Public Services International (PSI) is a global federation of public service unions, representing 685 unions in 160 countries. Together, these unions represent more than 20 million public sector workers in health and social care, central government, municipal and community services and in public utilities.

PSI runs a global Programme on International Migration and Women Health Workers.

The programme is run with the generous support from FNV Monidaal, Abvakabo/FNV, IMPACT and ILO ACTRAV.

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By Dr Jane Pillinger

7 April 2011
Preface

Public Services International is proud to present the Kenya National Report, which is a result of a literature review, mapping and participatory research on migration in the health and social care sectors conducted in Kenya.

The research is one of the activities conducted within PSI’s International Migration and Women Health and Social Care Workers Programme. The programme involves countries of origin and destination across all regions of the world and includes three countries in Africa (Kenya, Ghana and South Africa). Its main objective is to build the capacity of public sector trade unions in addressing the causes and impact of migration in the health and social care sectors.

In Kenya, a National Working Group representing affiliated public sector unions, has been established to implement the programme. These unions are the Kenya Local Government Workers Union (KLGWU), Kenya Union of Domestic, Hotels, Educational Institutions, Hospitals and Allied Workers (KUDHEIHA) and Union of Kenya Civil Servants (UKCS). The participatory research was carried out by members of the National Working Group, and the overall research and training was coordinated by and written up by the Research Consultant, Dr Jane Pillinger.

The Kenya national report is one of the several country reports that we are generating in key origin and destination countries, all of which will be consolidated into a Global Report on Migration in the Health and Social Care Sectors that will be presented to the PSI World Congress in November 2012. Through the research, we aim to build a strong evidence base from which we can build union tools and strategies to strengthen the health workforce and address migration issues.

As the world recovers from the economic crisis, quality public services, such as health and social care, are crucial in ensuring people’s welfare and achieving equality. Quality health services depend on a strong and sustainable workforce. It is hoped that the findings and recommendations of this report will contribute to strengthening the health workforce, reduce migration pressures, however ensuring that if and when migration occurs, it will result to a beneficial experience for all.

PSI wishes to thank the members of the National Working Group for their willingness and commitment to carry out the training as peer-researchers, and for their work in carrying out the interviews across Kenya and in holding the focus groups.

In particular, the PSI would like to thank Milka Isinta, from the National Working Group, who coordinated the research in Kenya; Hellen Apiyo, Ministry of Labour, who provided help in accessing information about Kenya; Elizabeth Owyer, Registrar, Nurses Council of Kenya, for providing up to date data from the Kenya Nursing Database; and PSI Regional Staff, David Dorkeeno, Khadija Mohamed and Sani Baba for their support to the work of the National Working Group.

Peter Waldorff
General Secretary
Public Services International
Section 1: Introduction and context

There is a chronic shortage of well-trained health workers. The shortage is global, but most acutely felt in the countries that need them most... Countries need their skilled workforce to stay so that their professional expertise can benefit the population. When health workers leave to work elsewhere, there is a loss of hope and loss of years of investment.

Dr Le Jong-wook, Director General, World Health Organisation (WHO 2006 World Health Report)

1.1 Introduction

This report documents innovative participatory research carried out by PSI affiliated public service trade unions in Kenya under the PSI's Programme on Women and International Migration in the Health and Social Care Sectors. The three trade unions participating in the programme's National Working Group, and who carried out the research, are the Union of Kenya Civil Servants (UKCS), the Kenya Local Government Workers Union (KLGWU) and the Kenya Union of Domestic, Hotels, Educational Institutions, Hospitals and Allied Workers (KUDHEIHA).

The Kenya research is part of a wider global research project, being carried out in Kenya, Ghana and South Africa, and in other locations across the world in countries of origin and destination. The research aims to provide an evidence base for trade union advocacy and campaigning work on the international migration of health and social care workers.

The outcomes and recommendations from this research situate Kenya in the broader context of global human resources for health (HRH) and the health related Millennium Development Goals (MDGs). It suggests ways in which trade unions, employers and the government can work together to ensure that Kenya moves from being an “HRH crisis country”, to one that achieves quality health care services, with decent working conditions and adequate staffing levels.

This broader context is essential if Kenya is to retain its trained nurses and midwives and overcome the situation where many health workers are forced to migrate to have decent pay and working conditions. While migration is a human right and a choice for many health and social care workers, it is essential that workers who migrate do so in the context of a positive migration policy framework, with information and support, decent working conditions and opportunities to re-integrate when they return. That said our research shows that the majority of health and social care workers want to live in and
contribute to the health, well-being and development of their country. A working environment that is rewarding, where workers are valued, that is safe and stress free, and that provides satisfying work and opportunities for career development, will avoid putting workers in a position to migrate.

Nurses and midwives are part of a global health workforce, meeting many of the health and social care needs of the richest countries. Kenya is one of many countries in sub-Saharan Africa that is experiencing the greatest difficulties in meeting the MDGs. At the same time developed countries have an increasing demand for health and social care staff resulting from low fertility rates and an ageing population. Health care workers in Kenya, as in other sub-Saharan countries, experience very poor and difficult working environments, poverty level wages, inadequate recognition of their value and poor career development (WHO 2006). Understaffing, a lack of skilled staff and lack of job satisfaction also impact on poor working conditions and stress at work (Mwita, Nyagero, O’Neil and Elqura 2009, Nurses Council of Kenya 2010).

The global economic crisis has had a social and economic impact on patterns of migration and has led to a significant increase in migrants returning home. Those countries of destination that have been affected by the crisis and growing public deficits, e.g. UK, USA and Ireland, have seen significant reductions in staffing levels and funding for health care, and an associated lower level of recruitment from overseas. It is migrant workers, who often work in a temporary capacity, who are the first to be affected by job cuts. Associated with this is the rise in anti-immigrant and discriminatory attitudes to migrant workers in many countries of destination. The economic effect also can be seen from reductions in foreign aid to developed countries and reductions in the flow of remittances to developing countries. Recent data from the World Bank shows that officially record remittance flows to developing countries fell by 5.5% (US$ 307 billion) in 2009.

1.2 The globalisation and feminisation of migration

Globally women account for nearly half of the 195 million international migrants, representing 94.5 million migrants or 49.6% of all migrants (UNFPA 2006). Today many women migrate alone and are a growing number are primary breadwinners, many of whom are parenting transnationally. Globally women remitted at least half of the US$ 328 billion sent through official channels in 2008. The majority of the global nursing and social care workforce are women. In Kenya, 91% of those seeking certification to work abroad are women.

At face value, migration appears not to be gender specific. However, women experience different patterns of migration, family responsibilities and access to economic and social resources. A gender-based analysis of migration legal frameworks and measures to ensure equality of treatment and recognition of the value of women’s care work is crucial in the light of the globalization of care relationships. Raising the political, economic and social value of care as “the basis of citizenship, of solidarity and of justice” (Williams 2010), is crucial if there are to be lasting and sustainable outcomes for economic and social development, reductions in poverty and inequalities in health, and in achieving gender equality.
Section 2: Overview of Kenya: health, policy and migration in Kenya

2.1 The health of the population in Kenya

The vision for health care in Kenya under the National Health Sector Strategic Plan II (2005-2010) is for: "An efficient and high quality health care system that is accessible, equitable and affordable for every Kenyan." However, achieving this vision has been difficult given the significant problems facing the Kenyan health care system.

Kenya faces significant challenges in the light of high rates of maternal and infant mortality and the burden of disease resulting from malaria, tuberculosis and HIV/AIDS. WHO's African region has 24% of the burden of disease but has only 3% of the world's health care workers. In contrast, the USA has 10% of the global burden of disease, 37% of the world's health workers and spends more than 50% of the world's health financing.

Poverty and poor living conditions result in serious inequalities in health for its population of 39.8 million. The statistics are alarming. In 2008, malaria continued to be the number one killer in the country, with a 30% case fatality rate for children under 5 years, while 6.7% of the population were affected by HIV/AIDS. Life expectancy at birth stood at 55 for women and 53 for men, with adult mortality rates being 371 per 1,000 population, compared to a global average of 180. Child mortality was at a rate of 84 deaths per 1,000 and infant mortality at 54.8 per 1,000 live births. Maternal mortality was 414 per 100,000, ranging from between 600 and 1,400 in the provinces. Deliveries conducted by skilled staff remained at 42% with a provincial variation from 8% to 67%.

2.2 Health expenditure

The current level of expenditure is woefully inadequate to meet these significant health needs, despite the increase in expenditure on health in recent years, as seen in Table 1.

Health expenditure per capita rose from 19.67 ($ US) in 2004 to 33.75 ($ US) in 2008, largely as a result of resources from external development aid. External assistance through development programmes have helped to address critical shortages in funding, for example, in relation to HIV/AIDS under the President's Emergency Programme for AIDS Relief (PEPFAR). An emergency recruitment programme took place in 2004 and 2007 focusing on areas of acute staffing shortages, staffing for HIV/AIDS and areas with a high prevalence of Malaria (Adano 2008). However, of the 2,333 nurses recruited through development partner support, only 2,045 remain in service, of whom 288 migrated to work overseas (Rakuom, 2010).

Table 1: Health expenditure

<table>
<thead>
<tr>
<th>Year</th>
<th>Public expenditure on health (%)</th>
<th>% of GDP spent on health</th>
<th>External resources for health (% of total expenditure)</th>
<th>Health expenditure per capita ($ US)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>8.49</td>
<td>1.96</td>
<td>15.17</td>
<td>19.67</td>
</tr>
<tr>
<td>2005</td>
<td>8.48</td>
<td>1.83</td>
<td>17.06</td>
<td>19.99</td>
</tr>
<tr>
<td>2006</td>
<td>8.81</td>
<td>1.89</td>
<td>19.78</td>
<td>23.15</td>
</tr>
<tr>
<td>2007</td>
<td>8.17</td>
<td>1.97</td>
<td>18.64</td>
<td>27.58</td>
</tr>
<tr>
<td>2008</td>
<td>7.79</td>
<td>1.99</td>
<td>24.11</td>
<td>33.75</td>
</tr>
</tbody>
</table>


1 With development assistance from the Danish Government, the Clinton Foundation, the Global Fund for HMT, PEPFAR and the USAid Capacity Project.
2.3 Government policies and fundamental rights in relation to health worker migration

A new Constitution was agreed in 2010, setting out the fundamental rights of Kenyans, including the right to the free movement of persons. The two main legislative provisions impacting on migration are the Employment Act, which regulates foreign employment, and the Immigration Act, which provides permits for workers and policies for refugees entering Kenya.

Employment policy

Employment policy and the implementation of labour laws and international labour standards is the responsibility of the Ministry of Labour and Human Resources Development. The 2002 National Employment Policy established an institutional framework to support the employment of Kenyans working abroad, including language training, skills training and the setting up of administrative systems. The Ministry has a role in providing information about overseas employment opportunities and in ensuring that these take place under decent working conditions, through the attestation of overseas contracts of employment and the registration of employment agencies. However, the attestations cover insufficient detail regarding job descriptions, terms and conditions and trade union rights. All prospective migrants are required to provide a letter of clearance from the Ministry and from the foreign employment agency. The Labour Office lacks capacity to verify if jobs abroad are genuine and to monitor the employment conditions of workers who are migrating.

Migration Policy

Two inter-ministerial committees have been established to respond to the significant outward migration of health workers: the Work Permits Committee and the National Steering Committee for Management of Migration of Human Resources for Health. Only the latter committee includes trade union and employer representatives, as required under the 1990 of ILO Convention No 144 on Tripartite Consultation. However, the National Steering Committee lacks resources and because it is a non-statutory body it does not have capacity to implement policy.

National Technical Working Group on Health Worker Migration

In addressing the crisis in health expenditure and health care migration a national Technical Working Group on Health Worker Migration (TWG) was established in 2006, under the International Labour Organization, World Health Organization and International Organization for Migration (ILO/WHO/IOM) Special Action Programme on Migration in the Health Sector. The Technical Working Group (TWG) has membership from government and the social partners. An action programme and activities plan was drawn up in 2009 with goals to:

- Develop an effective labour migration policy for human resources for health;
- Improve migration data collection and management systems;
- Improve the working environment to retain health workers;
- Provide services for migrants;
- Strengthen the capacity of social partners on health worker migration.

The TWG also carried two research studies. The first focussed on a review of migration health policy (Nyerere and Okech 2009) and made recommendations for an improved policy framework for migration management, investment in health care resources and for human resources planning. The second study on migration trends and data management (Arudo, Odago and Kamenju 2009), provided a baseline study on migration of health care professionals made recommendations for the introduction of an institutional mechanism for the collection of data in order to monitor migration of health workers.

2.4 Reform programmes in health

Structural adjustment policies and a lack of public finances have led to severe and lasting consequences for Kenya, resulting in a reduction in the wage bill and a moratorium on recruitment. This critical situation has led to a number of initiatives to improve the numbers of health care workers, working conditions, productivity and retention, as part of a broader programme of economic and social development. Measures put in place in recent years
to address staffing shortages have included an increase in the retirement age from 55 to 60 years and the harmonisation of salaries for civil servants under the Pay Policy Review for the Public Servants Board in 2006, resulting in pay increases for Registered and Enrolled nurses. Better opportunities exist for degree level and post-graduate programmes for nurses, following which nurses are bonded for three years. There is a five-year nursing plan to hire unemployed nurses as well as new graduates and measures to improve skill mix and task-shifting from higher qualified to lower qualified staff. A Strategy Plan for Nursing and a Scheme of Service for Nurses has been introduced to improve career progression and the retention and motivation of nurses. Other key reforms include the decentralisation of health care and the restructuring of the Ministry of Health to create a new Ministry of Medical Services and a Ministry of Public Health and Sanitation in 2008.

Despite these policy developments, which have resulted in some improvements in working conditions, pay and levels of staffing, Kenya continues to experience critical health shortages and to lose valuable health care workers through migration.

### 2.5 Human resources for health in Kenya

The Ouagadougou Declaration (WHO 2008) urges countries “to implement strategies to address the HRH needs and aimed at better planning, strengthening the capacity of health training institutions, management, motivation and retention in order to enhance the coverage and quality of health care” (Article 4-V).

Policies on HRH are essential in tackling the complexity of planning for training, recruitment and deployment of health care workers. Terms and conditions of work, pay, opportunities for career development and work-life balance are important elements of planning for HRH, and for recruiting and retaining workers in the health sector. However, HRH planning in Kenya is ad hoc:

“There is an absence of an explicit, coherent and codified policy addressing human resources for health…Together with compromised patient outcomes, the brain drain of young, highly skilled health workers brings about a severe reduction in the availability and quality of service (Nyerere and Okech 2009).”

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**Key reform programmes in Kenya**

- **The programme for Economic Recovery Strategy for Wealth Creation and Employment 2003-2007** (Ministry of Planning and National Development, 2003), set out a strategy for meeting the MDGs. Focus was given to reducing health inequalities and improving access to health care.

- **The National Health Sector Strategic Plan II 2005-2010**, set out a goal to reduce inequalities in health by enhancing health management. A joint programme of work and funding was established to improve the numbers of skilled workers and to recruit 427,000 health staff, of which 321,000 health workers would be recruited in community based services.

- **The Kenyan Essential Package for Health** (Ministry of Health 2005) has a goal to improve the health status of the population through the National Health Sector Strategic Plan II 2005-2010. Under the Package services are organised under five levels, with standards and norms for staffing levels, established by the Ministry of Health in 2006. In practice none of the objectives set out in the norms and standards for staffing levels have been met.

- **The Government of Kenya’s Vision 2030: Transforming National Development** is a national economic strategy, containing provisions for HRH. The vision anticipates that the public service will contribute to the economic transformation through employment opportunities and a reduction of poverty.
The chronic under-investment in HRH has resulted in human resources in health crisis in Kenya, in part a result of structural adjustment policies imposed by international monetary institutions (Rakuom 2010). Low levels of investment and recruitment of staff in public health care, poor working conditions, outward migration, a high attrition rate resulting from an ageing nurse workforce, and the impact of HIV/AIDS, have all impacted on the provision of health care. In addressing the maldistribution of staff and poor workforce planning, the Human Resources for Health Strategic Plan for the period 2007/8 to 2009/10 identifies key Human Resource Management and development constraints. It proposes strategies and plans to strengthen information systems, HR planning and management, performance management and training (Ministry of Health 2007).

### 2.6 Employment agencies and ethical recruitment

Ethical recruitment practices have had much greater visibility in Kenya in recent years following a significant increase in complaints from and media reports of exploitation of overseas workers. Ethical recruitment principles have been established by the International Council of Nurses and through bi-lateral agreements to facilitate migration, for example, with Lesotho and Namibia.

PSI has a migration policy that promotes ethical recruitment principles. Its European regional organization, EPSU, has established a Voluntary Code of Practice with the hospital sector in the EU.

The Employment Act requires the regulation and licensing of employment agencies. Only five of the twenty registered agencies in Kenya have followed the regulations regarding the attestation of contracts, while no private employment agencies providing HRH were registered (Nyerere and Okech 2009). The Kenyan Association of Private Employment Agencies established in 2006, as an umbrella organisation for agencies involved in recruiting Kenyan workers, has adopted a Code of Ethics, and is now recognised by the government, the ILO and the IOM.

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2 See PSI Policy Statement on International Migration with Particular Reference to Health Services [www.world-psi.org/migration](http://www.world-psi.org/migration) and EPSU-HOSPEEM code of conduct and follow up on Ethical Cross-Border Recruitment and Retention in the Hospital Sector [http://www.epsu.org/a/3715](http://www.epsu.org/a/3715)

3 See [http://www.kapea.org/ethics.html](http://www.kapea.org/ethics.html)
Section 3: The nursing workforce and the outward migration of nurses

3.1 Nursing Council of Kenya

The Nursing Council of Kenya is a statutory body responsible for the training, registration, licensing, and regulation of nursing professional practice and ethical standards, provided for under the Kenya Nursing Act. Although the Council keeps data on nurse registrations, including verification of certificates for clearance to work overseas, it does not monitor patterns of outward and return nurse migration once this verification has taken place. As a result it is very difficult to establish the extent to which nurses who have expressed an intention to work overseas actually migrated, for how long and whether they returned.

The Kenya nursing database was established by the Nursing Council of Kenya to facilitate evidence-based decision making in HRH and improved capacity to assess workforce trends and out-migration. It forms part of the Kenya Health Workforce Information System (KHWIS), established by the Ministry of Medical Services, the Ministry of Public Health and Sanitation and professional bodies.

3.2 Data on the nursing workforce in Kenya

The nursing workforce

Nurses are approximately 55% of the Kenyan health workforce;

86% of nurses and midwives in Kenya are women;

The majority of nurses are between the ages of 30 and 46 years. Nearly one-third of nurses and midwives are in the age range of 31-35 years, around one-fifth are over 45 years;

On average, 2,502 nurses are trained every year;

Nearly 50% of nurses and midwives are employed in the public sector;

Just over 80% of those employed in the public sector are in permanent employment.

| Table 2: Nurse registrations by nursing qualification, 2005-2010 |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| Kenya Enrolled Nurse | 2005   | 2006   | 2007   | 2008   | 2009   | 2010   |
|                   |        |        |        |        |        |        |
| Kenya Enrolled Midwifery | 2005   | 2006   | 2007   | 2008   | 2009   | 2010   |
|                   |        |        |        |        |        |        |
| Kenya Enrolled Psychiatric Nurse | 2005   | 2006   | 2007   | 2008   | 2009   | 2010   |
|                   |        |        |        |        |        |        |
|                   |        |        |        |        |        |        |
| Kenya Enrolled Community Health Nurse (PB) | 2005   | 2006   | 2007   | 2008   | 2009   | 2010   |
|                   |        |        |        |        |        |        |
| Kenya Registered Nursing | 2005   | 2006   | 2007   | 2008   | 2009   | 2010   |
|                   |        |        |        |        |        |        |
| Kenya Registered Midwife | 2005   | 2006   | 2007   | 2008   | 2009   | 2010   |
|                   |        |        |        |        |        |        |
| Kenya Registered Community Health Nurse (PB) | 2005   | 2006   | 2007   | 2008   | 2009   | 2010   |
|                   |        |        |        |        |        |        |
| Kenya Registered Psychiatric Nurse | 2005   | 2006   | 2007   | 2008   | 2009   | 2010   |
|                   |        |        |        |        |        |        |
| Kenya Registered Community Health Nurses [Basic] | 2005   | 2006   | 2007   | 2008   | 2009   | 2010   |
|                   |        |        |        |        |        |        |
| Kenya Registered Community Health Nurse (BScN) | 2005   | 2006   | 2007   | 2008   | 2009   | 2010   |
|                   |        |        |        |        |        |        |
| Kenya Registered Ophthalmic Nurse | 2005   | 2006   | 2007   | 2008   | 2009   | 2010   |
|                   |        |        |        |        |        |        |
| Kenya Registered Paediatric Nurse | 2005   | 2006   | 2007   | 2008   | 2009   | 2010   |
|                   |        |        |        |        |        |        |
| Kenya Registered Peri-Operative Nurse | 2005   | 2006   | 2007   | 2008   | 2009   | 2010   |
|                   |        |        |        |        |        |        |
| Kenya Registered Nurse Anaesthetist | 2005   | 2006   | 2007   | 2008   | 2009   | 2010   |
|                   |        |        |        |        |        |        |
| Kenya Registered Critical Care Nurse | 2005   | 2006   | 2007   | 2008   | 2009   | 2010   |
|                   |        |        |        |        |        |        |
| Kenya Registered Nephrology Nurse | 2005   | 2006   | 2007   | 2008   | 2009   | 2010   |
|                   |        |        |        |        |        |        |
| Source: Nursing Council of Kenya database | 1705   | 2429   | 2620   | 2781   | 4017   | 3157   |
In recent years there has been an increase in the number of nurse registrations, rising to a peak of 4,017 in 2009 and declining to 3,157 in 2010, as can be seen in Chart 1.

Table 2 shows the skills base of nurse registrations between 2005 and 2010, showing increases in registrations in almost all nurse skill areas, a doubling of registrations for Registered Community Nursing, and in the last three years new specialities.

![Chart 1: Registered nurses in Kenya, 2005-2010](image)

3.3 Nursing shortages in Kenya

The critical situation facing the shortage of nurses in Kenya is spelled out by Chris Rakuom, Chief Nursing Officer in the Ministry of Medical services in Kenya:

**Kenya’s case is unique. Over the past decade, it has been reported that there are over 7,000 unemployed nurses. Over 1,300 new nurses graduate annually from local colleges. At the same time, almost every functional health facility is understaffed with over 500 of Kenya’s 2,122 (2007) dispensaries throughout the country did not have a single nurse. In addition, an average of 500 nurses have been retiring annually at the age of 55 and between 300-400 nurses migrate abroad annually. (Rakuom 2010)**

The Kenyan health care system has been adversely affected by the migration of key skilled health workers. This situation is all the more critical in Kenya because of the concentration of health workers in urban areas and significant gaps in health coverage in remote and rural areas. WHO’s threshold of workforce density has identified Kenya as one of 57 countries that have critical shortages of health care staff and large numbers of unemployed health workers, making it unlikely that they will meet the health-related MDGs.

There were approximately 29,440 nurses working in the public and private sectors in Kenya in 2008, a ratio of 1 nurse per 1,345 population. This is less than half of the WHO recommended minimum of 2.5 nurses per 1,000 population. Based on the Ministry of Health’s health facility norms and standards there is a need for an additional 96,322 nurses. However, there were only 29,440 nurses in post in 2008, resulting in a shortfall of 65,782 nurses. In practice, if Kenya is to meet the MDG targets it would alone need to double its hospital-nursing staff (Rakumo 2010).

Despite these staffing shortages there is a pool of an estimated 5,000-7,000 unemployed health care workers (Campbell and Stilwell 2008, WHO 2006, Rakumo 2010). According to the WHO this is the result of ceilings put on public sector recruitment of health workers (WHO 2006). In addition, the mismatch in the supply and demand of nurses has resulted from inadequate HRH planning. For instance
between 2004 and 2006, 5,577 nurses graduated, while the number of new nursing staff appointed only amounted to 5,361 (Nyerere and Okech 2009).

3.4 Nurse migration

Kenya is a country of significant outward migration, with very minimal inward migration. Workers’ remittances in Kenya amounted to $1,686 million in 2009, which has more than doubled since 2005 (World Development Indicators, 2010). Migration results in a loss of the most highly trained nurse and reduces the number of younger nurses in a workforce that is ageing. It also decreases the potential for Kenya to increase its nursing workforce through training. The data collated through the PSI’s research, from the Nursing Council of Kenya and a mapping and verification exercise carried out by the Ministry of Health in Kenya (2007) suggests that many nurses and midwives have either considered migrating at some stage in the recent past or currently have plans to migrate overseas.

On average 840 applications are processed by the Nursing Council of Kenya each year, representing 33.57% of nurses who are trained each year;

Just over 40% of nurses who migrate are Registered Nurses, just over 30% are Registered Community Health Nurses; 10% are Enrolled Community Health Nurses; and just over 7% are Registered Midwives.

A recent analysis made by Gross et al (2011) of data from the Kenya Health Workforce Informatics System shows that between 1999 and 2007 6% of Kenya’s 41,367 nurses applied to migrate. Of those applying 85% were registered nurses or had a B.Sc. in Nursing and 49% applied within 10 years of their initial registration as a nurse. The study found that for every 4.5 nurses that enter the nursing workforce through training, one nurse from the workforce applies to migrate. This reduces by 22% Kenya’s ability to increase its nursing workforce through training.

Outward migration reached a peak in Kenya 2003, with 1,702 nurses applying to migrate, and has declined since then. Between 2005 and 2010 there were 1,299 applications for certification for nurses to migrate. Chart 2 shows the overall reduction in the trend, from 392 applications in 2006 to 78 applications in 2010. As a result of recruitment exercises, assisted by donors, in 2004 and 2007, enrolled and registered nurse registrations in Kenya rose from 40,081 in 2004 to 55,169 in 2007. A further fall in applications for outward migration in 2007 is attributed to improved pay and terms and conditions of employment. However, these registrations do not correspond to the actual numbers working, which declined from 16,146 registered and enrolled nurses in post in 2004 to 15,036 in 2007 (Government of Kenya, 2007).
Between 2005 and 2010, women were 91% of those making applications for registration to migrate. During this same period, of the 1,299 applicants, the main countries of destination were USA (737 applicants), UK (158 applicants), Australia (137 applicants), Canada (93 applicants), Ireland (51 applicants) and Namibia (48 applicants). It is also evident that many highly skilled nurses are migrating. Table 3 shows the outward migration skills set and the loss of trained nursing and midwifery staff, with the majority of those migrating being Registered Community Nurses, followed by Registered Midwives and Registered Nurses.
Section 4: PSI participatory research on the international migration of health and social care workers

4.1 Introduction to the participatory research and methodology

The participatory peer-led research was carried out by the three PSI public service unions in Kenya that are members of the National Working Group: KUDEIHA, UKCS and KLGWU. The objectives of the research were to:

- Provide an evidence base and data on the impact of migration on health and social care in Kenya;
- Identify future trends and potential migrationFollows;
- Identify key actions for trade unions and the government.

The research methodology encompassed:

- Face-to-face interviews with 330 nurses and midwives in Nairobi, Mombasa and Kisumu carried out in November and December 2010.
- Seven focus groups, with 42 nurses and midwives, carried out in November and December 2010 in Mombasa (4), Nairobi (2) and Kisumu (1).

The participatory peer-led research methodology was designed to empower and train a group of trade unionists with health and social care backgrounds to carry out interviews and focus groups with nurses and midwives across Kenya. The benefits of this method in a trade union context are two-fold. First, health workers were empowered and trained in research skills and through this to identify the needs of a wider number of health workers. This method is particularly valuable as it is more likely that peer health workers will be open, trusting and frank in discussing their needs and experiences. It also builds the research and data gathering capacity of trade unionists. Second, because the research was carried out by trade union members, this enabled the unions to disseminate the project’s Pre-Decision Kits and Passport to Workers’ Rights, and talk to participants about the work of the unions to improve information and policies on migration for health and social care workers.

Fourteen peer-researchers, who were members of the National Working Group, were trained during a two-day workshop held September 2010. A Research Coordinator for each union agreed to oversee the research and report to the National Working Group Research Coordinator. The PSI provided travel, subsistence and accommodation expenses to facilitate the research process. As well as developing a plan for the research, the training covered research methodology and ethics, interview skills, piloting of the questionnaire, and the holding of and reporting on focus group discussions. In addition, the Research Consultant also carried out a mapping and review of Kenyan legislation governing health, migration and employment, and carried out interviews with key informants in the Kenyan government and the trade unions.

By the end of the training the peer-researchers had developed the skills and confidence to carry out the interviews and focus groups. Comments included “I now have new skills to carry out research, this has
been very empowering”; “I am very excited about being part of this important research project”. The peer-research group were hugely committed and motivated to carry out the study.

4.2 Findings from the research

a) Number, geographic location and age of interviewees

A total of 330 interviews and seven focus groups were held with nursing and midwifery staff in Kenya, in Niarobi, Mombasa and Kisumu. Chart 1 shows the geographic locations of the interviews and by the union that carried out the interviews; 184 interviews were held in Niarobi, 101 in Mombasa, and 45 in Kisumu. The majority of those interviewed, 67%, were in the age range of 26-45 years. Of these 46% (n=153) were in the 26-35 years age group followed by 25% (n= 91) in the 35-45 years age group, and 16% (n=53) over 46 years of age.

b) Trade union membership and awareness of the PSI Project and Pre-Decision Kit

As well as contributing to an evidence base for the project, one of the objectives of the participatory research was to enable Kenyan unions to make contact with health care workers, inform them of the project activities, and disseminate the Pre-Decision Kit and Passport to Workers Rights that was prepared by the National Working Group in 2009.

Overall 67% of those interviewed were trade union members. Chart 5 breaks this down by each of the three unions that carried out the interviews. The research was also an opportunity to identify how many of those interviewed were aware of the PSI's project on international migration and of the Pre-Decision Kit. Overall 58% were aware of the PSI's project on international migration, with 51% aware of the Pre-Decision Kit.

“The passport for worker and union rights in Kenya I feel is a good programme. I have seen nurses from third world countries suffering in foreign countries. The linkage will assist our nurses and others in offering support and settlement in the foreign country”.

Chart 4: Interviews by union and place of interview

Chart 5: Percentage of interviewees who are trade union members, by union that carried out interviews
Many health workers are still intending to migrate and unions can make their experience better by providing information and support. Unions need to be more proactive in engaging the government on issues such as this. Through the interviews it was evident that most health workers are not satisfied with their wages, working conditions and staff levels. These urgently need to be addressed and the union can do much in the collective agreement which is main core business. The PSI project is indeed a vehicle for organising and recruiting workers to unions through education. Through the interviews all participants are now aware of the project, received a pre-decision kit and passport.

Peer researcher, KUDHEIHA

c) Migration decisions

There are many reasons why people migrate, the most important of which is economic, followed by poor quality health services, deteriorating working conditions, low opportunities for professional development and training, and political factors such as crime and political violence and demoralisation (Nyerere and Okech 2009, Nurses Council of Kenya 2010). According to the Nurses Council of Kenya (2010), migration results in significant economic and social costs to the country. Lives are lost because of inadequate staffing levels, the costs of investment in education and training are not recouped, and there is a loss of tax revenue to the government.

The findings from this research show that migration can be a positive and empowering experience for women, enabling women to gain autonomy and independence in their lives, experience and career opportunities and in positively shaping gender equality. However, our research shows that women migrants experience significant gender, ethnic and racial discrimination in their daily lives and in integrating into work and life in the countries they migrate to. Women's migration is often risky and open to exploitation, typified by discrimination, exploitation, low pay or poor conditions of employment, social isolation, loneliness and stress.

“Abroad is good but not the best. Home is the best place to be where you are close to family members and friends”.

Of the 303 nurses and midwives interviewed, an overwhelming 66% (n=218) had considered migrating at some stage in their working lives, as seen in Chart 6. This high level of nurses who have considered migrating is directly related to a multiple factors as shown in Chart 7. Wanting to earn a decent wage and having decent working conditions are overwhelmingly the most important factors influencing decisions to migrate, with 63% (n=207) stating that earning a decent wage was most significant factor, followed by working conditions for 55% (n=181), stress and pressure at work for 25% (n=82), and having valuable experience and opportunities for career progression for a further 38% (n=47) of interviewees.

“If the working conditions, pay, staffing, was better probably less Kenyan nurses would consider leaving the country”.

“The desire to work abroad is due to low wages and poor working conditions…and low staff motivation”.
The main factors that influence decisions to migrate: focus groups

- The two most common reasons for migrating reported in the focus groups were to earn better pay and have better working conditions. “To source greener pastures”, “to earn more money”, “to have better care for the family, education for kids, health and insurance cover”. Another said “I considered migrating to have an environment at work where I am respected”.

- The third most important factor was the opportunity for career development “to advance knowledge”. As one nurse said “Nurses have no time to go back to school and advance their knowledge and the institution does not allow time off or offer funding for further training”.

- Friendship networks also play an important role for those nurses that were planning to migrate “I want to migrate because my colleague is there and she is doing well”.

d) Factors influencing decisions not to migrate

Despite the high numbers of nurses who have considered migrating, there were a multiple and complex barriers that influence final decisions not to migrate. These ranged from hearing anecdotal stories of bad experiences working abroad, to complex and costly processes involved in migrating.

Chart 8 shows that the most significant barrier, reported by 52% (n=171) of interviewees, was the cost of registering and travelling to migrate. This was followed by 42% (n=139) who stated that uncertainty about the recruitment process influenced their decision not to migrate. A further 33% (n=109) stated that they decided not to migrate because it would be too difficult to leave their children and families. Factors such as having no practical support from the government were highlighted by 27% of respondents (n=89), while 21% (n=70) stated that they decided not to migrate because they found out that the cost of living was very high in the country that they had intended to migrate to.
Having paper work in order was also a factor affecting decisions to migrate. In one case a nurse was unable to migrate because her CGFNS Certificate had never been issued “despite passing the exam six years ago”.

The main factors influencing decisions not to migrate: focus groups

- Those that had planned to migrate but did not end up migrating stated that it was very difficult to migrate to work abroad. As one nurse said “The thought of not being able to go with my family made me change my mind”. Another said that “It was fear of not being able to get back to the system, when one is back. People have witnessed others who come back frustrated by this”.

- Others have decided not to migrate because of negative reports from nurses of exploitation and loneliness. “I changed my mind when one nurse died in Manchester in unclear circumstances”.

- In some cases the system was too complex and expensive: “It was too expensive to register and travel”.

The findings from the research also suggest that unions have a key role to play in providing information and assisting people in making decisions about the migration process. The survey found that 60% of respondents stated that their unions had not been of any help in influencing their decisions to migrate, despite the fact that 67% of those interviewed were trade union members. A large number had not thought about contacting their union. One nurse said “I never thought about consulting them”, while another said “I never thought they would help”. One nurse stated that she was not aware that the union could help as “The union has never talked to me about migration of skill to another country”. Another stated that participation in the PSI project influenced her decision not to migrate: “The PSI project on migration had just commenced in Kenya and I was lucky to participate in the project activities”.

**e) Working conditions, staffing levels, pay working environment and job satisfaction of nurses in Kenya**

The majority of the workers interviewed believed that significant additional resources were needed to improve the quality of health care, pay and working conditions in Kenya if nurses are to be retained in the workforce.

“It would be better to have working conditions, better pay and manageable stress. It would be better to build services at home and invest here rather than face the hardship of living as foreigners abroad”.

“With a high demand on quality health services, relatives and patients are expecting us to give our best which at times is not possible, especially with such high nurse-patient ratios. The government needs to recruit more health workers”.

The survey asked respondents to comment on the factors that impacted on their experience of working in the health sector in Kenya with regards to decent working conditions, adequate staffing levels, decent pay, a decent working environment and job satisfaction. Chart 9 shows that an overwhelming...
98% of interviewees stated that they did not have decent pay, 95% stated that they did not have decent working conditions, 97% stated that they did not have a decent working environment, 93% stated that there were inadequate staff levels to enable them to provide quality care. A further 91% stated that they did not have job satisfaction in their work. Comments included the need for employers to be more involved in motivating employees, while others stated that having affordable opportunities and release from duties for further education were very important. Several highlighted the importance of the government having a more strategic approach to human resource development and to having effective migration policies.

"Migration is about green pastures, if our government improves the pay, staff will work comfortably for their own people".

Chart 9: Extent to which nurses have decent working conditions, staffing levels, pay, working environment and job satisfaction

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<tr>
<th>Factor</th>
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<td>Decent working conditions</td>
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<td>Staffing levels</td>
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<td>Pay</td>
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<td>Job satisfaction</td>
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"The government should improve our health facilities in terms of equipment and medicine, and good pay, so that we are not forced migrate to other countries".

"I would like to see more opportunities for promotion, responsibility allowances, better staffing levels and the maintenance of nurses".

1) Migrants who have returned to Kenya

There is significant anecdotal evidence from trade unions in countries of origin and destination that some migrant health and social care workers experience exploitation and abuse of workers rights. Complaints include deception by recruitment agencies, employment contracts not being honoured, etc. The interviews and focus groups carried out through this research project captured some of these experiences, both positive and negative. Nurses returning face many challenges and there is a need to make return attractive, with policies to ensure that returning nurses are integrated into the nursing workforce. However, there is a limited evidence base and data on return migration in Kenya.

Fourteen interviews were carried out with migrants who had returned to Kenya after a period of work overseas and who had returned to work in the health sector in Kenya. Of the fourteen that had migrated, the main countries of destination were the USA (3), Canada (2), UK (4), Namibia (3), and other (2). The majority worked abroad for between one and five years. Ten had migrated alone, two had migrated with their partner, and two had migrated with their partner and children. Nine of the fourteen that migrated primarily to send remittances home for children and other family members, with a smaller number sending remittances home for investments for businesses or housing once they returned to Kenya.

Factor influencing decisions to migrate: focus groups

Those that had returned said that they migrated to have better pay.

In several cases having friends and colleagues made it easier to migrate. In one case a nurse said that she had worked in the UK “I was looking for better pay and the salary was higher in the UK. I had many friends there”. Another said “I went to make some money and then come back and invest”.

One woman who had returned stated that her experience had been “negative and depressing”. She had received no support or help from her unions in Kenya and the destination country.

Half of those that had migrated had a positive experience; the other half had a negative experience. Positive experiences included having a good working environment and access to technology, supportive line managers in the workplace, being treated with respect and dignity, better staff-patient ratios,
regulated working hours and a decent income to enable nurses to send remittances home.

“In Kenya nurses need to be motivated and be paid well. In outside countries nurses are respected, well paid and well taken care of. Where I went I did not get any problem because everything was organised by the government of Kenya and the country we went to we were received by the government of that country”.

“The country was quite go ahead on IT and management pays you any extra time worked for. The Chief Nursing Officer was quite supportive to ensure I settled in, she kept visiting me and encouraged me. The nurse to patient ratio was acceptable, not like we have here in Kenya”.

Negative experiences included being treated with disrespect, racism from staff and patients, an unfriendly living and working environment, a high cost of living and insufficient money to send money home, exploitative working conditions and long working hours, and working below potential and qualification levels. Some of the negative experiences were also related to isolation and loneliness, and particularly missing children and family members. Many of those that had negative experiences were working in care homes for the elderly or unregulated private establishments.

In the public sector, where there are guaranteed contractual conditions of employment, nurses are often working in lower skilled jobs that do not value their qualifications and skills. As one nurse said “Nurses working abroad are demoted, not recognised and are viewed less qualified”. Another nurse’s experience was not uncommon: “I was being paid less than my qualifications because I did not go through the registration process”. This does suggest the need for better systems for informing potential nurses of the recruitment and registration process in order to avoid unethical recruitment and situations where nurses work below their skills and potential.

Reasons for returning to Kenya were given as ending of a contract of employment, dissatisfaction with the job carried out which was not what had been expected, or wanting to return home to be with their children or to raise a family. Based on the experiences of working abroad, only one respondent stated that she would migrate again. In one case a nurse was able to return to her job because she had not resigned from her job and was able to return to her former position with no problems. In other cases nurses had to reapply for a job when they returned.

Two of those that had been recruited through a recruitment agency stated that the recruitment was carried out in an unethical way. Two were happy with the outcomes of the recruitment process. In the case of one nurse who had migrated through an unethical recruitment company, she said: “We were abandoned in a strange country. There was no immediate job as there as we did not have a work permit and license”.

“I never informed the government for fear that I would be sacked by my employer… it was confidential migration”.

Regarding the level at which nurses were employed, four stated that they worked at the same level that they had been working in Kenya, six at a level that was lower than in Kenya, and two at a higher level. All fourteen stated that their union had not been helpful to them prior to migrating. Only two were members of a trade union in their country of destination. Only two received help from the government when they first arrived. In one case a nurse was provided with help with food and housing when she first arrived, another
stated that she was “Provided orientation, housing and meals for three months”.

“I didn’t know that the union could have assisted me in any way, and therefore I never approached them or informed them”.

“I didn’t know that trade unions can assist”.

**g) Improving the experience of migration: the role of the Kenyan government**

“I wish the union would try to negotiate with government to enable the staff to earn a better pay and oppose their issue of migrating”.

“The government should improve salaries and add more staff to improve care given to the clients/patients”.

“From the government we request decent working conditions and better pay for those health workers who stick to their country”.

A key element of the research was to identify, from the perspective of the 303 nurses and midwives who were interviewed, and from the seven focus groups held as part of the research, what would need to be done to improve the migration experience.

The interviews focussed specifically on what the government and trade unions could do regarding the provision of information, advice and support prior to and during the migration process.

Recruiting and retaining nurses is directly attributed to the need for a better health care system. While pay ranks the most important factors, this is closely followed in nearly equal proportions by the need for improvements in staffing levels, better working conditions, more resources for equipment and medicines, opportunities for career progression and a less stressful working environment. While these are factors that have resource implications, they are also related to the need for improvements in the organisation and delivery of health care and more systematic approaches to HRH management and planning.

“The government should educate all health workers on migration and the benefits of working outside Kenya. The working conditions of health workers should be improved and terms of conditions looked into. These will help many health workers to be proud of working in Kenya. The working standards should be improved and the trade union should also be active in assisting the health workers to know about different countries”.

Chart 10 identifies how respondents ranked the main activities that the government should implement to improve the migration experience.

**Information about countries of destination**

Respondents ranked the most important activity to be providing information about countries of destination, including living expenses, housing etc., as these appear to be a key factor that have led to difficulties once people have migrated abroad.

**Information about migration policies and procedures**

The second ranking was given to providing more information about migration and particularly procedures for migrating. This includes the
requirements for registration and applying for jobs overseas and is particularly relevant to those nurses that have migrated to another country prior to receiving a job offer and authorisation from the Nurses Council to do so.

Government action to provide information: Focus groups

- There was an overwhelming view in the focus groups that migration should be made easier and the government should provide more support, information and pre-departure orientation to potential migrants: “Educate people about the best ways to migrate”, “Give information about other countries” and “Have a resource centre where one can get information on what is expected of them”.

- Improvements in salaries and conditions of work will enable the government to retain nurses in the labour market and not loose the skills and experience to countries overseas. “The Government should improve the terms and conditions of the worker”, “People need more pay”; “The country is a third world class level. Unless there are improved terms people will still continue to migrate”.

- There is a need to regulate working hours as many nurses and midwives work beyond their contractual hours because of insufficient staff.

- As one nurse said “Nursing work used to be a calling. But now it is a profession and hence needs to be paid well and to be able to meet basic needs”.

- Low pay, low status and poor opportunities for further education and training were seen to “demotivate and demoralise nurses in Kenya”.

Role of recruitment companies: focus groups

- Having information about recruitment companies and more scrutiny of recruitment agencies was seen as very important. “Identifying a good recruitment agency is a problem”. “The government should give advice about recruitment companies”.

- Some recruitment companies were seen to be unscrupulous “Many recruit in hotels, car parks and in hospitals. There have been cases were the companies have run away with a nurses money. It is hard to trust them”.

- Efforts should be made to develop bi-lateral agreements with countries of destination.

Support for migrants when they migrate to and arrive in a new country

Fourth in the ranking was the need for the government to provide more support when migrant nurses arrive in a new country, from the Kenyan government and the government in the country of destination. Of particular concern was the lack of recourse to overseas missions and embassies if unethical recruitment takes place or if workers were exploited. Fifth in the ranking was the need for the government to ensure that migrants are guaranteed levels of pay and working conditions.

“The recruitment procedures were taking too long and many things are involved such as visas, documents required”.

“As far as migration is concerned, clear guidelines should be given out by embassies”.

“There should be a law in Kenya to prosecute any agency that cons the Kenyan citizen”.

The role of recruitment companies

Third in the ranking was the role played by recruitment companies. Evidence from the survey shows significant mistrust of recruitment companies and their bona fides, and negative experiences resulting from unethical recruitment processes. Knowing which agencies to trust was identified as a key factor.

The research findings show that many health workers are unaware of and are not following recruitment procedures. As one peer researcher from the Union of Kenya Civil Servants stated “Most of the agents were charging a lot of money from them which majority can’t afford”. Where recruitment procedures were being followed these were very complex, adding a disincentive to nurses thinking about migration. The experience from colleagues who had migrated and came back was that many had experienced unethical recruitment. As one nurse stated she was aware of many cases of unethical recruitment: “The Agents were not faithful, a lot of cheatings”.

There was an overwhelming view in the focus groups that migration should be made easier and the government should provide more support, information and pre-departure orientation to potential migrants: “Educate people about the best ways to migrate”, “Give information about other countries” and “Have a resource centre where one can get information on what is expected of them”.

Improvements in salaries and conditions of work will enable the government to retain nurses in the labour market and not loose the skills and experience to countries overseas. “The Government should improve the terms and conditions of the worker”, “People need more pay”; “The country is a third world class level. Unless there are improved terms people will still continue to migrate”.

There is a need to regulate working hours as many nurses and midwives work beyond their contractual hours because of insufficient staff.

As one nurse said “Nursing work used to be a calling. But now it is a profession and hence needs to be paid well and to be able to meet basic needs”.

Low pay, low status and poor opportunities for further education and training were seen to “demotivate and demoralise nurses in Kenya”.
“There should be communications from the government in the event that there is a partnership with other countries as exists for example between Kenya and Namibia”.

“With East African community countries are now working together it would be good if the Kenyan government would liaise with those other countries so you don’t have to migrate far from home”.

“The government should allow nurses to travel without putting so many obstacles in the way”.

Help in settling into a new country and ensuring decent working conditions

Sixth in the ranking was the need for more help in settling into a new country, both from embassies in countries of destination and from the Kenyan government to ensure that migrants are given support and help when needed. Other suggestions included provision by the government to assist with the migrants’ financial welfare during the migration process, which the “migrant can pay back once they start earning”.

Government action to ensure that there are decent working conditions in countries of destination: focus groups

- In countries of destination there should be more help for migrants, particularly from Embassies and host governments. “The government should make sure everyone is protected against abuse”, “The Embassy in the other country needs to do follow-ups”, “The Government should intervene so that the attitude of receiving countries towards Kenya or black nurses changes”.

- There should be supervisory visits to evaluate the conditions that people are working under.

- Ensure that there are no rights violations in countries of destination.

- Provide help for returning migrants so that they are integrated back into the labour market, including a scheme of service that enables migrant nurses to have the option to have their jobs back when they return.

h) Improving the experience of migration: the role of trade unions

“Nurses should be recognised and involved in the union activities. They should be given continuous education. Some of us nurses do not even know their rights because they are not knowledgeable on union matters”.

“Unions should intervene in the workplaces here in our country Kenya and so that employers do not exploit workers”.
The role of the National Working Group has been hugely important in building capacity and awareness of international migration. As mentioned above the PSI's project has led to the development of key resources, including the Pre-Decision Kit and Passport to Workers' Rights.

Chart 11 shows that in terms of the role that unions can play, interviewees ranked advice about contracts and working conditions as being the most important, while information about unions in countries of destination and information about the migration process were ranked equally second and third. Other issues highlighted included the role that unions can play in improving conditions of work, which would avoid so many workers migrating to earn decent wages and to improve their working conditions. Trade unions were seen to play a key role in providing support by partnering with unions in countries of destination and in providing a follow up after a person has migrated to ensure that they have decent working conditions.

**The role that trade unions can play in supporting workers who are planning to migrate: focus groups**

- Trade unions should provide more support and advice for people thinking of migrating, and information about unions in countries of destination: “The unions should issue Pre-Decision Kits to everyone right across the country”.

- It is important that there are trade union rights for all workers. A nurse working in one private hospital in Mombasa stated that “Nurses are not allowed to join the union so there is no body to fight for our rights – they are only encouraged to join an association, which tries to take care of their welfare”. Another said that “There is sometimes resistance from an employer when an employee wants to join a union or is processing migration, they may be sacked”.

### Summary of the findings from the participatory research

**Interview profile**

- 330 interviews and seven focus groups were held, in Mombassa, Niarobi and Kisumu. The majority were in the age range of 26-45 years. 67% were trade union members

**Factors influencing decisions to migrate**

- 66% of those interviewed had considered migrating at some stage in their working lives;
- 63% stated that the main push factor was to earn a decent wage, 55% stated that this was because of working conditions, 38% saw migration as an opportunity for career development, 25% stated that stress and pressure at work were a key factor.

**Factors influencing decisions not to migrate**

- 52% of those who decided not to migrate in the end stated that this was because of the costs of registering and travelling to migrate; 42% stated that this was because of uncertainty about the recruitment process;
- 33% decided not to migrate because it was too difficult to leave their children and families;
- 27% stated that there was a lack of practical support from the government;
21% found that cost of living was too high in the country that they intended to migrate to;

60% stated that their union had been of no help in influencing their decisions to migrate.

**Working conditions, staffing levels, pay working environment and job satisfaction**

- 98% of interviewees stated that they did not have decent pay; 95% did not have decent working conditions; 97% did not have a decent working environment; 93% stated that there was inadequate staffing to provide quality care; and 91% stated that they did not have job satisfaction in their work.

**Migrants who have returned to Kenya**

- Fourteen interviews were held with migrants who had returned to Kenya; the majority worked abroad for between one and five years;
- Nine had migrated primarily to send remittances home for children and family members, and a smaller number for investments or housing.
- Half of those that had migrated had a positive experience; the other half negative;
- Two had experienced unethical recruitment practices.

**Recommendations about the role of the government**

- Provide clear and accurate information about countries of destination;
- Ensure that potential migrants are informed about migration policies and procedures;
- Improve the regulation and monitoring of recruitment companies and procedures;
- Provide support for migrants when they arrive and settle into a new country;
- Improve the monitoring of employment conditions in countries of destination.

**Recommendations about the role of trade unions**

- Provide information about contracts and working conditions;
- Give information about and contacts for trade unions in countries of destination;
- Information about migration processes, registration and recruitment procedures;
- Bargaining to improve pay and conditions of work, to avoid workers having to migrate;
- Support by partnering with unions in countries of destination.
Section 5: Conclusions and recommendations

This research, the first of its kind carried out in Kenya, documents the critical situation that faces Kenya’s health care system. Despite recent reform programmes and initiatives to address health worker migration and HRH planning, many health workers are still planning to and continue to migrate from Kenya.

There is substantial evidence from the review of policy and data, and from the participatory research, to show that there is an urgent need for fundamental changes to HRH policies and an investment of resources to address the chronic underfunding of the health care system. The research points to underlying conditions that are a push factor to migrate, resulting from Kenya’s health care crisis, the understaffing in health care facilities, significant numbers of unemployed nurses, the lack of implementation of key health care reforms, the inadequacies in HRH policy and workforce planning, and poor working conditions.

The evidence base from the participatory research gives voice to the continuing concerns and issues facing Kenya’s nursing and midwifery workforce. As a trade union study it provides an evidence base for the further development of trade union advocacy, information and campaigning work. The trade unions bring key resources, knowledge and perspectives that can enhance the development of HRH policies and policies on migration, which in turn will benefit Kenya’s economic and social development. Being part of a global research project, the findings from Kenya will also link strategically into the PSI’s global advocacy work with international organisations.

It is of great concern to the trade unions that growing poverty and inequalities in health, and severe constraints on public finances, will make it difficult if not impossible for Kenya to achieve the health related MDGs. It is of equal concern to the trade unions that many nurses are not aware of registration and migration procedures and receive insufficient information to enable informed choices and decisions when migrating. The research has pointed to the factors that influence migration decisions and to the experiences of nurses and midwives working in Kenya and overseas. These include low levels of pay, poor working conditions, difficult working environments, inadequate opportunities for career development, overstretched and stressed staff and the low value given to care work. These factors demotivate and demoralise workers, making it difficult for them to achieve satisfying and rewarding careers, and livelihoods for themselves and their families.

The research points to the need for trade union and government action to provide a coherent and ethical migration policy framework. Concerted action is needed to increase expenditure on health, enhance HRH planning, and improve the staffing levels, pay, working conditions, and working environment of existing nurses and midwives. If addressed there will be dividends for the economic and social development of Kenya, in meeting the health related MDGs, and in creating the optimum conditions for migration.

Through the social dialogue and collective bargaining, trade unions in Kenya can play an active role in forging the economic and social conditions that are necessary to retain trained and valued health care staff, in progressing gender equality and decent work, and in contributing to the overall economic and social development of the country. In the light of the global economic crisis, it will also become
increasingly important for attention to be given to the integration of returning migrants.

**Recommendations for trade unions**

- Trade unions need to further build the capacity of their membership to advocate for quality public health care services, in engaging in collective bargaining on HRH and migration policy.

- The evidence from this research provides an evidence base for trade unions to engage with relevant government ministries in improving working conditions and wages to improve the retention of nurses and midwives, and in establishing improved procedures and protections for those planning to migrate, for example, with regards more effective systems for the attestation of workers’ contracts, simplified procedures for nurses seeking registration to work overseas and ethical recruitment practices. Through these measures the National Working Group members are now in a position to engaging in an advocacy campaign to address the underlying causes of migration.

- Trade unions can also play a more active role in assisting workers in the migration process. Information dissemination is crucial to enable workers to make informed choices about migration, a solid basis for which has begun through the dissemination of the Pre-Decision Kit and Union Passport.

- The establishment of a union outreach programme, such as the “Migrant Desk” will make the role of the unions visible and attractive to migrant workers.

- The project’s activities on ethical recruitment, information dissemination through the Pre-Decision Kit and Union Passport, and the findings from the research, can be used strategically as tools for organising and recruiting workers in the health sector.

- Trade unions are well positioned to develop bi-lateral arrangements with unions in countries of destination and through this to ensure that health care workers are aware of their employment and migration rights and responsibilities.

- Trade unions can also use the evidence of unethical recruitment practices to advocate for improved processes for registering and monitoring the practices of private recruitment companies, and in implementing the WHO Code of Practice on ethical recruitment.

**Recommendations for the Kenya Government**

- Implementing a coordinated policy framework for managing the migration of health and social care workers is essential to HRH planning, to managing internal and external migration flows and to implementing international regulations and agreements on ethical recruitment and migrant workers rights.

- The WHO Code of Practice on ethical recruitment should be formally adopted and implemented in Kenya in a partnership between the government, employers, trade unions and
professional bodies. This should also lead to the establishment of a policy and a register of recruitment companies and the implementation of robust ethical recruitment standards.

- There is a key role for greater coordination of ministerial functions in Kenya across the different departments that deal with migration of health workers. This is particularly important in monitoring the conditions of workers abroad, for example, by improving the coordination with Kenyan embassies in providing a specialist Labour Attaches role.

- While good progress has been made on data collection, there is a need for more robust systems to be put in place to track and monitor inward and outward migration patterns and outcomes.

- Labour legislation should be fully compliant with international labour standards and will need to be reviewed to this end. While Kenya having ratified the ILO Migrant Workers Conventions No. 97 and No. 143, it can further affirm its commitment to migrant workers’ rights by ratifying the UN International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families.

- A government agency should be established to coordinate the activities of recruitment agencies, government departments, professional bodies and Kenyan missions abroad, for example, to ensure compliance with ILO Convention No 181 on Private Employment Agencies, to implement the WHO Code of Practice on ethical recruitment and the Commonwealth Code of Practice on migration, and in developing ethical and rights based bi-lateral arrangements between countries.

- The social dialogue framework coordinated by the Technical Working Group offers great potential for policy setting in strengthening HRH and promotion of ethical recruitment as provided for in the WHO Code of Practice. Through this mechanism it is recommended that an agreement be established between the trade unions and the government as an employer to ensure that nursing and health personnel are provided with opportunities to reintegrate into the labour market when they return, and to provide opportunities for secondment to work overseas, as has already been established with the Sudan and Lesotho.
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World Health Organisation Global Code of Practice on the International Recruitment of Health Personnel


