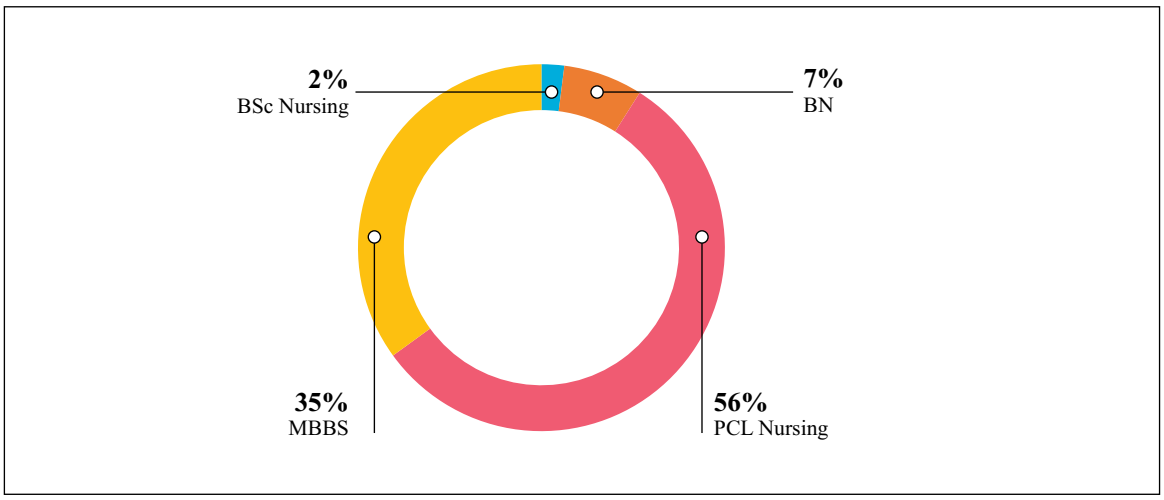
A total of 294 final-year medical and nursing students were included in this survey. Of them, 189, or 64.2 per cent, of the sampled population were nursing students, while 104, or 35.4 per cent, were medical students completing their internship requirement. Of the nursing category, respondents were further stratified on the basis of the three major programmes[55] they were enrolled in: Bachelor of Science (BSc) in Nursing (2 per cent), Bachelor in Nursing (BN) (6.8 per cent) and Proficiency Certificate Level (PCL) Staff Nursing (55.4 per cent)[56] (figure 4.1). The age group of the respondents ranged from 17 to 37 years.

[54] Stark, 1991; Glinos et al., 2011; Amani and Poz, 2014.

[55] Although nursing education in Nepal comprises five programmes, the study focused on PCL Staff Nursing, BSc Nursing and Bachelor in Nursing because they are the most widely offered courses in Kathmandu Valley. PCL Staff Nursing is a three-year course that can be pursued on the completion of a school-leaving certificate. There is a total of 96 institutes offering the course in Nepal, 34 of which are in Kathmandu Valley. The Bachelor in Nursing is a three-year course, which students are eligible to enroll into on completion of the PCL Staff Nursing and two years of work experience. Across Nepal, 33 institutes offer this course; 18 of them are located in the Kathmandu Valley. The BSc Nursing programme is a four-year course, for which students can apply on the completion of high school or equivalent level of education. There are a total of 39 institutions offering the course in Nepal, of which 20 are located in the Kathmandu Valley (see Nepal Nursing Council Database, www.nnc.org.np/pages/search-institute/index.php#srh (accessed 9 June 2016).

[56] The numbers are skewed towards the PCL program not only because it has a larger annual intake, compared with the other programme, but also because the majority of the colleges that were sampled were institutions offering only the PCL Staff Nursing programme. This was the result of the random sampling design.

Figure 4.1. Composition of survey participants, by course degree



Note: BSc Nursing=Bachelor of Science in Nursing; BN=Bachelor of Nursing; PCL Nursing=Proficiency Certificate Level in Nursing; and MBBS=Bachelor of Medicine, Bachelor of Surgery.

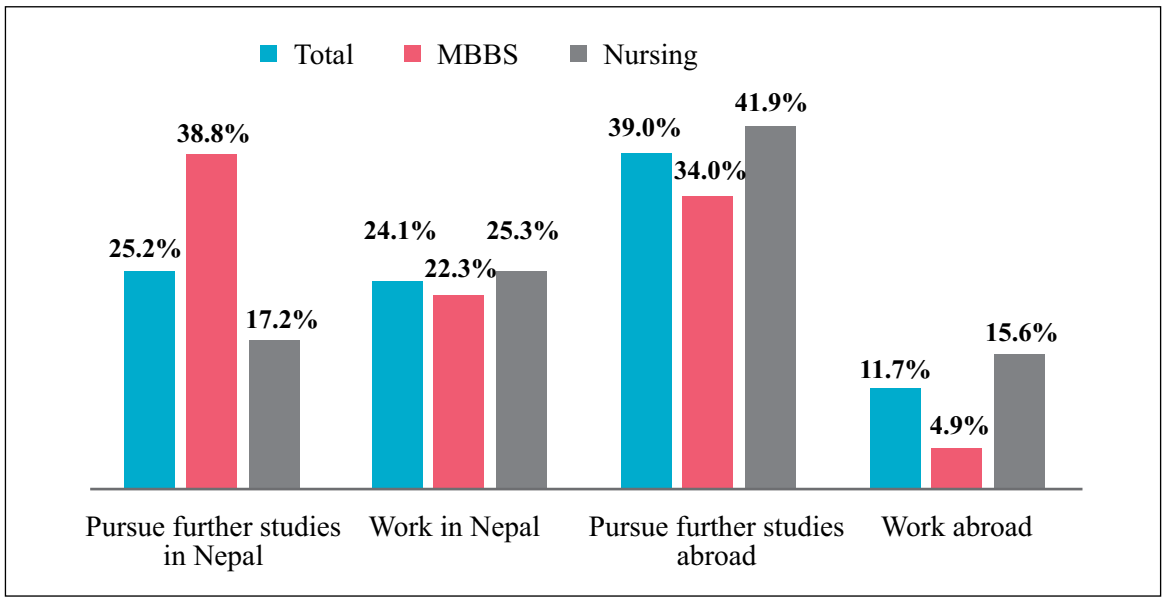
By sex, 40 participants were male (13.6 per cent), and 252 were female (85.7 per cent).[57] The skewed distribution reflects the larger number of participants from nursing programmes where almost all the students are female. Consistent with the ethnic distribution in the Nepali health sector (see section 2.1), the three dominant caste or ethnic groups represented amongst the student participants were: Bahun (at 26.2 per cent), Chettri (at 20.7 per cent) and Newars (at 19.4 per cent). The largest proportion of participants, at 22.8 per cent, was from Kathmandu, followed by 11.9 per cent from Lalitpur and 9.9 per cent from Bhaktapur. A small majority of participants, at 159 (54.1 per cent), were from middle-income households.[58] Almost all of the participants, at 272 (92.5 per cent), were unmarried. Somewhat consistent with their place of origin, 30.6 per cent of the participants had completed their secondary schooling from Kathmandu, followed by 16.3 per cent from Lalitpur, and 8.8 per cent from Bhaktapur. An overwhelming number of participants, at 219 (74.5 per cent), had attended private school for their secondary education, compared with 55 participants (18.7 per cent) who had gone to public school.

4.2 INTENTION TO MIGRATE AND THE PREFERRED DESTINATIONS

The survey revealed that a total of 147 participants (more than 50 per cent) planned to migrate abroad to either pursue further studies (39 per cent) or to work (11.7 per cent) upon completion of their degree programme in Nepal. Only 73 participants (25.2 per cent) intended to stay in Nepal to pursue higher-level studies, while 70 participants (24.1 per cent) planned to work in Nepal (figure 4.2).

[57] While the total number of surveyed respondents was 294, the discrepancy in numbers here is due to missing data in relation to the sex of the participants.
[58] Three income categories were derived from an earlier study (see Huntington et al., 2012, pp. 417–428.) These categories were: total family income of less than NPR25,000 per month (low income), NPR25,000–NPR60,000 (middle income) and more than NPR60,000 (high income).

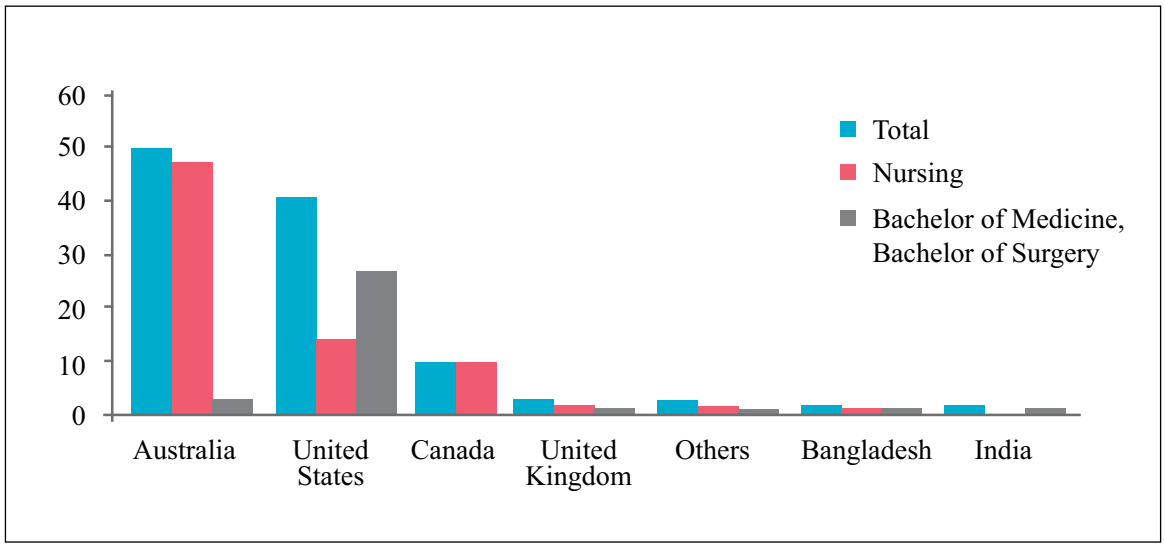
Figure 4.2. Migration intentions of research participants



Note: MBBS= Bachelor of Medicine, Bachelor of Surgery.

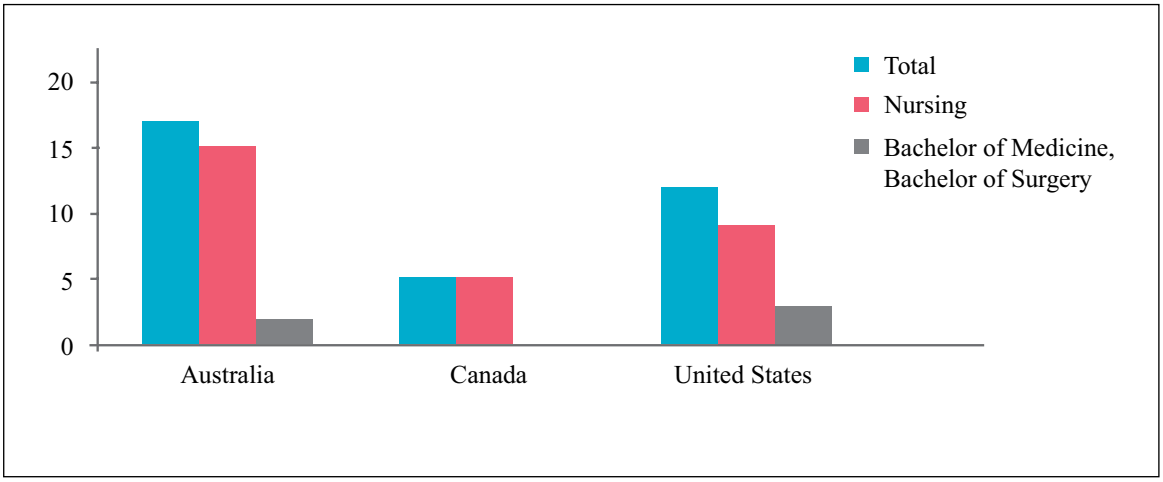
Among those who wanted to migrate abroad to pursue further studies, Australia (at 44.2 per cent), the United States (at 36.3 per cent) and Canada (at 8.8 per cent) emerged as the top destinations of choice. However, there were variations between the two categories of health workers – Australia was the top choice to pursue further studies for nursing students, while the United States was the top choice for medical students (figure 4.3). These findings are in sharp contrast with the data provided by the NMC in which the top-three destinations for postgraduate studies among medical students and doctors were China, India and the Philippines. While the NMC records reveal the reality in terms of where Nepalis generally go, either for further studies or for employment, the survey sheds light on the aspiration of those pursuing careers in the health sector, which explains the discrepancy.

Figure 4.3. Aspiring destination to pursue further studies abroad (in numbers)



With regards to employment abroad, only three destinations were cited by those who wanted to migrate for work. As shown in figure 4.4, these were the traditional migrant-receiving countries for medical professionals: Australia (50 per cent), the United States (35.3 per cent) and Canada (14.7 per cent).[59]

Figure 4.4. Aspiring destination for working abroad (in numbers)



There are several factors that help explain the choice of destination, including the actual outcome. According to the interviews conducted, migration to such destinations as Australia and the United States seldom occur at the undergraduate level because the costs are high and the study programmes are time-consuming. For Australia, the estimated tuition fee for a medical degree per year is AU$60,000–AU$80,000, excluding living expenses. In the United States, students are required to take a four-year pre-medicine degree before they can apply to a medical school. Hence, it typically takes eight years to complete a medical degree in the United States.[60] Comparatively, pursing an undergraduate degree in countries like Bangladesh, China or the Philippines is much cheaper, ranging from $20,000 to $30,000 for the entire programme. That is even cheaper than studying in Nepal, where costs range from $37,000 to $56,000.[61]

Despite the lower costs associated with pursuing postgraduate studies in Nepal or other parts of Asia, students still aspire to go to countries in Global North for various reasons. First, due to limited seats for postgraduate courses in Nepal, enrolment in medicine and nursing is extremely competitive.[62] Likewise, the seats for residency are not fixed, and it depends on the number of hospital beds and the number of professors available.[63] As one medical officer explained, “It is very, very tough to get a place in a residency programme in Nepal. Every year around 2,500 students graduate with a [Bachelor of Medicine, Bachelor of Surgery] degree. However, there will only be 250 [positions for residency] across Nepal. This can stretch up to 300 maximum. If 2,500 medical officers are vying for those [positions] every year, it definitely becomes bottleneck competition.”

[59] Australia, Canada, United Kingdom and United States remain primary destination countries for health workers migrating from all over the world, including China, India, Pakistan, the Philippines and South Africa. See Khadria, 2010; Labonte et al., 2015, p. 82; OECD, 2015.
[60] Interview with the president of the Educational Consultancy Association of Nepal, 10 May 2016.
[61] Interviews with the managing director of Orbit Medical Entrance Pvt. Ltd, 28 Mar. 2016 and the managing director of Seven Educational Consultancy Pvt. Ltd, 9 May 2016.
[62] Interviews with three consultants and two returned doctors and one prospective doctor.
[63] Group interview with medical officers, 13 June 2016.

Said another medical officer: "To find residency positions in the institution of your choice or in Kathmandu, to be specific, is extremely difficult. It is almost close to impossible. Not every specialization is available in all the colleges in the first place. For instance, the trend at the moment is to specialize in radiology. If you want a seat in radiology in Kathmandu University, you have to rank first in the written exam, as there is only one position every year."

The situation is similar for nurses. The group interview with nurses revealed that there are only two institutes for all of Nepal, and they offer only 20 seats for a Master in Nursing degree, compared with the annual graduation of 4,000 nurses with a bachelor's degree in nursing.

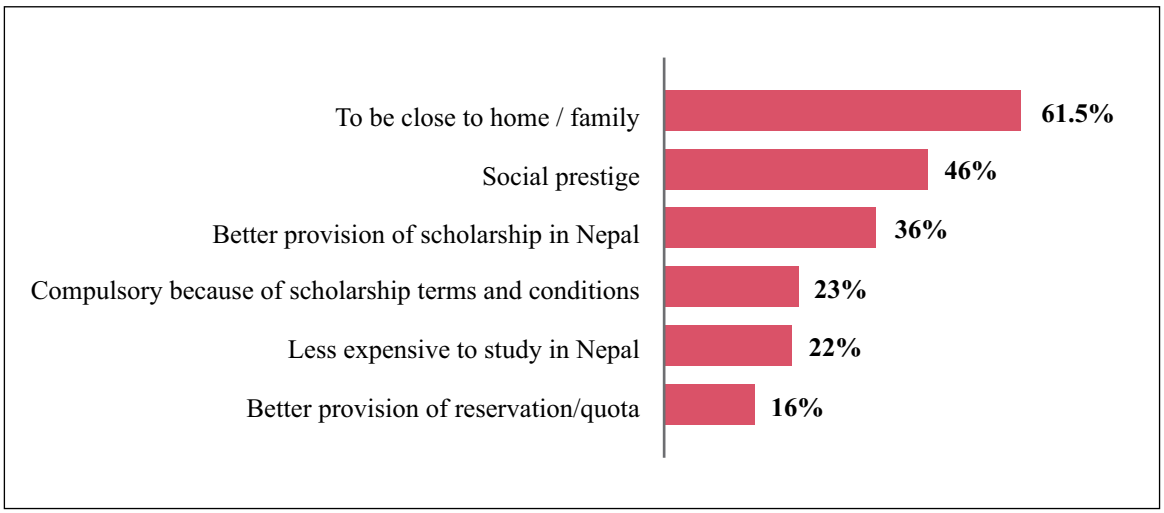
Other factors that influence the choice of country are individuals' plan for long-term (permanent) settlement abroad, better pay[64] and working conditions as well as better quality life.[65] Because health workers invest significant amounts of money for their education as fee-paying students, whether in Nepal or abroad, they have to find commensurate work that allows them to at least recover their investment or to repay their loans.

4.3 DECISIONS TO STAY HOME

Among the 73 respondents who stated that they wanted to stay in Nepal to pursue further studies, 32 were studying nursing and 40 were doing their Bachelor of Medicine, Bachelor of Surgery (MBBS) degree course.[66] The primary reason for wanting to stay in Nepal was to be close to home and family – 61.5 per cent of those who expressed their intention to stay in Nepal marked this as "very important". This was followed by other factors, such as social prestige (45.5 per cent) and better provision of scholarship in Nepal (36.4 per cent)[67] (figure 4.5). Notably, monthly family income also seemed to have a bearing on the intention to stay in Nepal. In particular, the survey results indicate an inverse relationship between monthly family income[68] and decision to stay – 55.7 per cent of participants in the low-income bracket expressed their plan to remain in Nepal, compared with 49.4 per cent from the middle-income category and 37.5 per cent from the high-income category.[69]

[64] Nurses reportedly earn about AU$50,000 to AU$80,000 annually in Australia. Similarly, in the United Kingdom, nurses earn from a low of £16,000 up to £78,000 annually.
[65] Interviews with two education consultants.
[66] One respondent did not respond.
[67] This was a multiple choice question for which individuals were asked to rank each item. The listed percentage is in accordance with what the respondents ranked as "very important".
[68] Low-, middle- and high-income brackets indicate respondents whose family income was less than NPR25,000 per month, NPR25,000–NPR60,000 per month and NPR60,000 per month, respectively. These categories were derived from Huntington et al., 2012, pp. 417–428.
[69] There were nine non-responses for this question.

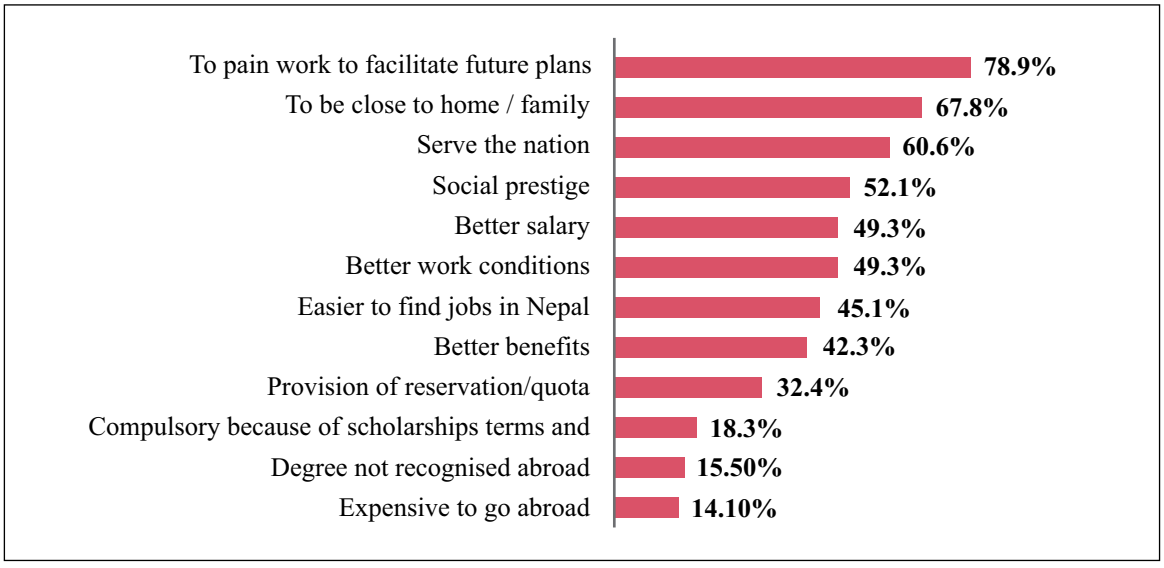
Figure 4.5. Reasons for staying in Nepal to pursue further studies



Note: The factors mentioned in the figure indicate issues that were ranked as "very important".

Among the 70 respondents who wanted to stay in Nepal to work, the main reason reported was to gain work experience that would support their future plans (78.9 per cent). Unfortunately, the survey did not include a question on what the future plans could be. However, medical officers in the group interview mentioned that those who opt for employment in within the country upon completion of their MBBS were mostly the ones intending to apply for residency in Nepal, and work experience is a requirement for residency.[70] Other reasons cited for wanting to stay in Nepal to work included being close to home or family (67.8 per cent) and aspirations to serve the nation (60.6 per cent) (figure 4.6). One influencing factor that might have caused respondents to indicate "being close to family" as very important could be their marital status: among those who wanted to stay in Nepal, 60 per cent were married.

Figure 4.6. Reasons for wanting to work in Nepal



Note: The factors mentioned in the figure indicate issues that were ranked as "very important".

[70] The duration of the requisite work experience for residency keeps changing but ranges from one to two years. Group interview with doctors, 13 June 2016.

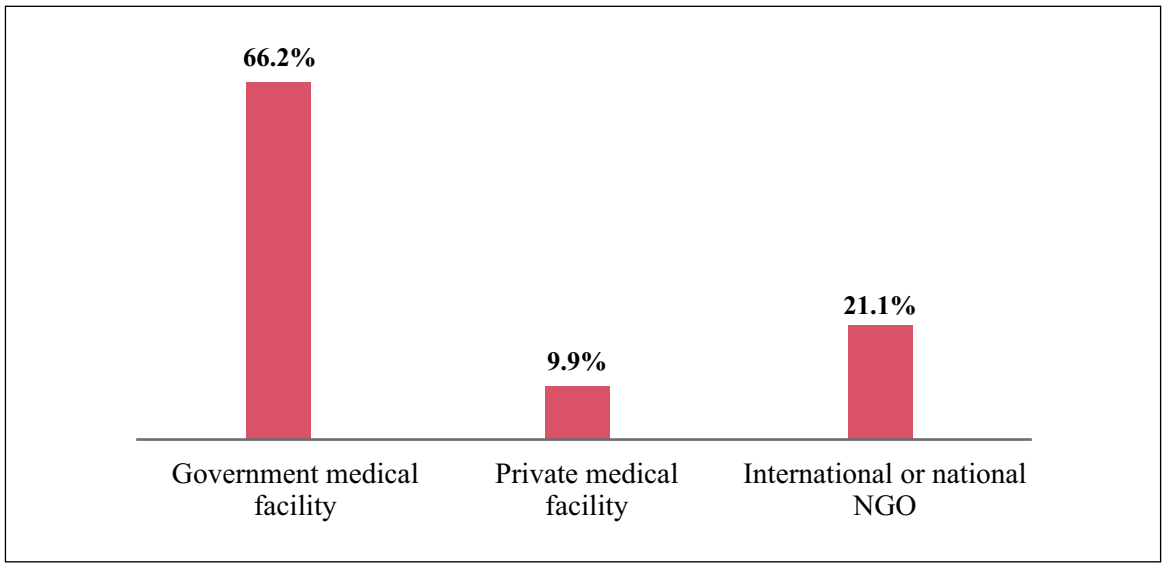
Lalitpur, it also helps explain why there might be a chronic shortage of health workers in the rural areas. Other reasons repeatedly mentioned for wanting to remain in Kathmandu, particularly the urban centres of Kathmandu and Lalitpur include: (i) lack of proper incentives or education and employment opportunities for health care workers and their family in rural areas; (ii) lack of a proper or quality health system outside of Kathmandu Valley, which would allow health workers to provide quality service while also enhancing their own skills and knowledge; and (iii) poor quality of life in rural areas, compared with the cities.

As one returned doctor mentioned, "If the people are in an urban area, the wife of the doctor also gets employment opportunities, which is not possible in rural areas. Further, the education of children is also good in the urban centres. There is no incentive for doctors to stay in rural areas."

Another respondent working in a public hospital mentioned the poor provisions and monetary gains through rural service: "If you stay here [in Kathmandu] as a consultant, you earn up to NPR100,000 rupees a month, whereas the salary for those going to rural areas is merely NPR40,000 a month, with no facilities and inadequate resources and equipment. It is demoralizing. Further, the skills that we learn here will not be utilized there. There is no place to apply your skills and use what we learn."

In terms of the type of institutions that medical students aspired to work in, the main preference for an overwhelming 66.2 per cent was a government institution (figure 4.7). As pointed out during the course of the study, the main reasons for wanting to work in government institutions included provisions for non-practising allowances, overtime stipend, pensions, yearly bonus, stipulated annual leave in addition to the basic salary. On the contrary, health professionals in the private sector only receive monetary compensation for the hours they work.[71]

Figure 4.7. Workplace preference of medical and nursing students



[71] Group interview with medical officers, 13 June 2016.

The preference for a government institution was the same among nurses, and here, too, pay and perks were the main considerations. Nurses in public hospitals with the permanent jobs earn up to NPR32,000 per month in addition to allowances and benefits as per government rules, compared with nurses in private hospitals, who earn as little as NPR5,000 a month and nothing more.[72] Also, because their salary is determined in part by the number of beds they attend to and because public hospitals tend to have more beds, nurses' salaries tend to be higher in public institutions.

The non-government sector also scored higher than private institutions, with the largest preference for organizations engaged in the medical field, such as the WHO, the United Nations Children's Fund, the World Food Programme, the Association of Medical Doctors of Asia and the Red Cross.[73] The attraction of these organizations was attributed to their reputation as leaders in the international field as well as the perceived prospects for quick career advancement.

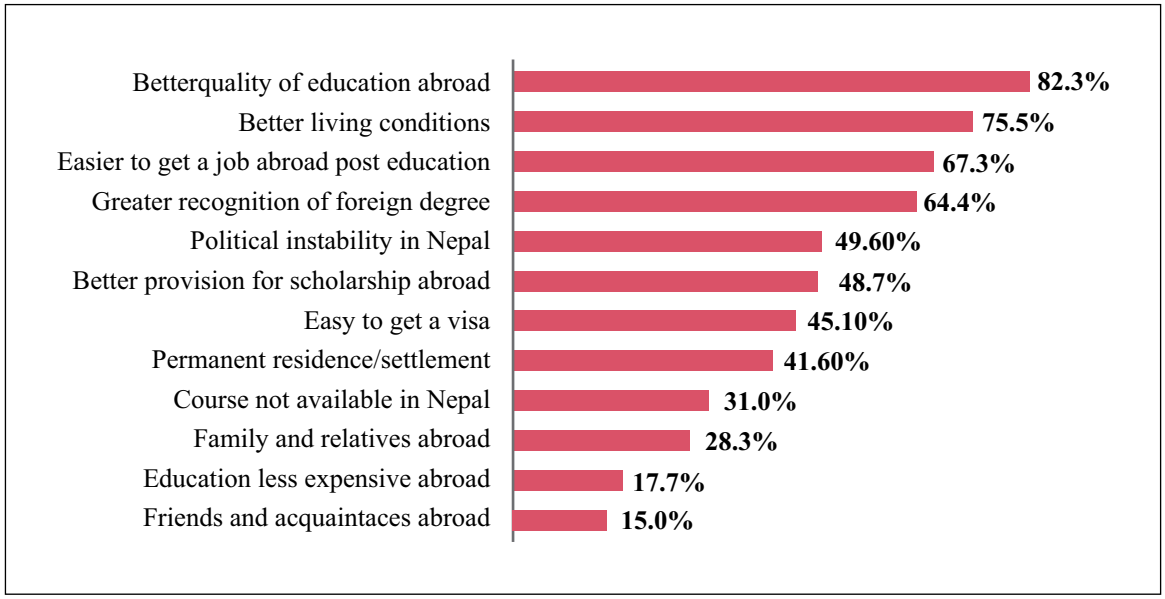
A crucial aspect of human resources for health in Nepal has been the overproduction of doctors and nurses due to the liberal distribution of licences to new educational institutions, arguably to ensure the availability of health personnel to serve in rural areas. But the reality is different. A senior health bureaucrat said that hardly 10 per cent of the new doctors licensed annually opt for rural services because it is seen as detrimental to professional growth in terms of non-use of skills acquired, in addition to the inadequate salary and lack of social recognition, which comes in urban settings. This is partly because the Government has not created proper infrastructure for health personnel to practise in rural areas, especially in terms of adequate resources and equipment. The inadequate transport infrastructure in the rural areas also impedes patient flow. Further, given the centralization of specializations in the urban centres, particularly in Kathmandu, there is little scope for consultants to practise effectively in rural areas. Hence, health workers who cannot find employment in urban centres opt for emigration.[74]

4.4 DRIVERS OF MIGRATION

Of those planning to migrate abroad for further studies, the most cited reasons were better quality of education (82 per cent), better living conditions (74 per cent) and ease of securing a job abroad afterwards (67 per cent) (figure 4.8).[75]

[72] Interview with the president of Nepal Nursing Association, 6 May 2016. This was further corroborated by group interviews with nurses on 13 June 2016 and 23 June 2016.
[73] Group interview with doctors, 13 June 2016.
[74] Group interview with doctors, 13 June 2016. Also, Dixit, 1998, p. 1.
[75] This was a multiple choice question in which individuals were asked to rank each item. The listed percentage is in accordance with what the respondents ranked as "very important".

Figure 4.8. Factors ranked as "very important" as reasons for pursuing studies abroad



Both doctors and nurses agree that a foreign degree is recognized worldwide and provides better career prospects. At the same time, medical professionals also have a strong desire to receive exposure through training opportunities to learn about new practices and modern technologies and equipment. These are not available in Nepal. For instance, in the case of nurses, a majority of them find no prospect of professional growth in Nepal. They also find that their work in Nepal is increasingly losing respect due to worsening working conditions, such as long working hours and less remuneration.[76]

Nurses seem to prefer to migrate to countries like Australia and the United States because they see the possibility of engaging in part-time work even as they pursue their studies. As a returned nurse from Australia said, "Although expensive, Australia is the land of opportunity. I was convinced that the nursing course in Australia has more scope for job placement. It is a respected job. There are people who have done full-time jobs, working overtime and even studying and working at the same time. And, if you are talented enough, there is the possibility to reach higher positions as well." A prospective migrant doctor to the United States said, "If I get a licence from the United States, I can go and work anywhere in the world. But if I have a licence from here, it is not necessarily valid in other countries."

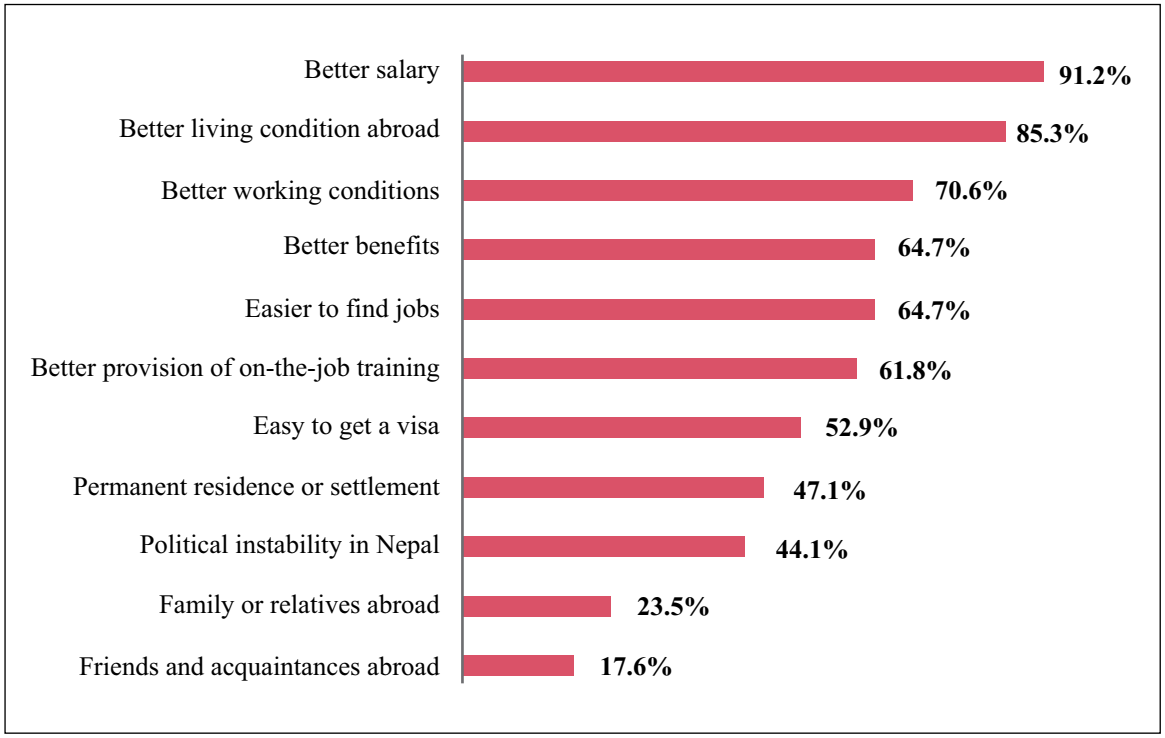
There were, however, some variations between doctors and nurses in their reasons for further studies abroad. While 75 per cent of the nurses marked easier access to job after completion of education abroad as important, only 49 per cent of the doctors thought so. This is consistent with the general situation in which doctors are more easily employed than nurses, particularly because doctors have alternative avenues of job security, such as opening their own clinic.[77]

[76] Based on interviews with three returned nurses.
[77] Interview with a returned doctor, 3 May 2016 and WHO officials, 10 May 2016.

Nurses find it difficult to get a job after their education because of the underutilization of nurses in hospitals.[78] As the president of the Nursing Association of Nepal explained, "The nurse-to-patient ratio should be three nurses per one operation table, and there should be nurses equal to the number of general and intensive care unit beds. However, the hospitals in Nepal are not following these rules, not even the government hospitals. One nurse in our government hospital does the work of seven nurses."[79] Similarly, a Ministry of Health official explained, "To study medicine is very expensive. It costs at least NPR5.5 million–NPR5.6 million. People sell their land for this. That is why the NPR26,000 salary the Government provides is not enough for them. You cannot get returns on your investment immediately, so they go abroad. Even if a doctor gets a government job and spends six months in the rural areas, they will go abroad as soon as they start thinking about their loans."[80]

The reasons for migration are somewhat different when individuals choose to migrate for work (figure 4.9). The top-three factors cited as motivating people to migrate were better salary (91.2 per cent), better living conditions abroad (85.3 per cent) and better working conditions (70.6 per cent).[81]

Figure 4.9. Factors ranked as "very important" as reasons for working abroad



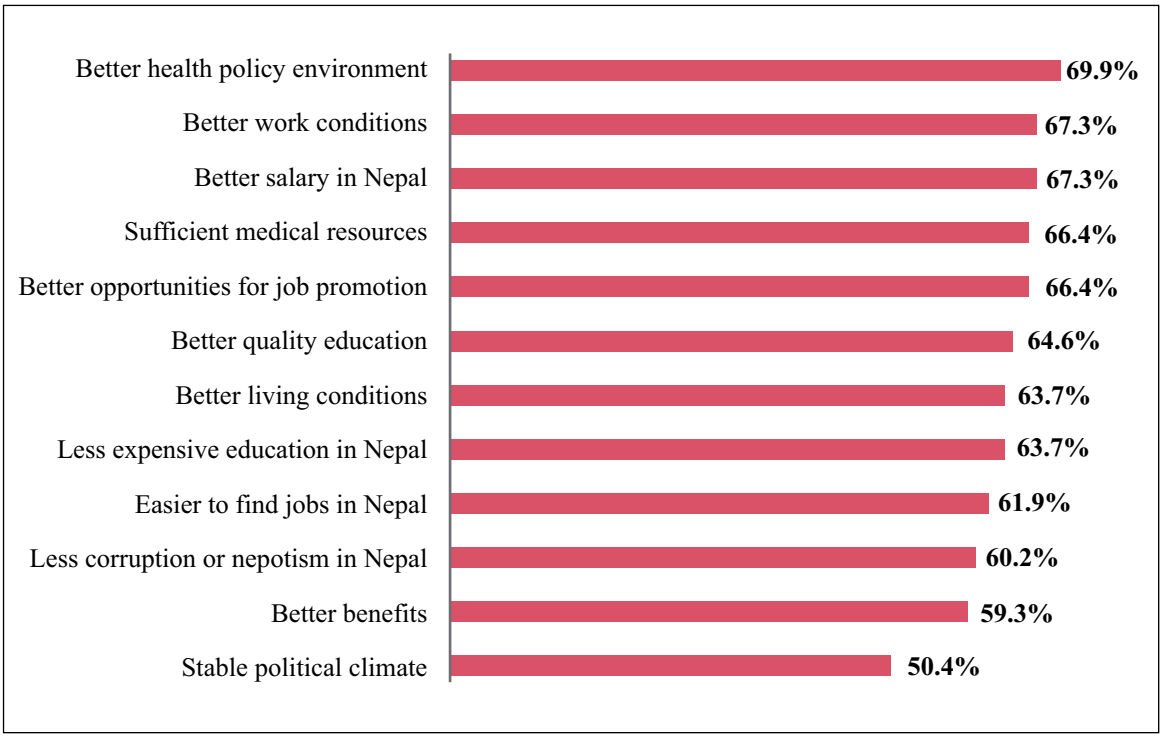
[79] Interview with the NNC registrar, 6 Mar. 2016.
[80] Interview with a MOH senior public health administrator, 8 Apr. 2016.
[81] This was a multiple-choice question for which individuals were asked to rank each item. The listed percentage is in accordance with what the respondents ranked as "very important".

In terms of remuneration, there is wide disparity in what one earns in Nepal and what one earns abroad. As a medical officer pointed out, "In India, a medical officer earns 60,000 Indian rupees (INR) (equivalent to NPR96,000). Recently, it was increased to INR65,000. In Nepal, it is a maximum of NPR27,000–NPR28,000 rupees. This is for private hospitals. In the government sector, it is NPR22,000–NPR23,000. The Government has announced an increase by 25 per cent, although it has not been implemented yet. Once you are a [consultant physician],[82] if you go to places like Australia or the United States, your starting salary will be approximately NPR1.2 million rupees, whereas here it will be merely NPR100,000. Why would anyone want to come back?"

The view of a nurse reflected a similar disparity in her profession: "Abroad, even if you work part time, you can earn up to NPR100,000 a week. Here, you earn merely NPR10,000. Why would anyone want to stay in Nepal?"

To further understand the drivers of migration, respondents were also asked under what conditions they would not migrate. Among those who wanted to migrate abroad to pursue their studies, the primary factors cited that would dissuade them from migrating were: better health policy environment[83] (69.9 per cent), higher salary (67.3 per cent) and better working conditions[84] (67.3 per cent) (figure 4.10).[85]

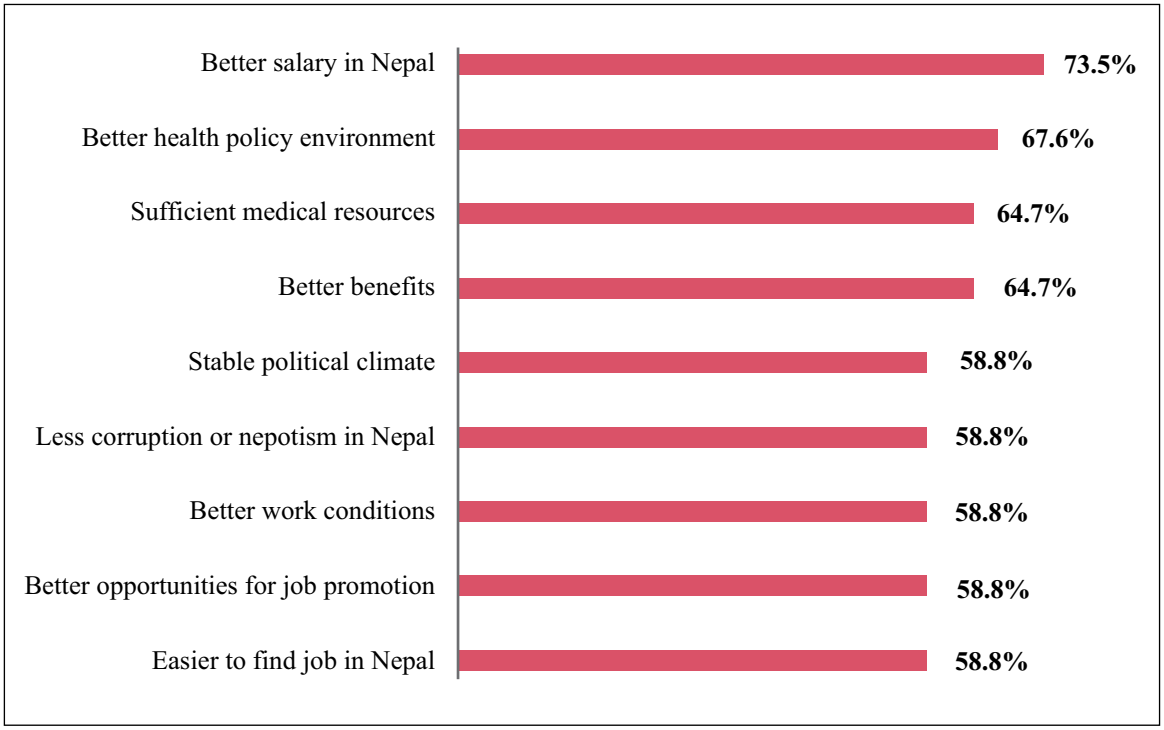
Figure 4.10. Conditions under which health workers would not migrate for study abroad



[82] Consultant physicians are senior doctors who specialize and practise in a particular medical field. Unlike a general physician, they are responsible for establishing a diagnosis and providing treatment where appropriate.
[83] Health policy environment refers to policies regulating health sector.
[84] In the survey, examples of "better work conditions" included flexible work hours and occupational safety.
[85] This was a multiple-choice question in which individuals were asked to rank each item. The listed percentage is in accordance with what the respondents ranked as "very important".

Likewise among those who wanted to migrate to work abroad, the top factors that would dissuade them from seeking to migrate were: better salary in Nepal (73.5 per cent), better health policy environment (67.6 per cent), better benefits (64.7 per cent)[86] and sufficient medical resources (64.7 per cent)[87] (figure 4.11).

Figure 4.11. Conditions under which health workers would not migrate for work abroad



A significant number of respondents also mentioned that nepotism, favouritism and corruption, along with the fragile political situation, are some of the push factors in the migration of health workers. For instance, a prospective migrant doctor to the United States remarked: "If you know people in Nepal, you will easily get a promotion."

And a returned doctor from China said, "I would have studied in Nepal. However, the Maoist-led insurgency movement was intensifying in Nepal. I knew I would not be able to perform well if I studied in Nepal. That was the only reason I decided to go abroad."

And a prospective migrant doctor to the United States said, "The Nepali education system is such that people are promoted to the post of professors based on nepotism. And, they are the ones who eventually reach the higher posts and formulate the education and health policies. When nepotism overrides, capable people do not get opportunities to reach good posts."

[86] In the survey, the examples of better benefits included pension, housing facilities and paid leave.
[87] This was a multiple-choice question in which individuals were asked to rank each item. The listed percentage is in accordance with what the respondents ranked as "very important".

To sum up, when the reasons for migration, either for work or study, are compared with factors that would dissuade potential health workers from migrating, the reasons are mostly the same – better quality education, living conditions, better salaries and better working conditions. These are structural issues that are perhaps difficult to address in the immediate term. However, issues such as better health policy environment in terms of regulation of the health care system and sufficient medical resources are factors that can be addressed in the near term and perhaps lead to immediate action if Nepal is to consider addressing the migration of its health personnel more seriously.

4.5 CHANNELS AND PROCESS FOR MIGRATION

The official process of migration for health personnel is stipulated in the 2007 Foreign Employment Act, whether they apply for a vacancy abroad on their own or through a recruitment agency. In the case of the latter, the recruitment agency needs to have received a demand letter for workers from employers in destination countries. After the demand is examined by the Department of Foreign Employment, the recruitment agency is granted pre-approval, following which the agency needs to advertise the vacancy for seven days. Thereafter, prospective workers are selected, and the visa process begins. Once all the formalities, such as medical check-ups, pre-departure orientation and a deposit into the Foreign Employment Welfare Fund are fulfilled, the recruitment agency is granted final approval to send workers abroad.[88] If workers seek foreign employment on their own, which is a channel largely used by medical professionals,[89] an application is made to the Department of Foreign Employment stating the country of migration, the nature of work, the letter of approval from the employer institution, the agreement letter, a certificate demonstrating that the applicant has participated in orientation training and a medical certificate.[90]

The findings from this research, however, indicate that few, if any, recruitment agencies directly engage in the process of facilitating the migration of health personnel. And few health professionals utilize the regular migration channels. This is primarily for three reasons, as follows.

First, unlike general migrants, health workers cannot simply migrate and begin working. The process of registration of medical professionals from foreign countries varies from country to country. The most common requirement in all countries to get registered as an overseas health professional is a transcript and a licence to practise in their home country. Some countries grant foreign health workers permission to practise on the basis of their documents and sponsorship from employment agencies. In the more desirable countries, however, medical councils have set up examinations to ensure that foreign doctors and nurses are eligible to practise in their country. Some of these include the United States Medical Licensing Exam, the National Council Licensure Examination for Registered Nurses and the National Council Licensure Examination for Practical Nurses in the United States; the Professional and Linguistic Assessment Board and the Nursing and Midwifery Council's computer-based test in the United Kingdom; and the Australian Medical Council's examination in Australia (table 4.1 presents the general requirements in some of the top destination countries for Nepali health workers).

[88] A labour permit refers to the formal permission given to any worker going abroad for employment; it comes in the form of a sticker affixed on the worker's passport on the completion of the stipulated procedure. This includes providing details of the employer (name and complete address), type of employment, salary and facilities available to the workers, copy of certified demand letter, copy of the contract and so on. The labour permit is acquired by a licensed institution, referred to as "licensee" engaged in foreign employment business for the worker (Foreign Employment Act, 2007).
[89] Interview with the director of the Department of Foreign Employment, 16 Mar. 2016.
[90] Government of Nepal, 2007.

Because of these stringent requirements, health workers from Nepal tend to opt for the student visa route to migrate. Quite often, health professionals go abroad to acquire postgraduate degrees [91] and thereafter apply for registration with the relevant medical council upon completion of their studies. This is evidenced by the number of verification requests received by governing bodies, like the NMC and NNC, from abroad. According to the Administrative Officer at the NMC, "We get emails from medical councils from the United Kingdom, Canada, the United States – mostly from the United Kingdom. Nepalis apply for licence after fulfilling the criteria there to become a licence holder. When they apply for their registration abroad, the councils email us for verification. They ask us to verify whether the certificate we have issued is original or not. We receive these emails at the rate of three to four per day."

Table 4.1. Requirements for registration in top countries of destination

Country		Registration exam and programmes	Cost	Language requirement
Australia	Doctor	Australian Medical Council CAT MCQ exams Australian Medical Council clinical exams[a]	$362[b]	IELTS: Overall score of 7, with no less than 6.5 in each component[c]
	Nurse	Overseas Qualified Nurse Programme[d]	AU$14 250[e] ($10 389)	IELTS: Overall score of 7, with no less than 7 in each component[f]
United Kingdom	Doctor	Professional and Linguistics Assessment Board (PLAB) Test[g]	£1,070[h] ($1,537)	IELTS: Overall score of 7.5, with no less than 7 in each component[i]
	Nurse	Nursing and Midwifery Council (NMC)- Computer Based Test (CBT) and practical objective clinical examination[j]	£117[k] ($168)	Minimum score of 7 in each component[l]
United States	Doctor	USMLE (United States Licensing Exams)[m]	$3 440[n]	TOEFL: Computer-based score of 213 Paper-based score of 550[o] (*It might vary in different states)
	Nurse	Commission on Graduates of Foreign Nursing Schools (CGFNS) screening as well as National Council Licensure Examination for Registered Nurses (NCLEX-RN) and National Council Licensure Examination for Practical Nurses (NCLEX-PN)[p]	$750[q]	TOEFL: Paper-based minimum score of 540 Computer-based score of 83 IELTS: Overall score of 6.5[r]
Canada	Doctors	Medical Council of Canada evaluating examination (MCCE exams and MCCEQ) Part 1 and Part 2[s]	$5 151[t]	TOEFL score of 213 IELTS score of 7 (minimum in each component)[u] *(It might vary in different states)
	Nurses	National Nursing Assessment Service (NNAS) Registration Substantially Equivalent Competence[v]	$500[w]	Overall score of 6.5, with a speaking score of 7 and no less than a 6 in the other components.[x]

[91] Interview with the managing director of Orbit Medical Entrance Pvt. Ltd, 28 Mar. 2016; the managing director of Seven Educational Consultancy Pvt. Ltd, 9 May 2016; and the president of the Educational Consultancy Association of Nepal, 10 May 2016.

Country		Registration exam and programmes	Cost	Language requirement
India	Doctors	Temporary registration at Medical Council of India	INR5 000[y] ($74)	-
	Nurse	Information not available		
Bangladesh	Doctors	Temporary registration at Bangladesh Medical and Dental Council	BDT2 500[z] ($31)	
	Nurse	NA		

Note: IELT=International English Language Testing System; TOEFL= Test of English as a Foreign Language.
Source: a= Australian Medical Council Ltd, "AMC examinations (Standard Pathway)", not dated (accessed 15 May 2016); b=Medical Board Australia: "Medical Board Australia schedule of fees effective 22 July 2015", www.medicalboard.gov.au/Registration/Fees.aspx (accessed 15 May 2016); c=Medical Board Australia: "Registration standards", www.medicalboard.gov.au/Registration-Standards.aspx (accessed 15 May 2016); d=Australian Health Practitioner Regulation Agency: "Approved programmes of study", www.ahpra.gov.au/Education/Approved-Programs-of-Study.aspx?ref=NurseandType=Bridging (accessed 15 May 2016); e=Australian Centre for further education: "Student application form", http://acfe.edu.au/wp-content/uploads/2016/02/IRON-EN-RN-application-form.pdf (accessed 15 May 2016); f=Australian Centre for further education: "Student application form", http://acfe.edu.au/wp-content/uploads/2016/02/IRON-EN-RN-application-form.pdf(accessed 15 May 2016); g=General Medical Council: "Professional and Linguistic Assessment Board (PLAB) Test", www.gmc-uk.org/doctors/plab.asp (accessed 15 May 2016); h=General Medical Council: "Fees", www.gmc-uk.org/doctors/fees.asp (accessed 15 May 2016); i=General Medical Council: "Knowledge of English: International medical graduates", www.gmc-uk.org/doctors/registration_applications/24986.asp (accessed 15 May 2016); j=Nursing and Midwifery Council: "Test of competence Part 1. For the applicants trained outside the European Union and European Economic Area", www.pearsonvue.com/nmc/Test-of-Competence-Part-1-Candidate-Handbook.pdf (accessed 15 May 2016); k=Nurses 4 London: "Overseas nurses registration guideline", www.nurses4london.co.uk/overseas.cfm (accessed 15 May 2016); l=MG MEDICAL Recruitment: "IELTS requirements for nurses working in the UK", www.mgmedical.co.uk/ielts-requirements-for-nurses-working-in-the-uk/ (accessed 15 May 2016); m=National Board of Medical Examiners (NBME): "NBME self-assessments", https://nsas.nbme.org/home (accessed 15 May 2016); n=Educational Commission for Foreign Medical Graduates: "Fees and payments", www.ecfmg.org/fees/ (accessed 15 May 2016); o=Fulbright Norway: "Medical licensure in US"; p=American Nurses Association: "Foreign educated nurses", www.nursingworld.org/foreigneducatednurses (accessed 15 May 2016); q=Brilliant Nurse: "Ultimate guide: U.S. NCLEX application and license instructions for international RNS and LPNs", https://brilliantnurse.com/foreign-international-nclex-application/ (accessed 15 May 2016); r=CGFNS International: "English proficiency information", www.cgfns.org/cerpassweb/help.jsp?headerText= per cent22English+Proficiency+Information per cent22andhelpText= per cent22help.englishtests.details.text per cent22 (accessed 15 May 2016); s=Medical Council of India: "Medical Council of Canada evaluating examination", http://mcc.ca/examinations/mccee/ (accessed 15 May 2016); t=Medical Council of India: "Examination and service fees", http://mcc.ca/examinations/examination-service-fees/ (accessed 15 May 2016); u=The University of British Columbia: "International Medical Graduate Office", http://imgbc.med.ubc.ca/eligibility/ (accessed 15 May 2016); v=Nurses 4 Canada; w=College of Registered Nurses of British Columbia: "Application process", https://crnbc.ca/Registration/RNApplication/InternationalEN/Pages/Fees.aspx (accessed 15 May 2016); x=Nurses 4 Canada: "Registration requirements", www.nurses4canada.com/englishrequirement.html (accessed 15 May 2016); y=Medical Council of India: "Application form details", www.mciindia.org/InformationDesk/ForMedicalProfessionals/PriceofApplicationForms.aspx (accessed 15 May 2016); z=Bangladesh Medical and Dental Council: "Application for Temporary registration on the register of medical dental practitioners", http://bmdc.org.bd/wp-content/uploads/2014/02/temp_reg_form_foreign_doc.pdf (accessed 15 May 2016).

Another reason is that many prospective migrant health workers, especially nurses, turn to international education consultancies for assistance because the practicalities of migration are complex.[92] Previously, these consultancies oriented graduates towards international markets and helped aspiring migrants prepare official documents for their visa application, such as the course or job acceptance letter from a foreign university or employer, bank statements and so on. For exorbitant service charges, they would also offer visa and interview preparation courses and English language courses and prepare financial and police reports.[93] But the role of these international education consultancies, which evidently also served the role of recruitment agents, has now been limited to providing information on educational opportunities and assisting prospective students with admission procedures; they no longer can provide information on employment abroad.[94]

As an educational consultant explained, "The role of educational consultancies is to send people for education, not for work….It is the work of [employment] agencies. We can support them with documents, but we cannot support the whole migration process. The main work of the educational consultancies is to give counselling about careers. We can inform them that, once they complete nursing exams there, they can find jobs. But, we do not help them with that."[95]

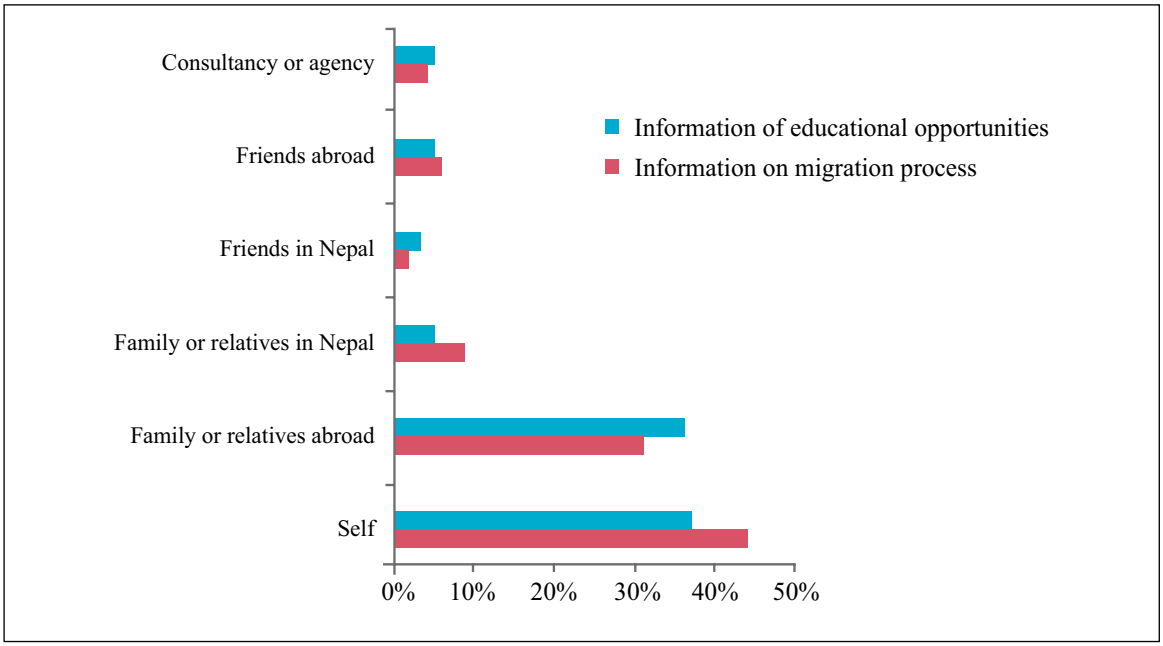
The role of recruitment agencies in the case of health worker recruitment is limited, however.[96] As the president of the Educational Consultancy Association of Nepal pointed out, "There is one problem in Nepal. The [employment] agencies do not supply highly skilled [professionals] abroad. Nepal's employment agencies have not been able to support the highly skilled [professionals] because they work on a demand system."

Third, individuals increasingly rely on the internet or on their personal networks as opposed to employment agencies to get information about opportunities abroad, both in terms of work and education opportunities. Among the survey respondents looking for opportunities to study abroad, 50 individuals (44.2 per cent) sought information relating to educational opportunities themselves, while 35 (31 per cent) relied on information provided by family members and/or relatives who were already abroad. This trend was true for the migration process as well (figure 4.12).

According to one of the prospective migrants, "Those who take [United States Medical Licensing Examination] do not take help from consultancies…. The seniors generally guide us through the process. Now that I have passed, I will be giving practical exam training to the next batch looking to go." She added, "My main source of information is the internet. Things keep changing, and people only know about what the process was when they went. In my time, things will be different. Therefore, my main source is the internet. I follow blogs and chat with other people going through the same process…. My friends have used consultancies for assistance with the visa process. But the consultancies usually are not well informed. I applied myself."

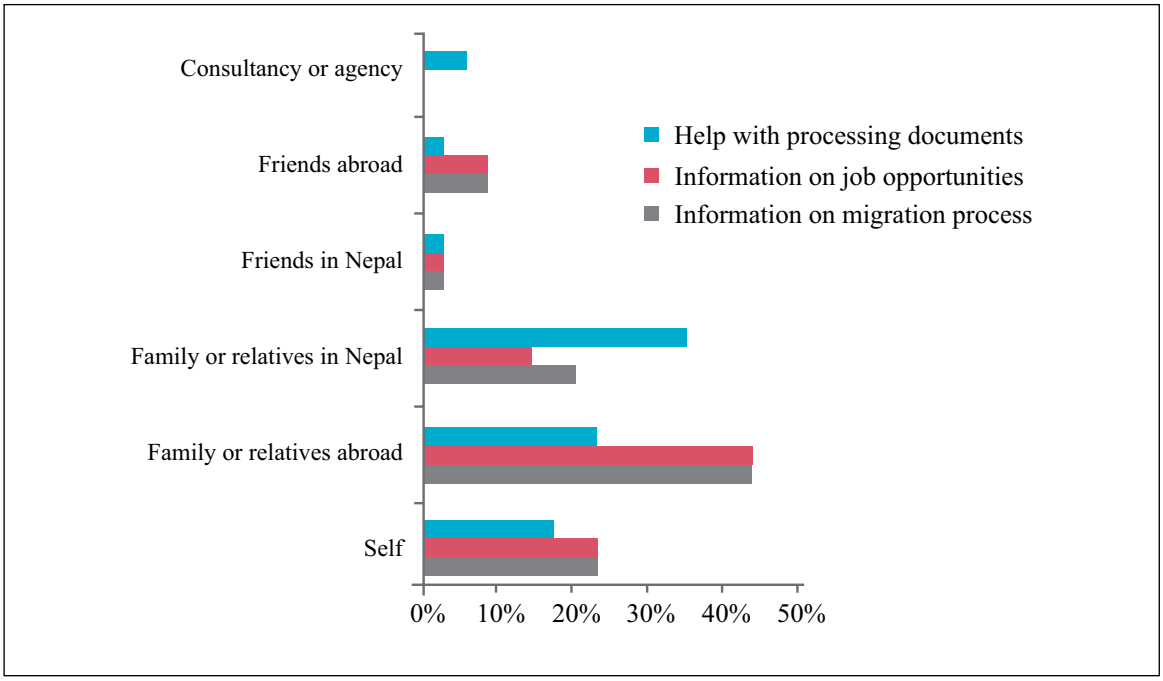
[92] Adhikari, 2012.
[93] Adhikari, 2009–2010, pp. 122–138.
[94] Interview with the president of the Educational Consultancy Association of Nepal, 10 May 2016 and the managing director of Seven Educational Consultancy Pvt. Ltd, 9 May 2016.
[95] Interview with the managing director of Seven Educational Consultancy Pvt. Ltd, 9 May 2016.
[96] Owing to this phenomenon, the research team could not identify recruitment agencies sending health workers for foreign employment either.

Figure 4.12. Main source of information on studying abroad



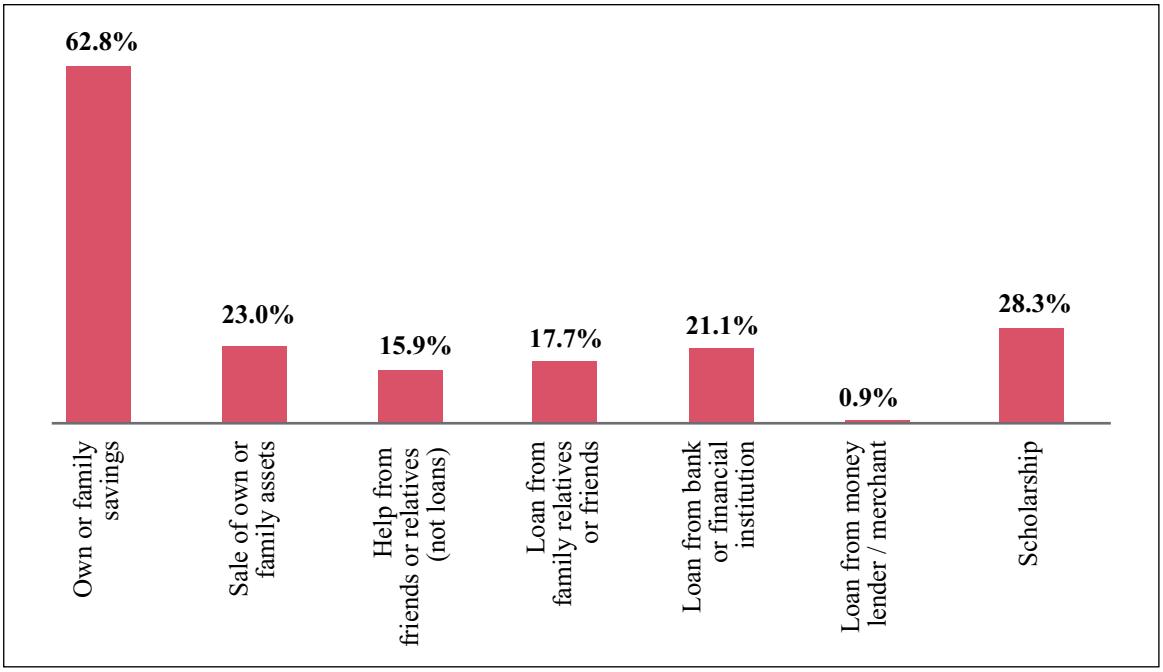
Among those seeking to migrate to work, the reliance on information from family and relatives abroad seemed to be even more pronounced, especially for information on job opportunities and the migration process. Around half of the survey respondents seeking to migrate abroad for work mentioned consulting family or friends abroad. These dynamics highlight not only the role of social networks in supporting migration but also that information relating to migration is obtained primarily from destination countries instead of employment agencies or other support providers in Nepal. The greater reliance of prospective migrants seeking support from family or relatives abroad for work opportunities, compared with those seeking educational opportunities, can perhaps be explained by the fact that inroads into the job market are more difficult from afar, and hence prospective migrants resort to family members or relatives already working abroad.

Figure 4.13. Main source of information or help for going abroad to work



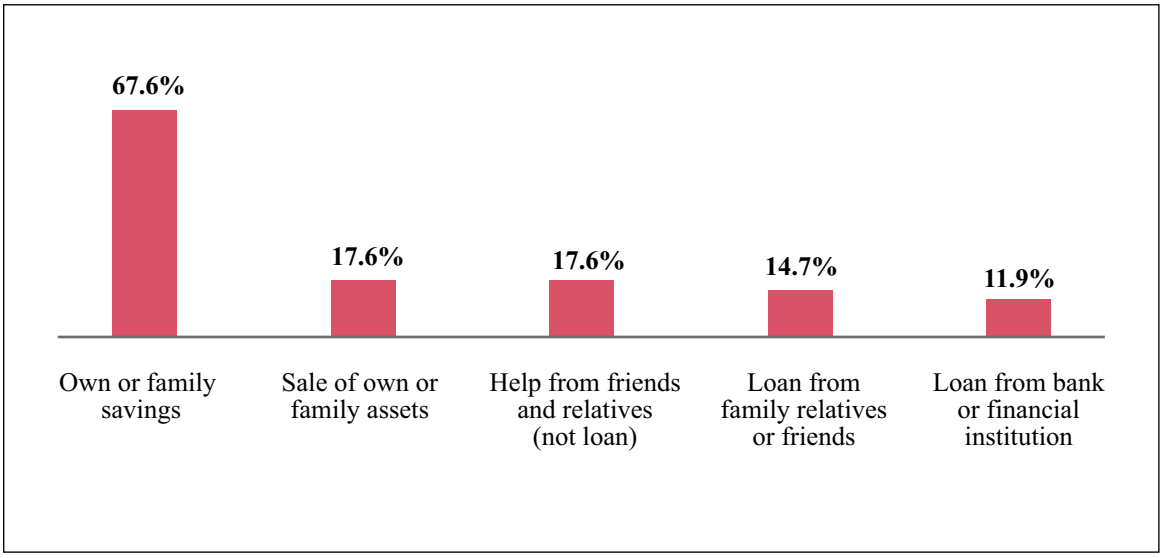
In terms of covering the cost of the migration process, of those who wanted to go abroad for studies, 71 (62.8 per cent) said that they would fund their migration process through their own or family savings (figure 4.14). Of them, 82 per cent were from middle- or high-income groups (households with a monthly income of more than NPR25,000).

Figure 4.14. Funding the migration process for education abroad



The source of funding was similar among those who wanted to migrate abroad to work – 23 respondents (67 per cent) mentioned that they would use their own or family savings to bear the cost of migration (figure 4.15). As in the previous case, a sizeable majority, at 69.9 per cent, of these individuals were from the middle- and high-income categories.

Figure 4.15. Funding migration process for education abroad



To conclude, the migration of health professionals is not channelled through traditional recruitment agencies that generally facilitate labour migration from Nepal or education consultancies that provide services to those seeking to go abroad for studies. Instead, individuals rely on self-search and personal networks to seek out educational or employment opportunities overseas. This is largely because the migration of health professionals is guided by regulations for overseas medical professionals in destination countries rather than by legal stricture in Nepal.

5. CONCLUSIONS AND RECOMMENDATIONS

The international migration of health workers from Nepal has been a largely unexplored area. Although a few studies have delved into the phenomenon, they have either focused on a single category of health workers and/or on a particular geographical area. In comparison, the issue of internal migration of health workers, particularly in relation to rural retention, has received far more attention. In the recent policy initiates of the Government, international migration of health workers has been recognized as an issue but remains an "unseen phenomenon", with no records being maintained on the outflow. This study intended to generate a basic overview of the situation of emigration and migration in the health sector in Nepal and the various dynamics therein.

The findings of the research, to a certain extent, are limited by the lack of data available on the outflow, especially in terms of assessing the impact of outmigration of health workers. The NMC and NNC records suggest that the number of health professionals migrating for employment abroad is not numerically high, especially when compared with those who go abroad as low-skilled labour migrants or even the production of health professionals each year. However, the study revealed that a culture of migration might have set in, and the aspirations to go abroad, whether for further studies or employment, is high among students who are currently pursuing medical and/or nursing degrees.

Another crucial finding of the study is the lack of policy relating to the migration of health workers from Nepal, which can be attributed to the absence of any interaction between policies governing the health sector and those related to migration. The migration of health workers from Nepal is a complex phenomenon in which individuals opt for various indirect channels, such as migrating as students. Regulations governing migration have seldom taken this complexity into account. A sign of this is the absence of any reliable data on the movement of health personnel.

The study also points to a quite peculiar conundrum – on one hand, there seems to be an oversupply of doctors as well as nurses, particularly in terms of the numbers graduating from medical and nursing institutes each year; yet, on the other hand, the country continues to suffer from a low health worker-to-population ratio, which points to a chronic shortage of health workers, particularly

in rural areas. This issue is further compounded by institutional problems in the health sector that relate to ineffective planning and budgetary allocations especially in relation to human resource management.[97] Evidently, the number of medical workers who graduate every year are seeking career opportunities in urban centres, where the demand has reached saturation levels. Thus, instead of seeking career opportunities in rural areas,[98] they choose to migrate. The prime drivers of migration have been in relation to substandard working conditions, including insufficient remuneration, lack of benefits and the weak health policy environment in Nepal.[99]

Based on these issues and challenges, the following recommendations are offered in relation to the managed migration of health workers.

■ **Data management system for migrants, including health workers:** Broadly, there is a need for the Department of Foreign Employment, the main body responsible for issues relating to foreign labour migration, to maintain an effective data system. This would require better organizing and classifying of the occupations and skills of migrant workers who go abroad. There is also a need for coordination among the Department of Foreign Employment and the professional councils, like the NMC and NNC, to reconcile the different migration pathways of health workers. The Ministry of Health should also set up a system to track and assess the distribution of health workers across the country. This would help formulate measures to address the challenges cited in the study, particularly the trends in outflows of health workers (both internal and external) and their impacts.

■ **Reconsideration of the incentive structure:** At present, the main strategy that the Government has adopted to retain health workers, especially in rural areas, is a bonding scheme. Studies in other contexts have shown that highly skilled professionals, like health workers, respond to positive incentives more than sanctions and/or control measures. Recent health strategies and programmes have mentioned introducing different incentives for retaining health workers within the country, but it is not clear what they would entail. Countries like Ireland, Malawi and Thailand launched various incentive packages comprising of funding for research, financial incentives and other services and assistance to retain health workers. Financial incentives that the Government could consider include: higher salary, housing allowances, benefit packages (such as pensions and retirement packages), access to loans or tax waivers and opportunities for education funding and training. Non-financial incentives could involve improved working conditions, manageable workload levels, flexible working schedules, access to training and career development opportunities, benefits for family members (such as education allowances for family members) and health insurance.[100]

However, these incentive programmes must be based on the specific needs of the health care system in Nepal and require strategic planning, investment and changes in organizational structure.[101] As

[97] Interview with the MOH head public health administrator, 20 Apr. 2016.
[98] According to a senior health bureaucrat, hardly 10 per cent of the new doctors licensed annually opt for rural services because it is seen as detrimental to professional growth in terms of non-use of skills acquired, in addition to the inadequate salary and lack of social recognition, which comes in urban settings.
[99] Group interview with doctors, 13 June 2016. Also, Dixit, 1998, p. 1.
[100] Mackey and Liang, 2013, pp. 1–7.
[101] ibid.

an example of long-term incentive programmes, the state government of Tamil Nadu in India introduced a scheme in which health workers had to serve five years in a rural area to earn the monetary incentive in the duration and to ensure a subsidized placement in a medical doctor programme in a government institution. The government of neighbouring Andhra Pradesh State has since replicated the programme to retain health workers.[102] Similarly, the Ministry of Health for Zambia introduced a retention scheme for rural-based medical officers in 2003. First, it increased the salaries of rural health workers and improved the working conditions for the doctors initially but subsequently also for nurses, clinical officers and laboratory technicians. It then increased travel opportunities and created opportunities for training. In exchange, workers committed to three years of service in rural areas. The success of the retention scheme is evident by the fact that 88 doctors completed the contract, and 65 per cent renewed a second three-year term.[103]

■ **Regulation of production:** One of the primary reasons for the overproduction of health workers is the liberal distribution of licences to new educational institutions, arguably to ensure the availability of health personnel to serve in rural areas. This strategy to address rural shortages has backfired, with health workers choosing to emigrate due to lack of employment in urban areas. Hence, rather than producing more doctors and nurses, the Government should consider measures to limit the annual supply of health workers according to the needs of the health care system and follow such a measure with an incentive structure to ensure that the rural population is served. For instance, in Ghana, the strategy to focus on practical skills through short-term training catered towards community practice, as was done through ophthalmic nurse training programme, was critical in improving geographical coverage and access to eye care.[104] A complementary strategy in Nepal would be to curtail the amount or number of government scholarship schemes for those pursuing medical and nursing degrees and divert the resources to train and develop the capacity of community health workers, like the female community health volunteers and the auxiliary nurse midwives.

■ **Task shifting:** One way to address the poor distribution of health workers is to decentralize and delegate health care service delivery, especially in remote rural areas from health care professionals to less specialized health workers (female community health volunteers and the auxiliary nurse midwives). In Uganda and many other East and Central African countries, this approach has been tried quite successfully to provide universal access to HIV prevention, treatment, care and support. However, it is pertinent that such a measure be preceded first by introducing enabling policy, regulations or legal protection to those who undertake the additional tasks.

■ **Strategic partnerships and approaches:** The Ministry of Health, the Ministry of Labour and Employment, the Ministry of Education, NMC, NNC, WHO and partner organizations need to coordinate among each other to formulate concrete guidelines to govern the migration of health

[102] Interview with official from IOM, 15 Mar. 2016.
[103] Gow et al., 2011, pp. 476–488.
[104] Dussault and Franceschini, 2006.

workers both internally and outside of Nepal. The lack of coordination and dialogue between stakeholders has evidently resulted in ineffective policies, if not complete absence of policies governing this area. As reflected in the new health sector strategy and policy, the migration of health workers has been raised as an issue requiring strategic considerations. This study's findings indicate that while the out-migration of health workers may not be at alarming levels, the aspiration to migrate is certainly gaining ground. There is thus a need to recognize that health worker migration is likely to increase, and hence there is a need to shift more attention towards managed migration[105] by developing strategic approaches that would help Nepal in the medium and long terms. These could include adhering to the WHO Global Code of Practice on the International Recruitment of Health Personnel and entering into bilateral agreements with countries where Nepali health workers are migrating to.

A good example of such a bilateral agreement is the Memorandum of Understanding the Reciprocal Education Exchange of Healthcare Concepts and Personnel, signed between the United Kingdom and South Africa in 2003. The objectives of the agreement are to share information and expertise and to provide technical assistance and facilitate collaboration between institutions. The agreement includes provision of time-limited placements between countries, support for ethic recruitment between the two countries and exploration of new ways to manage health worker flows bilaterally over time.[106]

■ **Further research:** This study has only been able to cursorily delve into some of the pertinent issues regarding the international migration and emigration of health workers from Nepal. Given the limited research into and understanding of the matter, further research focused on various aspects of this complex phenomenon needs to be conducted to inform policies and programmes dealing with it. Some of research areas can include: policy and institution analysis; exploration of the rural-urban dynamics in terms of seeking to study and work abroad; analysis of the impact of country-specific processes on the outflow of health workers; an in-depth analysis of choice of country of destination; and the flow of remittances from health worker migration. A similar survey can be administered in other migrant health worker-sending countries to look for regional and/or global comparative patterns.

[105] OECD, 2010; Bach, 2010, pp. 249–266; Winkelmann-Gleed, 2006.
[106] See the Memorandum of Understanding between the Government of the United Kingdom of Great Britain and Northern Ireland and the Government of the Republic of South Africa on the Reciprocal Education Exchange of Healthcare Concepts and Personnel, www.aspeninstitute.org/sites/default/files/content/images/memo per cent20united-kingdom---south-africa per cent5B1 per cent5D.pdf (accessed 30 Apr. 2016).

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ANNEX I.

Classification and subclassification of health workers according to International Standard Classification of Occupations (ISCO-08)

Health professionals	22 Health professionals
	221 Medical doctors
	2211 Generalist medical practitioners
	2212 specialist medical practitioners
	222 Nursing and midwifery professionals
	2221 Nursing professionals
	2222 Midwifery professionals
	223 Traditional and complementary medicine professionals
	2230 Traditional and complementary medicine professionals
	224 Paramedical practitioners
	2240 Paramedical practitioners
	225 Veterinarians
	2250 Veterinarians
	226 Other health professionals
	2261 Dentists
	2262 Pharmacists
	2263 Environmental and occupational health and hygiene professionals
	2264 Physiotherapists
	2265 Dieticians and nutritionists
	2266 Audiologists and speech therapists
	2267 Optometrists and ophthalmic opticians

Health associate professionals	32 Health associate professionals 321 Medical and pharmaceutical technicians 3211 Medical imaging and therapeutic equipment technicians 3212 Medical and pathology laboratory technicians 3213 Pharmaceutical technicians and assistants 3214 Medical and dental prosthetic technicians 322 Nursing and midwifery associate professionals 3221 Nursing associate professionals 3222 Midwifery associate professionals 323 Traditional and complementary medicine associate professionals 3230 Traditional and complementary medicine associate professionals 324 Veterinary technicians and assistants 3240 Veterinary technicians and assistants 325 Other health associate professionals 3251 Dental assistants and therapists 3252 Medical records and health information technicians
Personal health workers in health service	532 Personal care workers in health services 5321 Health care assistants 5322 Home-based personal care workers
Health management, support personnel	
Other health service providers not classified elsewhere	

Source: ILO, 2012.

ANNEX II.
Informant interviews

Date	Individual and organization
1 Mar. 2016	Administrative officer, Nepal Medical Council
6 Mar. 2016	Registrar, Nepal Nursing Council
11 Mar. 2016	Registrar, Nepal Health Professional Council
15 Mar. 2016	International Organization for Migration
16 Mar. 2016	Director, Department of Foreign Employment
28 Mar. 2016	Managing director, Orbit Medical Entrance Pvt. Ltd
8 Apr. 2016	Senior public health administrator, Ministry of Health and Population
20 Apr. 2016	Head public health administrator, Ministry of Health and Population
6 May 2016	President, Nepal Nursing Association
9 May 2016	Managing director, Seven Educational Consultancy Pvt. Ltd
10 May 2016	President, Educational Consultancy Association of Nepal
10 May 2016	World Health Organization

ANNEX III.

Sample framework, sample size, survey tests

The sample design for the study attempted to extract a representative sample of final-year medical and nursing students in the Kathmandu Valley to estimate, among others, the proportion of students that are likely to go abroad either for work or further studies upon graduation and the various socio-economic indicators that are likely to affect this decision.

SAMPLE SIZE, ALLOCATION AND SELECTION[107]

Based on the method explained in Annex IV, the sample size was determined to be n=600. The sample design was based on a stratified two-stage cluster design with probability proportionate to size (PPS) selection – with the number of students in the final year as the measure of size – in the first stage and systematic random sampling in the second stage. Accordingly, medical and nursing educational departments were the primary sampling units (PSUs) and final-year students enrolled in those institutions were the secondary sampling units (SSUs).

Stratification

First, medical and nursing educational institutions were stratified into two mutually exclusive categories: (i) medical schools and (ii) nursing schools. This ensured that the final sample were representative of the MN student population in terms of field of study and/or institutional characteristics.

Selection

In the first stage of selection, PSUs were selected from each stratum by the PPS method, with the total number of final-year students as the measure of size. The number of PSUs selected in each strata were calculated, such that it was proportional to the total medical and nursing student population in that particular strata,[108] which was evaluated once the research team had complete information on student enrolment in all relevant institutions. A total of 20 PSUs was selected at the first stage. In the second stage, 30 students were selected from each PSU via systematic random sampling, giving a sample total of 600 respondents.

[107] The actual number of PSUs and cluster sizes will be revised in future drafts once relevant information becomes available.
[108] Given that, as mentioned later, the final number of students selected within each PSU (cluster size) will be 30

PRE-TESTING

Prior to the administration of the draft questionnaire for pilot testing, it was subjected to in-depth qualitative testing on nine respondents representing all the various degree programmes. The testing was conducted among three students from the BSc (nursing) programme and two students each from the BN (nursing), PCL (nursing) and MBBS (medicine) programmes. As there were two categories of tests, at least one student from each of the four degree programmes was administered for the first test category while at least one other from each programme was administered for the second test category.[109]

The first test category, Category A, asked respondents to fill the questionnaire in full as if they were completing the final survey. Respondents were free to ask questions to the test supervisors, with the latter being responsible for noting down those questions. One of the supervisors was responsible for noting the body language of the respondent to see any signs of difficulty or confusion after beginning each new question; all relevant gestures and the total time required to complete the survey were recorded. All completed interviews were immediately followed up with a brief unstructured discussion, which asked the respondents if they found any issues or challenges in 13 criteria: (i) instruction clarity; (ii) flow of questionnaire; (iii) wording; (iv) technical terms; (v) question vagueness; (vi) reference period; (vii) inappropriate assumptions; (viii) knowledge of certain topics; (ix) recall issues; (x) computation of calculation; (xi) question sensitivity; and (xii) response categories. The brief discussion was followed up with cognitive interviews (see Annex VI), which involved an in-depth probing on specific questions from the survey identified a priori by the research team as being possibly confusing or prone to misinterpretation. This was done to test the respondents' understating of the questions and to ensure that respondents were correctly interpreting the questions (as well as the response categories) and to assess respondent reaction to "difficult" questions.

The second test category, Category B, also asked respondents to complete the questionnaire in full but additionally asked the respondents to assign a "confidence rating" after answering each question. The rating scale comprised the following four options: (i) very accurate; (ii) rather accurate; (iii) rather inaccurate; and (iv) very inaccurate. The scale was intended to gauge each respondent's own perception of how accurately they understood the question and how accurately they were able to answer the question with the given response categories. All other test procedures were the same for this category except for the fact that follow-up probing or interviewing was conducted on responses that the respondents had rated with anything lower than "very accurate".

Finally, the survey instrument was updated to reflect the findings of the pre-tests, which meant that it was improved in terms of the 13 criteria listed previously.

[109] Category A: 1 BN, 2 BSc, 1 PCL and 1 MBBS students; Category B:1 BN, 1 BSc, 1 PCL and 1 MBBS student.

PILOT TESTING

Following the pre-tests, pilot tests were conducted at a medical school and a nursing school, which of course had not been selected for the final sample, with 30 students at each of the institutions. Students were selected via systematic sampling to ensure a diverse sample, especially at the nursing school, which comprised three nursing degree programmes. The administration of the pilot emulated the planned method of administering the final survey. The instructions and guidelines for respondents represented the ones for the final survey and the students were gathered in a classroom for self-administration of the instrument, also as planned for the final survey. This helped in testing the questions with a larger group as opposed to individuals, like in pre-testing phase. Debriefing sessions followed the administration of the survey in which the participants could give their feedback in terms of lucidity, clarity, relevance and so forth. The comments were incorporated into the final survey. Further, the pilot study also gave the researchers an indication into how difficult it would be to gather medical students who were interning; it also demonstrated that this was the best category to conduct the survey with because they were the ones most informed about their future plans.

ANNEX IV.

Survey questionnaire for monitoring migration of health workers

Monitoring Migration of Health Workers

Survey Questionnaire

Institution Name: Himalayan Medical Education Society Nursing Campus	Institution ID: 10
	Respondent ID: 34

Please tick ☑ the appropriate option.

A. Demographic Information

1. Degree Pursuing	☐ 1. B.Sc. Nursing ☐ 2. B.N. ☐ 3. P.C.L. Nursing ☐ 4. M.B.B.S
2. How are you funding your education?	☐ 1. Self-Investment ⟹ **[Go to question 4]** ☐ 2. Full Scholarship ☐ 3. Partial Scholarship
3. If you are receiving scholarship, what kind of scholarship is it?	☐ 1. Government ☐ 2. Private ☐ 3. Others
4. What is your average mark (in board exams) in your current degree program up until now?	☐ 1. Less than 40% ☐ 2. 40% to less than 50% ☐ 3. 50% to less than 60% ☐ 4. 60% to less than 70% ☐ 5. 70% to less than 80% ☐ 6. 80% to less than 90% ☐ 7. 90% and above
5. Age	☐

6. Gender	☐ 1. Male ☐ 2. Female ☐ 3. Other
7. Caste/Ethnicity	
8. Marital Status	☐ 1. Single ☐ 2. Married ☐ 3. Other
9. Monthly Family Income	☐ 1. Less than NRs. 25,000 per month ☐ 2. NRs. 25,000 – NRs.60,000 per month ☐ 3. More than NRs. 60,000 per month
10. Place of Birth	
a. Town/village Type	☐ 1. VDC ☐ 2. Municipality ☐ 3. Sub-Metropolitan or Metropolitan City
b. District	
11. Place of Secondary Schooling (S.L.C. or equivalent)	
a. Town/village Type	☐ 1. VDC ☐ 2. Municipality ☐ 3. Sub-Metropolitan or Metropolitan City
b. District	
12. What kind of institution did you complete your secondary schooling (S.L.C or equivalent) from?	☐ 1. Government/Public School ☐ 2. Private School ☐ 3. Public-Private Mixed School ☐ 4. Others

B. History of Migration and Medicine

Now, we would like to ask you about the history of migration and medical practice in your family and how you came to be involved in the medical field.

13. Have any of your **immediate** family members (i.e. your mother, father, own brothers or own sisters, and husband or wife) studied/worked abroad **OR** permanently settled abroad?

- ☐ 1. Yes, but in the past
- ☐ 2. Yes, at present
- ☐ 3. No ⟹ **[Go to question 15]**

14. Have any of those **immediate** family members (mentioned above in question 13) studied and/or worked **abroad** as a doctor or a nurse?

- ☐ 1. Yes, but in the past
- ☐ 2. Yes, at present
- ☐ 3. No

15. Have any of your **immediate** family members studied and/or worked as a doctor or a nurse in **Nepal**?

- ☐ 1. Yes, but in the past
- ☐ 2. Yes, at present
- ☐ 3. No

16. Who are the **major actors** that influenced your decision to be in the medical field?
[Choose ALL that apply]

- ☐ 1. Self (personal interest in medical field and/or in social service)
- ☐ 2. On the recommendation/advice/influence of family members and/or relatives other than those in the medical field
- ☐ 3. On the recommendation/advice/influence of family members and/or relatives in the medical field
- ☐ 4. Others, please specify: _____

17. What are the **major factors** that influenced your decision to be in the medical field?
[Choose ALL that apply]

- ☐ 1. Family pressure (despite interest to be in a different field)
- ☐ 2. Easier to go abroad
- ☐ 3. Easier to find jobs in Nepal
- ☐ 4. Better salary
- ☐ 5. Better benefits (e.g. pension, housing facilities, paid leaves, etc.)
- ☐ 6. Better prospects of job promotion
- ☐ 7. Social Prestige
- ☐ 8. To serve the nation
- ☐ 9. To establish/run my own business (hospital/educational institute/clinic/company)
- ☐ 10. Others

C. Future plans after graduation/training

18. What do you plan to do after the completion of your degree? (If you are not sure, please choose the most likely option.)

- ☐ 1. Pursue further studies in Nepal **[Go to Question 19, pg. 4]**
- ☐ 2. Work in Nepal **[Go to Question 20, pg. 5]**
- ☐ 3. Pursue further studies abroad **[Go to Question 25, pg. 7]**
- ☐ 4. Work abroad **[Go to Question 35, pg. 11]**

D. If you are planning to PURSUE FURTHER STUDIES IN NEPAL,

19. How important are **each of the following factors** in terms of why you want to pursue your further studies in Nepal?

	1. Not important at all	2. Somewhat important	3. Very important
a. To be close to home/family	☐	☐	☐
b. Social prestige	☐	☐	☐
c. Less expensive to study in Nepal	☐	☐	☐
d. Better provision of scholarship in Nepal	☐	☐	☐
e. Compulsory because of scholarship terms and conditions	☐	☐	☐
f. Better provision of reservation/quota in Nepal	☐	☐	☐
g. Others, please specify: _____	☐	☐	☐

Now, Please go to question 48 on page 15

E. If you are planning to WORK IN NEPAL,

20. How important are **each of the following factors** in terms of why you want to work in Nepal?

	1. Not important at all	2. Somewhat important	3. Very important
a. To be close to home/family	☐	☐	☐
b. Social prestige	☐	☐	☐
c. To serve the nation/Public service	☐	☐	☐
d. Compulsory because of scholarship terms and conditions	☐	☐	☐
e. Better provision of reservation/quota in Nepal	☐	☐	☐
f. Better work conditions (e.g. flexible work hours, occupational safety, etc.)	☐	☐	☐
g. Better salary	☐	☐	☐
h. Better benefits (e.g. pension, housing facilities, paid leaves, etc.)	☐	☐	☐
i. Easier to find jobs in Nepal	☐	☐	☐
j. To gain work experience to facilitate future plans	☐	☐	☐
k. Expensive to go abroad	☐	☐	☐
l. Degree not recognized abroad	☐	☐	☐
m. Others, please specify_____	☐	☐	☐

21. Do you have an idea as to which location you would prefer to work in after the completion of your degree?

☐ 1. Yes
☐ 2. No ➡ **[Go to question 23]**

If yes,

a. District ☐

b. Town/village Type
☐ 1. VDC
☐ 2. Municipality
☐ 3. Sub-Metropolitan or Metropolitan City

22. What is the **main** reason you want to work in that region? **[Choose ONE option]**	☐ 1. Hometown/ To be closer to home/family ☐ 2. Better living conditions (e.g. better provision of shelter, food, clothing, electricity, drinking water supply, safety, etc.) ☐ 3. Shortage of health personnel in the region ☐ 4. Better salary ☐ 5. Better benefits (e.g. pension, housing facilities, paid leaves, etc.) ☐ 6. To gain work experience to facilitate future plans ☐ 7. Compulsory because of scholarship terms and conditions ☐ 8. Others, please specify: _____
23. What type of institution would you **primarily** prefer to work in? **[Choose ONE option]**	☐ 1. Government Medical Institutes (Hospital/Clinic/Health Post) ☐ 2. Private Medical Institutes (Hospital/Clinic) ☐ 3. I/NGOs ☐ 4. Others, please specify: _____
24. What is your **main reason** for choosing that institution? **[Choose ONE option]** **Now, Please go to question 48 on page 15**	☐ 1. Better opportunities for job promotion ☐ 2. Good reputation of the institution ☐ 3. Better salary ☐ 4. Better benefits (e.g. pension, housing facilities, paid leaves, etc.) ☐ 5. Better work conditions (e.g. Flexible work hours, occupational safety, etc.) ☐ 6. Compulsory because of scholarship terms and conditions ☐ 7. Others, please specify: _____

F. If you are planning to GO ABROAD TO STUDY

25. Which country are you planning to migrate to?
[Choose ONE option]

- ☐ 1. Australia
- ☐ 2. Bangladesh
- ☐ 3. Canada
- ☐ 4. India
- ☐ 5. China
- ☐ 6. UAE
- ☐ 7. United Kingdom
- ☐ 8. United States of America
- ☐ 9. Other, please specify: _____

26. How important are **each of the following factors** in terms of why you want to migrate abroad to study?

	1. Not important at all	2. Somewhat important	3. Very important
a. Family/Relatives abroad	☐	☐	☐
b. Friends and acquaintances abroad	☐	☐	☐
c. Better quality of education abroad	☐	☐	☐
d. Course/training not available in Nepal	☐	☐	☐
e. Education less expensive abroad	☐	☐	☐
f. Better provision for scholarship abroad	☐	☐	☐
g. Greater recognition of foreign degree	☐	☐	☐
h. Easier to get a job abroad after completion of education	☐	☐	☐
i. Better living conditions abroad (e.g. better provision of shelter, food, clothing, electricity, drinking water supply, education, safety, etc.)	☐	☐	☐
j. Easy to get a visa	☐	☐	☐
k. To facilitate permanent residence/settlement abroad	☐	☐	☐
l. Political instability in Nepal	☐	☐	☐
m. Other, please specify: _____	☐	☐	☐

27. Which of the following steps have you completed in order to go abroad? **[Choose ALL that apply]**	☐ 1. Submitted college application ☐ 2. Submitted visa application ☐ 3. Registered for country-specific licensing exams (e.g. PLAB, USMLE, NMC-CBT, etc.) ☐ 4. Registered for language tests such as IELTS ☐ 5. Obtained No Objection Letter ☐ 6. Others. Please specify: _____ ☐ 7. None of the above
28. Who is your **main** source of information regarding the process of going abroad? (This includes information on acquiring passports, visa process, documents required for visa, etc.) **[Choose ONE option]**	☐ 1. Self (through internet, books, etc.) ➡ **[Go to question 30]** ☐ 2. Family members/relatives abroad ☐ 3. Family members/relatives in Nepal ☐ 4. Friends in Nepal ☐ 5. Friends abroad ☐ 6. Consultancy/agency in Nepal ➡ **[Go to question 30]** ☐ 7. Consultancy/agency abroad ➡ **[Go to question 30]** ☐ 8. Not applicable ➡ **[Go to question 30]**
29. Has the main source of information mentioned above (in question 28) ever worked/ studied as a doctor or a nurse?	☐ 1. Yes ☐ 2. No
30. Who is your **main** source of information regarding educational opportunities available abroad? (This includes information on educational institutions, college application process, exams/tests to be taken, etc.)? **[Choose ONE option]**	☐ 1. Self (through internet, books, etc.) ➡ **[Go to question 32]** ☐ 2. Family members/relatives abroad ☐ 3. Family members/relatives in Nepal ☐ 4. Friends in Nepal ☐ 5. Friends abroad ☐ 6. Consultancy/agency in Nepal ➡ **[Go to question 32]** ☐ 7. Consultancy/agency abroad ➡ **[Go to question 32]** ☐ 8. Not applicable ➡ **[Go to question 32]**

31. Has the main source of information mentioned above (in question 28) ever worked/ studied as a doctor or a nurse?	☐ 1. Yes ☐ 2. No
32. How are you funding or planning to fund your migration and education abroad? (This includes funding costs from: licensing examination like PLAB or USMLE, language tests like IELTS or TOEFL, consultancy/agency fee, passport fee, visa fee, airfare/travel expenses, and college fees.) **[Choose ALL that apply]**	☐ 1. Own/immediate family savings ☐ 2. Own/immediate family sale of property ☐ 3. Helped/sponsored by other relatives (**NOT** loans) ☐ 4. Loan from family, relatives or friends ☐ 5. Loan from bank or other financial institution ☐ 6. Loan from moneylender/merchant ☐ 7. Scholarship ☐ 8. Others
33. How likely is it for you to return back to work in Nepal once you migrate?	☐ 1. Highly likely ☐ 2. Somewhat likely ☐ 3. Neither likely nor unlikely ☐ 4. Somewhat unlikely ☐ 5. Highly unlikely

34. Now we would like to know under what conditions you would stay in Nepal instead of migrating abroad. Please rate in terms of how important **each of the following factors** would be for you to stay in Nepal.

	1. Not important at all	2. Somewhat important	3. Very important
a. Better quality of education in Nepal	☐	☐	☐
b. Less expensive education in Nepal	☐	☐	☐
c. Easier to find jobs in Nepal	☐	☐	☐
d. Better opportunities for job promotion in Nepal	☐	☐	☐
e. Better salary in Nepal	☐	☐	☐
f. Better benefits in Nepal (e.g. pension, housing facilities, paid leaves, etc.)	☐	☐	☐
g. Better work conditions (e.g. flexible work hours, occupational safety, etc.) in Nepal	☐	☐	☐
h. Better living conditions in Nepal (e.g. better provision of shelter, food, clothing, electricity, drinking water supply, education, safety, etc.)	☐	☐	☐

	1. Not important at all	2. Somewhat important	3. Very important
i. Less corruption/nepotism in Nepal	☐	☐	☐
j. Stable political climate in Nepal	☐	☐	☐
k. Sufficient medical equipment/resources in Nepal	☐	☐	☐
l. Better health policy environment/framework in Nepal	☐	☐	☐
m. Other, please specify:_____	☐	☐	☐

Now, please go to question 48 on page 15

G. If you are planning to GO ABROAD TO WORK

35. Which country are you planning to migrate to? **[Choose ONE option]**

- ☐ 1. Australia
- ☐ 2. Bangladesh
- ☐ 3. Canada
- ☐ 4. India
- ☐ 5. China
- ☐ 6. UAE
- ☐ 7. United Kingdom
- ☐ 8. United States of America
- ☐ 9. Other, please specify: _____

36. Have you already received a job offer in that country?

- ☐ 1. Yes
- ☐ 2. No

37. How important are **each of the following factors** in terms of why you want to migrate abroad to work?

	1. Not important at all	2. Somewhat Important	3. Very Important
a. Family/Relatives abroad	☐	☐	☐
b. Friends or acquaintances abroad	☐	☐	☐
c. Better living conditions abroad (e.g. better provision of shelter, food, clothing, electricity, drinking water supply, education, safety, etc.)	☐	☐	☐
d. Easy to get a visa	☐	☐	☐
e. To facilitate permanent residence /settlement abroad	☐	☐	☐
f. Easier to find jobs abroad	☐	☐	☐
g. Better provision of on-the-job training abroad	☐	☐	☐
h. Better salary abroad	☐	☐	☐
i. Better benefits abroad (e.g. pension, housing facilities, paid leaves, etc.)	☐	☐	☐
j. Better work conditions abroad (e.g. flexible work hours, occupational safety, etc.)	☐	☐	☐
k. Political instability in Nepal	☐	☐	☐
l. Other, please specify: _____	☐	☐	☐

38. Which of the following steps have you completed in order to go abroad? **[Choose ALL that apply]**	☐ 1. Submitted job application ☐ 2. Submitted visa application ☐ 3. Registered for country-specific licensing exams (e.g. PLAB, USMLE, NMC-CBT, etc.) ☐ 4. Registered for language tests such as IELTS ☐ 5. Others. Please specify: _____ ☐ 6. None of the above
39. Who is your **main** source of information regarding the process of going abroad? (This includes information on acquiring passports, visa process, documents required for visa, etc.) **[Choose ONE option]**	☐ 1. Self (through internet, books, etc.) → **[Go to question 41]** ☐ 2. Family members/relatives abroad ☐ 3. Family members/relatives in Nepal ☐ 4. Friends in Nepal ☐ 5. Friends abroad ☐ 6. Consultancy/agency in Nepal → **[Go to question 41]** ☐ 7. Consultancy/agency abroad → **[Go to question 41]** ☐ 8. Not applicable → **[Go to question 41]**
40. Is the main source of information mentioned above (in question 39) working/ studying as a doctor or a nurse?	☐ 1. Yes ☐ 2. No
41. Who is your **main** source of information regarding job opportunities available abroad? (This includes information on job and internship availability/vacancies, salary, benefits etc.)? **[Choose ONE option]**	☐ 1. Self (through internet, books, etc.) → **[Go to question 43]** ☐ 2. Family members/relatives abroad ☐ 3. Family members/relatives in Nepal ☐ 4. Friends in Nepal ☐ 5. Friends abroad ☐ 6. Consultancy/agency in Nepal → **[Go to question 43]** ☐ 7. Consultancy/agency abroad → **[Go to question 43]** ☐ 8. Not applicable → **[Go to question 43]**

42. Is the main source of information mentioned above (in question 41) working/ studying as a doctor or a nurse?	☐ 1. Yes ☐ 2. No
43. Who is your **main** source of help regarding processing your employment documents or facilitating job search? (This includes sending out job applications, helping prepare CV/Cover letters, contacting prospective employers, etc.)? **[Choose ONE option]**	☐ 1. Self (through internet, books, etc.) ➡ **[Go to question 45]** ☐ 2. Family members/relatives abroad ☐ 3. Family members/relatives in Nepal ☐ 4. Friends in Nepal ☐ 5. Friends abroad ☐ 6. Consultancy/agency in Nepal ➡ **[Go to question 45]** ☐ 7. Consultancy/agency abroad ➡ **[Go to question 45]** ☐ 8. Not applicable ➡ **[Go to question 45]**
44. Is the main source of help mentioned above (in question 43) working/ studying as a doctor or a nurse?	☐ 1. Yes ☐ 2. No
45. How are you funding or planning to fund your job-recruitment and migration abroad? (This includes funding costs from: licensing examination like PLAB or USMLE, language tests like IELTS or TOEFL, consultancy/agency fee, passport fee, visa fee, and airfare/travel expenses.) **[Choose ALL that apply]**	☐ 1. Own/immediate family savings ☐ 2. Own/immediate family sale of property ☐ 3. Helped/sponsored by other relatives (**NOT** loans) ☐ 4. Loan from family, relatives or friends ☐ 5. Loan from bank or other financial institution ☐ 6. Loan from moneylender/merchant ☐ 7. Others. Please specify: _____
46. How likely is it for you to return back to work in Nepal once you migrate?	☐ 1. Highly likely ☐ 2. Somewhat likely ☐ 3. Neither likely nor unlikely ☐ 4. Somewhat unlikely ☐ 5. Highly unlikely

47. Now we would like to know under what conditions you would stay in Nepal instead of migrating abroad. Please rate in terms of how important **each of the following factors** would be for you to stay in Nepal.

	1. Not important at all	2. Somewhat important	3. Very important
a. Easier to find jobs in Nepal	☐	☐	☐
b. Better opportunities for job promotion in Nepal	☐	☐	☐
c. Better salary in Nepal	☐	☐	☐
d. Better work benefits in Nepal (e.g. pension, housing facilities, paid leaves, etc.)	☐	☐	☐
e. Better work conditions in Nepal (e.g. flexible work hours, occupational safety, etc.)	☐	☐	☐
a. Better living conditions in Nepal (e.g. better provision of shelter, food, clothing, electricity, drinking water supply, education, safety, etc.)	☐	☐	☐
b. Less corruption/nepotism in Nepal	☐	☐	☐
c. Stable political climate in Nepal	☐	☐	☐
d. Sufficient medical equipment/resources in Nepal	☐	☐	☐
e. Better health policy environment/framework in Nepal	☐	☐	☐
f. Others, please specify:_____	☐	☐	☐

H. Reflections on health care system in Nepal

48. Finally, how would you rate **each of the following aspects** of the health care system in Nepal? Please tick below the appropriate response.

	1.Very Bad	2. Somewhat Bad	3. Neither Good nor Bad	4. Somewhat Good	5. Very Good
a. Quality of medical education and training	☐	☐	☐	☐	☐
b. Post-education employment opportunities	☐	☐	☐	☐	☐
c. Salary, benefits, and working conditions	☐	☐	☐	☐	☐
d. Policies and regulation governing the health sector	☐	☐	☐	☐	☐

Now, please go to question 49 on page 17

I. Conclusion

Institution Name: Himalayan medical Education Society Nursing
Institution ID: 10
Respondent ID: 34

49. Thank you very much for giving us your valuable time and participating in this study.

We might have to conduct some follow-up interviews in the future if the need arises. This could happen if there is a need to gather more information on a certain topic. Is it okay for us to contact you for such a follow-up discussion?

☐ 1. Yes [Please fill in your details below]
☐ 2. No

Name: _____

Phone Number: _____

E-mail: _____

ANNEX V.
Sample size determination

For the study, the sample size (n) was determined as follows:

n = (z^2 (p)(1-p)f) / (e^2 r)

Where,
z is the z-statistic for the desired level of confidence
p is a previous estimate for the key indicator to be measured by the survey
f is the design effect of the survey
e is the margin of error to be attained
r is the anticipated response rate.

The z-statistic was set to the value of 1.96, given that the study would use a 95 per cent confidence level in assessing the margin of error. The value of "p", which represents the proportion of medical and nursing students who are likely to go abroad for work or study after graduation – was taken to be 12 per cent, or 0.12, and the value of "r" at 85 per cent, or 0.85, came from a previous study.[110] Given budgetary constraints, the margin of error, e, was set at±4 per cent. And finally, the design effect was assumed to be 2, as recommended by the UN Statistics Division.[111]

Given these figures, the sample size for the study was set at approximately: **n = 600.**

[110] Huntigton et al., 2012, pp. 417–428.
[111] UN Statistics Division, 2005.

ANNEX VI.

Questionnaire for cognitive interview for the pre-pilot testing phase

Pre-pilot test protocol
Observational interviews, follow-up probing, and confidence rating

1. Please choose the test-protocol ☐ a. Category A: Observational interviews in full (followed by probing on specific questions listed below) ☐ b. Category B: Cognitive interviews (confidence rating, follow-up probing, and paraphrasing) on specific questions listed below.
2. Date of interview: ___ /___ /_____ (DD-MM-YYYY)
3. Degree programme of respondent: MBBS BN BSc PCL
4. (a) Year in the degree programme _____ OR Graduated
5. If graduated, which year was the graduation _____ A.D.
[Question 5] **Probe questions:** a. What do you understand by the phrase "average marks (in board exams) in this program up until now"? b. How many such exams have you taken? c. Who is the main authority/university administering this exam? d. Is this the appropriate scoring system for your program? Or do you receive **letter** grades for your board exams? e. **If letter grade is used,** how did you convert into marks? f. Did you know by-heart the overall average or did you only know year-by-year marks? g. Did you have to calculate the overall average? If so, **how** did you do it? h. Did you have any difficulty recalling your score, overall or year by year (as relevant)?

[Question 8]
Probe questions:

a. Did you have any difficulty or confusion to assign yourself to one of the caste/ethnic groups? What kind of difficulty or confusion?
b. What is your understanding of "hill" or "tarai" groups listed in the available options – do you think it is referring to their ancestral origin or their current place of residence?
c. What do you understand by "Other hill caste" or "Other tarai caste" listed in the response? Can you give some examples of what group of people would be classified in that group?

[Question 14]
Probe questions:

a. What do you understand by the phrase "lived abroad"?
b. Let's think of a hypothetical scenario: A woman from Nepal went to the United States for three weeks to attend a work-related seminar. The seminar was two weeks long, so she used the extra one week just for sight-seeing.
Now, in your opinion, do you think the woman mentioned in the example has "lived abroad"? Why or why not?
c. Do you have in mind a duration of stay (time period) abroad in order to qualify as having "lived abroad"?
d. What other criteria do you have in mind to qualify as having "lived abroad"?

[Question 15]
Probe questions:

a. Let us think of a hypothetical scenario:
A Nepali man named Ram migrated to the United States in 1980 to work as a medical doctor. He worked as a full-time medical doctor in the Unites States for about 25 years and retired in 2005. He still lives in the United State on a permanent basis.
Now, if Ram was one of your immediate family members, what would your response to this question be?
☐ a. Yes, but in the past
☐ b. Yes, at present
☐ c. No

[Question 17]
Probe questions:

a. What do you understand by the phrase "close relatives"?
b. Keeping in mind the definition of "close relatives" provided in the question, please list all the relationships (NOT NAMES) that you would consider to be "close relatives".
c. While answering this question, did only think about close relatives who are either doctors or nurses? Or did you also think about other close relatives?

[Question 22]
Probe questions:

a. What do you understand by the phrase "plan to do after the completion of your degree"? Did you understand in terms of career or education (or both) or in more general terms?
b. What reference period did you think of after reading this question? Did you think immediately after receiving degree, within few months, within few years, or what?
c. Did you experience any confusion as to which section you needed to skip to after answering the question?
d. Do you think more response options are needed here? In other words, is the list comprehensive?

[Question/Instruction 23]
Probe questions:

a. Is the instruction clear? What did you understand by the instruction?

[Question 23.c]
Probe questions:

a. What do you understand by the phrase "social prestige"?

[Question 23.d]
Probe questions:

a. What do you understand by the phrase "better provision of scholarship"?
b. Was your understanding that it is easier to receive scholarships in Nepal or that scholarships cover a larger percentage of the educational expenses or both?

[Question/Instruction 24]
Probe questions:

a. Is the instruction clear? What did you understand by the instruction?

[Question 23.b]
Probe questions:

a. What do you understand by the phrase "Serve the nation and/or public service"?

[Question 24.d]
Probe questions:

a. What do you understand by the phrase "social prestige"?

[Question 24.e]
Probe questions:

a. What do you understand by the phrase "better work conditions"?
   Did you think of anything other than the things mentioned in the example? (i.e. **EXCEPT** flexible work hours, occupational safety, and insurance)

[Question 24.g]
Probe questions:

a. What do you understand by the phrase "better benefits"?
b. Did you think of anything other than the things mentioned in the example? (i.e. **EXCEPT** pension, housing facilities, and paid leaves)

[Question 24.i]
Probe questions:

a. What do you understand by the phrase "gain work experience to facilitate future plans"?
b. What specifically did you think of when you read "future plans"?

[Question/Instruction 30]
Probe questions:

a. Is the instruction clear? What did you understand by the instruction?

[Question 30.f]
Probe questions:

a. What do you understand by the phrase "greater recognition of foreign degree"?
b. Who or which institutions might give a foreign degree a "greater recognition"?
c. Did you think it meant greater recognition in Nepal or abroad or both?

[Question 30.h]
Probe questions:

a. What do you understand by the phrase "better living conditions abroad"? Please list out all the things that you think fall under "living conditions"?

[Question 31]
Probe questions:

a. What do you understand by the phrase "official process"?
b. Other than the activities mentioned in the example, please list out other activities that you

think fall under "official process"? (i.e. EXCEPT college application, visa application, and obtaining No Objection Letter)

[Question 32]
Probe questions:

Let us consider a hypothetical scenario:
Geeta is planning to go abroad to study as a medical doctor at the post-graduate (MD) level. In order to go abroad, she needs to take a specific medical entrance examination for that country. She believes that if she joins an educational consultancy she can boost her entrance examination score. Therefore, she registers for a training course at a private educational consultancy which prepares students for that particular entrance examination.

Now, would you say that Geeta has started the "official process" to go abroad?
☐ Yes
☐ No
☐ Don't know

[Question 33]
Probe questions:

a. What do you understand by the word **"help"** in the context of this question?
b. Other than the sources of help mentioned in the example, please list out other activities that you think fall under "help"? (i.e. **EXCEPT** providing you information or processing documents)
c. Did you think of financial assistance? And did you include this in your response?

[Question 34]
Probe questions:
a. Are the response categories clear?
b. Are they comprehensive?
c. Is the formatting of the response categories clear? Are the arrows confusing?
d. Let us consider a hypothetical scenario:
You have a friend who is enrolled full-time as an electrical engineer at Pulchowk Engineering Campus. This friend is your main source of information regarding the process of going abroad. Now, given the scenario, what would your response to this question be?
_____ [Record response category from the available options]

[Question/Instruction 38]
Probe questions:
a. Is the instruction clear? What did you understand by the instruction?

[Question 38.h]
Probe questions:
a. What do you understand by the phrase "better health policy environment/framework"?

[Question/Instruction 41]
Probe questions:
b. Is the instruction clear? What did you understand by the instruction?

[Question 41.c]
Probe questions:
b. What do you understand by the phrase "better living conditions abroad"? Please list out all the things that you think fall under "living conditions"?

[Question 42]
Probe questions:
c. What do you understand by the phrase **"official process"**?
d. Other than the activities mentioned in the example, please list out other activities that you think fall under "official process"? (i.e. **EXCEPT** college application, visa application, and obtaining no-objection letter)

[Question 43]
Probe questions:
Let us consider a hypothetical scenario:
Geeta is planning to go abroad to study as a medical doctor at the post-graduate (MD) level. In order to go abroad, she needs to take a specific medical entrance examination for that country. She believes that if she joins an educational consultancy she can boost her entrance examination score. Therefore, she registers for a training course at a private educational consultancy which prepares students for that particular entrance examination.

Now, would you say that Geeta has started the "official process" to go abroad?
☐ Yes
☐ No
☐ Don't know

[Question 44]
Probe questions:

d. What do you understand by the word **"help"** in the context of this question?
e. Other than the sources of help mentioned in the example, please list out other activities that you think fall under "help"? (i.e. **EXCEPT** providing you information or processing documents)
f. Did you think of financial assistance? And did you include this in your response?

[Question 45]
Probe questions:

e. Are the response categories clear?
f. Are they comprehensive?
g. Is the formatting of the response categories clear? Are the arrows confusing?
h. Let us consider a hypothetical scenario:

You have a friend who is enrolled full-time as an electrical engineer at Pulchowk Engineering Campus. This friend is your main source of information regarding the process of going abroad.
Now, given the scenario, what would your response to this question be?
_____ [Record response category from the available options]

[Question 46]
Probe questions:

a. Are the response categories clear?
b. Are they comprehensive?
c. Is the formatting of the response categories clear? Are the arrows confusing?
d. Let us consider a hypothetical scenario:
e. Did you find that this question was overlapping with Question 45?

[Question 47]
Probe questions:

a. What did you understand by the phrase "processing your employment documents or facilitating job search"?
b. Other than the activities listed out in the example, could you please list out other activities that came to your mind? (i.e., **EXCEPT** sending out job applications, helping prepare CV/ Cover letters, contacting prospective employers)
c. Did you find that this question was overlapping with Question 46? If yes, how so? (REF 46. "Who is your **main** source of information regarding job opportunities available abroad?")

[Question/instruction 50]
Probe questions:

b. Is the instruction clear? What did you understand by the instruction?

[Question 50.j]
Probe questions:

b. What do you understand by the phrase "better health policy environment/framework"?

MIGRATION OF HEALTH WORKERS FROM NEPAL

The international migration of health workers has sparked multiple debates, particularly around the ethics of the recruitment process. It is an especially contentious topic, considering the chronic global shortage and inequitable distribution of health workers that brought about the alarming rates at which health workers are migrating from countries of the global South to countries of the global North.

Although the volume of health workers leaving Nepal has been on a steady rise and the implications seem significant, there has been no study to identify the drivers of such migration. Neither are there any policies in Nepal to govern and manage the migration of health workers. This study aimed to fill the gaps.

This reports draws on a survey comprising of final-year undergraduate medical and nursing students to analyse main drivers pushing Nepali health workers to seek employment opportunities abroad. In addition, the report explores legal mechanisms and policy frameworks specifically established to govern the migration of health workers from Nepal, other than the laws that govern foreign employment in general.

The South Asia Labour Migration Governance project is funded by the European Union.

Promoting safe migration and protecting migrant workers

ILO Country Office for Nepal
P.O. Box: 8971, Dhobighat – Nayabato
Lalitpur, Kathmandu, Nepal
Tel: +977 1 5555777, 5550691
Email: kathmandu@ilo.org

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ISBN: 9789221291060