



A disposable workforce: Foreign health professionals in the South African public service

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The Migrating for Work Research Consortium

Building on over a decade of research experience in migration studies, the African Centre for Migration & Society (ACMS) at Wits University has embarked on a partnership with a range of academic (GovINN, University of Pretoria; United Nations University – Centre for Comparative Regional Integration Studies; UNESCO Chair on Free Movement), government (Department of Labour; South African Local Government Association; Statistics South Africa), and international (International Labour Organization; International Organization for Migration) partners. This partnership is expressed through the Migrating for Work Research Consortium (MiWORC).

MiWORC is based on a matching fund principle. The European Union, in the framework of the EU-South Africa Dialogue Facility (EuropeAid/132200/L/ACT/ZA), funds 50 per cent of the consortium. Beyond an ambitious scholarly agenda, one of MiWORC's objectives is to avail empirically based evidence to the EU-SA Dialogue Facility, a bilateral on-going strategic partnership between the European Union and South Africa, as well as to a range of key stakeholders in government, organised labour, business, and the NGO sector.

Work Package 3: Sectoral studies on low and highly skilled foreign workers in South Africa

WP3 explores the impact of low and high skilled migration in key sectors of the South African economy: construction and mining, commercial agriculture, hospitality, domestic work, and public health.

The first component of the WP seeks to understand why and how the South African economy is structurally dependent on low skilled foreign labour by examining existing legal frameworks, recruitment strategies, conditions of employment, and mobilization in the domestic work, hospitality, mining and commercial agriculture sectors.

The component on highly skilled labour explores the link between skilled migration and South Africa's state and economic development, with an emphasis on skills issues in the public health care and mining sectors. Specific questions relating to this study include: Why do skilled migrants come to South Africa? What informs their recruitment and are their conditions of employment similar to those of South Africans? Do they fill long term structural or temporary skills shortages?

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Abbreviations and acronyms

ACMS	African Centre for Migration & Society
AHP	African Health Placements
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
AU	African Union
CS	Community Service
COSATU	Congress of South African Trade Unions
DENOSA	Democratic Nursing Organisation of South Africa
DHA	Department of Home Affairs
DoH	Department of Health
DoL	Department of Labour
DRC	Democratic Republic of Congo
DSD	Department of Social Development
ECFMG	Educational Commission for Foreign Medical Graduates
EU	European Union
FPD	Foundation for Professional Development
FWMP	Foreign Workforce Management Programme
FWMT	Foreign Workforce Management Task team
GGA	Government-to-government agreement
HIV	Human Immunodeficiency Virus
HOSPERA	Health and Other Service Personnel Trade Union of South Africa
HPCSA	Health Professionals Council of South Africa
HR	Human Resources
HRH	Human Resources for Health
HSRC	Human Sciences Research Council
IELTS	International English Language Testing System
ILO	International Labour Organisation
JMAC	City of Johannesburg Migrant Advisory Council
LFS	Labour Force Survey
MSF	Médecins Sans Frontières – Doctors Without Borders
NEHAWU	National Education, Health and Allied Workers' Union
NHRHPF	National Human Resources for Health Planning Framework
NHS	National Health Service (UK)
NQF	National Qualifications Framework
NSFAS	National Student Financial Aid Scheme
NUPSAW	National Union of Public Service and Allied Workers
OECD	Organisation for Economic Cooperation and Development
OSD	Occupational Specific Dispensation
PERSAL	Personnel Salary System (part of the DoH)
PHC	Primary Health Care
PHR	Physicians for Human Rights

PHSDSBC	Public Health and Social Development Sectoral Bargaining Council
PSA	Public Servants Association of South Africa
PSCBC	Public Service Co-ordinating Bargaining Council
RHI	Rural Health Initiative
RuDASA	Rural Doctors' Association of South Africa
RWOPS	Remunerative Work Outside Public Service
SAAFP	South African Academy of Family Practice
SADC	Southern African Development Community
SAHRC	South African Human Rights Commission
SAMA	South African Medical Association
SAMP	Southern African Migration Project
SANC	South African Nursing Council
SAQA	South African Qualifications Authority
SETA	Sector Education Training Authority
SNR	Supernumerary Registrar
TOEFL	Test-Of-English-as a Foreign-Language
TPP	The Placement Project
WHO	World Health Organisation



Executive summary

Background of the study

Expert opinions regarding the recruitment of foreign staff into the South African public health sector are divergent. Over the past two decades, the National Department of Health (DoH) and the Health Professionals Council of South Africa (HPCSA) have adopted a principled position against the recruitment of staff from developing countries and increasingly enforced restrictive measures. Meanwhile, many voices in the sector, particularly in rural health care, have called for increases in foreign staff, better coordination of their recruitment, targeted training programmes, and incentives to their retention in the public sector. The recently articulated DoH strategy on human resources (HR) recognises the current challenges and the need for further recruitment without any concessions regarding the ban on recruiting from developing countries. However, the vast majority of foreign doctors employed in South Africa are from the Southern African Development Community (SADC) region.

The seventh in a series of research reports devoted to the impact of foreign labour on the South African labour market, *A disposable workforce* documents and addresses these various tensions and dilemmas. **Methodologically**, this study is based on two years of qualitative and quantitative research spanning 2013 and 2014. In addition to the statistical analysis of the DoH overall payroll data set (2013), 11 key informants and 61 randomly sampled health professionals (both South African and foreign) from Gauteng hospitals and clinics were interviewed totalling over 62 hours. This was supplemented by an in-depth analysis of available literature and documentation. Conceptually, the study makes use of **four main frameworks**: the history of the medical professions in South Africa; the national labour market for health; the global mobility of health professionals; and workplace dynamics in the health sector.

The report is divided into six chapters in addition to its introduction and conclusion. These chapters reflect key thematic areas that have emerged from the empirical data. Chapter 2 provides an **overview** of the current profile of foreign health professionals based on statistical and sociological data. Chapter 3 clarifies the state of **existing policy and legal frameworks** regulating the recruitment and employment of foreign health professionals in South Africa. Chapters 4, 5, and 6 then document three key dimensions of their situation in the country: Chapter 4 looks into the complexities of their **recruitment** into the system; Chapter 5 highlights key aspects pertaining to their **conditions of employment**; and Chapter 6 explores in further detail processes of **de-skilling (the loss of skills due to their non-utilisation) and remigration (migration to a further destination)** from South Africa. The conclusion then synthesizes key findings and points to a set of policy recommendations as well as further research dimensions.

Profile of foreign health professionals

Statistical trends

Drawing on Personnel Salary System (PERSAL) data, as captured by the system on 28 February 2013, the report opens on a statistical analysis highlighting nationwide trends in the current employment of foreign health professionals in the public service. Out of the total public health workforce, foreign personnel are about **1,5 per cent or 2 640 out of 173 080 qualified staff**.

The situation varies widely between professions. Foreigners represent 13,1 per cent of the workforce among medical practitioners, 7,5 per cent among specialists, 3,8 per cent among dentists, 3,4 per cent among pharmacists and less than 0,3 per cent among nurses. Foreigners represent lower shares of the total number of positions per occupation if one takes into account vacant positions: foreigners' overall share drops to 1,4 per cent of all qualified positions, 11,3 per cent of the medical practitioner positions, and 6,4 per cent of specialist positions in 2013. If one then looks at the origin of foreign personnel in the most qualified health professions, SADC countries are the origin of 38 per cent of the foreign medical practitioners, specialists, dentists or pharmacists, while 26 per cent are from the rest of Africa, and 36 per cent from the rest of the world.

While still limited, these data show us that there are **patterns of recruitment and settlement of foreign professionals in South Africa**. While the distribution per facility seems homogeneous, the geographical distribution, particularly per profession and against vacancy rates, seems highly imbalanced and calls for more targeted state intervention.

Sociological background of interviewees

Professionals interviewed for this study were asked several questions about their place of origin, the occupation of their parents, their studies and who supported them, as well as their current household situation (marital status, children, ties with family in home country or home town). While the study's qualitative nature precludes generalisations on the basis of these indications, the following characteristics helps contextualise the analysis of empirical material developed in the report.

Foreign nurses interviewed were balanced in terms of gender with an almost equal number of female and male nurses. Apart from isolated cases, most nurses interviewed had parents who were civil servants, junior clerks, teachers, or even health professionals (nurses, pharmacists). There was a clear divide among foreign nurses between Congolese and Ugandans on the one hand and Zimbabweans on the other in terms of education funding. Whereas the Congolese and Ugandan nurses had been supported by their families only (parents, uncles and aunts, or older siblings with an income) and never benefitted from state support, the Zimbabwean nurses were fully sponsored by the government throughout their studies. An overwhelming number of foreign nurses was originally from urban centres and had attended government nursing colleges.

Doctors were characterised by two clear divides: firstly in terms of socio-economic origin of the parents; secondly in terms of funding patterns of studies. Regarding parents, foreign African doctors were from upper middle class to elite families whereas South Africans originated more from lower middle class families of lower level civil servants or clerks. Whereas Southern Africans (South Africa, Botswana, Zimbabwe) had completed state-subsidised studies, other Africans were either self-sponsored or sponsored by development aid. As with nurses, the majority of foreign doctors came from urban backgrounds and had studied at state medical schools.

Policy frameworks

Foreign health professionals' recruitment and employment in South Africa is regulated by South African labour, immigration and health legislation and are also informed by the World Health Organisation's (WHO) Global Code of Practice on the International Recruitment of Health Personnel. **While the employment of**



foreign health staff is not new in South Africa, its regulation has become more stringent over the past two decades, particularly as a result of concurrent policy dynamics. On the one hand the Department of Home Affairs (DHA) has imposed more and more restrictive legislation regarding the employment of foreign nationals, which all sectors of the South African economy and government have had to align with; on the other hand, the HPCSA has striven to retain its independence regarding the assessment of foreign skills and competence and has gradually negotiated a more prominent role for itself in the issuance of immigration permits to foreign medical personnel.

Policy development within the DoH and the boards of professionals was found to have been incremental and in several instances lacking strategic direction. While the statistical analysis of current and planned outputs, as well as attrition rates, points to the caveats of the dominant restrictive approach, this conservative position continues to dominate within government. The reluctance to prioritise foreign recruitment and the very limited efforts undertaken to develop government-to-government agreements (GGAs) even with countries which have surplus personnel indicate that policy approaches are currently governed by a combination of nationalist prejudice and the incapacity to strategise. **The particularly conservative stance adopted on recruitment from developing countries seems to have been chosen on the basis of prejudice rather than to serve the ethical position it claims to purport.** Overall, there is little sense that the DoH policy on foreign staff recruitment is truly intended to meet shortages but rather seems designed to prevent ‘undesirables’ from getting into the system.

Making one’s way into the system

The reality of foreign personnel’s recruitment documented in the report points to **major shortcomings**. Turnaround times in the processing of applications by the DoH and provincial administrations were found to be unacceptably high and contributing to demotivation, de-skilling, and exploitation of applicants in related sectors such as care giving.

Specific aspects of recruitment are in need of **urgent attention**. Among others, one can cite the interdependency between verification of qualifications, competence within the DoH, and migration permitting by the DHA. This situation seems to delay processes considerably and it is unclear what independence was gained by the DoH vis-à-vis the DHA since so many steps in the process remain dependent on assessment by the DHA, a department notorious for its administrative inefficiency in the processing of immigration matters, regardless of applicants’ level of qualification. Urgent general improvements in administrative functions within the DoH are necessary to improve processes and turnaround times.

A second dimension of recruitment shortcomings is the **outsourcing of credentials verification** to an overseas company based in the US. Not only is this particularly time-consuming and costly for applicants, but it also means that related expertise is not being built within the DoH including for applicants from SADC.

The **use of asylum as a backdoor to recruitment** for developing country nationals emerged as a particularly contentious and complex issue. From a state perspective, the fact that some sections of public administration directly or tacitly encourage their public to exploit loopholes in public legislation seems short-sighted and irresponsible, particularly with such consequences as increased corruption and long-term

precarisation of part of the workforce. It also points to a lack of political courage to undertake the necessary reforms to facilitate the intake, stabilise and retain such a workforce.

In general, several of the shortcomings documented in the report are linked to the broader ambivalent position adopted by the boards and the DoH on the longer-term role of the foreign workforce in its policy design. A **complete rethink** of this dimension, focusing on the need to shift policy efforts towards regional development rather than regional antagonisms and isolation seems urgent 20 years after the end of apartheid. This rethink could encompass the following: regional GGAs; support to professionals from the region to retain linkages with their workplace or university of origin; twinning of facilities; and a shift to a system of recruitment quotas managed on the basis of known regional outputs and surpluses.

Holding one's ground within

Our enquiry into the lived work experiences of South African and foreign health professionals reflected the general context of a very strained public service seriously affected by under- and inadequate staffing and attrition of staff to the private sector and emigration, and faced with a quadruple burden of disease. Within that context, our foreign interviewees reported more positively on their work experience than on their registration and recruitment experiences, which was insignificant for South Africans as their induction was greatly facilitated by their nationality. However, several challenges continued to render their experience in public service particularly difficult as a direct result of their nationality. Firstly, their conditions of employment were characterised by: a seemingly growing division of labour between locals and foreigners; contract precarity due to their immigration status and a lack of policy direction; and exploitation, particularly in the period leading to registration, with employment in illegal conditions (locums) or in occupations well below their level of qualifications. Different parallel economies seem to be thriving as a result of foreign health professionals' precarious positions. Chapter 4 describes how a parallel economy of asylum 'benefitted' from the ban on African nationals. Chapter 5 documents the interconnection between the caregiving economy and of illegal locum networks and the availability and extended waiting times imposed on foreign health personnel. The interdependency between employment in the public service and immigration permitting seems to impact very negatively on foreign staff's morale, and their relationship with HR services at facility and provincial levels.

Interviews with South African and foreign health professionals also revealed discrimination at the workplace. Reports of xenophobic attitudes were common, particularly among nurses, and they sometimes led to illegal acts, endangering patients. A general sense of hostility, which at times manifested beyond the workplace in surrounding communities, impacted very negatively on interactions. South African staff interviewed either confirmed the abuse to which their foreign colleagues were subjected or themselves reflected high levels of prejudice. Many were misinformed about the realities of their colleagues' recruitment. Even in places where people did not report major problems, the level of fragmentation characterising the milieu, with tensions along language, ethnic, racial, gender, hierarchical and professional lines, was adding to foreigners' difficult integration. Foreign staff in those situations tended to withdraw and adopt invisibility strategies. While some were unionised, many expressed distrust and defiance in the unions or indicated having never been approached by them. South African staff, while often demotivated and despondent about unions, reflected a very different organisational culture in which union protection played an important role. Diverging attitudes were blatant between foreign and South African staff in terms



of responses to overtime, understaffing, etc., but mostly repressed for lack of engagement space where such incomprehension could be discussed and addressed.

However, some positive aspects were identified which could serve as the baseline for a more inclusive approach to foreign staff's integration into the South African workplace environment. The formalisation of administrative recruitment processes, in spite of continuing hiccups, was considered as positive as it gave a firmer footing to foreign staff once they were employed. Foreign staff valued the South African experience for many reasons: some were particularly interested in the acquisition of clinical experience with pathologies they were unfamiliar with; others liked the quality of technical equipment compared to other developing countries; yet others were interested in the organisation of health care and the systems management experience. Many, whether local or foreign, valued the international and multicultural dimension of the teams they worked within at large Gauteng facilities. Finally, pay was considered reasonable, except in the case of high-level specialists.

Remigration and retention

For a majority of our foreign interviewees, including those from SADC, South Africa was initially a second choice, identified by default and through networks. Interviewees would have preferred to go to Europe (Belgium, France, UK), North America (Canada, USA) or Australia. This is a classic trend for the highly skilled migrant who gathers information about employment opportunities through networks, other nationals or relatives already in South Africa. South Africa, with its specific policies and practices, then has to be integrated into a migration project in which it did not initially fit. While there was a strong appreciation of South Africa's generally high medical and nursing standards, the hostility and incoherence of the recruitment system were pointed to as strong deterrents to pursuing one's experience further or encouraging others (alumni, relatives) to join them. In instances, **health professionals were already planning to relocate, mostly to Western Europe and North America.**

This does not necessarily mean that interviewees will eventually leave South Africa but simply that this kind of rationale does exist among foreign staff alongside the view that South Africa is a final destination, meeting professionals' long term life expectations. Officials from the DoH also indicated that for some professionals in GGAs, in particular it seems for Tunisian doctors, experience acquired in South Africa with specific pathologies such as TB, HIV/AIDS and trauma, was considered valuable because it could be marketed in other contexts.

In spite of the serious challenges described earlier, **the administrative and workplace contexts in which foreign staff are recruited is not hopeless.** Not only are systems in place, even though they may be greatly dysfunction and need fixing, but there was also broad consensus among the majority of the South African staff we interviewed around the need for their skills and presence. Most South African staff considered that shortages were such that 'foreign doctors were better than no doctors at all', and that they allowed the public health system to survive. Some went further by insisting on their appreciation of foreign staff's hard work, and ability to cope with difficult conditions and publics. Others appreciated their high level of specialisation, particularly for first world doctors.

This consensus constitutes **a critical baseline from which the current policy can be expanded** and should be better explained. However, major challenges need to be overcome. The complexities, delays and precarity associated with immigration permits were almost unanimously resented by foreign interviewees

as well as South African administration managers. Whether before registration or during employment, some respondents expressed incomprehension and dismay at the level of skills waste in a country so affected by shortages.

Conclusion and recommendations

The South African public health sector faces numerous challenges, some historical, some contemporary. Twenty years into democracy, it is now evident that South Africa will not by itself meet its health staff shortages with its current policy instruments. While government's sustained policy efforts in tertiary education have, of late (since 2012), reversed the dramatic decade-long decrease in outputs in medical schools and nursing colleges, other structural (disease burden, educational output of secondary schools) and systemic (attrition to private sector and emigration) factors remain largely unchanged. **In the face of these challenges, the South African government has chosen to prohibit immigration from developing countries, including from its own region and sub-region (SADC). This has been done in spite of the fact that large numbers of African professionals, mostly from SADC, are already employed in and keep arriving to South Africa.** While the dependency of the South African system on African professionals claimed by some seems exaggerated given foreigners' small share of the total workforce, it is also clear that in certain facilities, specialities, and rural areas, they have become a vital component of extremely fragile and vulnerable systems. Yet, government seems to remain caught in its own dilemma and unable to instill forward-looking policies.

This **unresolved policy dilemma seems less and less sustainable in the global context of competition for skills.** It jars with the experiences of South African staff who work daily with foreign staff and, while unwilling to compromise on standards and management, seem inclined toward making their integration easier and more efficient. For the vast majority of foreign interviewees, South Africa was the default option. While most foreign staff declared they were in the country to stay, several referred to aspirations to move to the private sector, abandon their current project, or accumulate as much experience, qualifications and savings as possible to move on to greener pastures. Many already belong to global professional diasporas and are closely connected to transnational networks of relatives and co-nationals successfully settled elsewhere. While beyond the scope of this study, the possibility of remigration, that is, using South Africa as a stop-over, is real for at least a portion of those who have managed to register here. The questions then are: **Why would South Africa (and Southern Africa for that matter) be unable to retain health professionals who are very likely to successfully resettle in developed countries in the same profession? What, in the South African administrative and workplace environments, makes those professionals less performant than similar professionals who operate in developed countries?**

Drawing on all the empirical and theoretical observations made in the course of the study, this final section proposes **a series of 21 concrete recommendations** intended to enrich policy discussions and the reform of administrative practices. In places, it also identifies persistent knowledge gaps and charts the way for future research. Recommendations are formulated in the following areas:

- Policy coherence and harmonisation
- Governance reform of registration and recruitment
- Conditions of employment and retention
- Global market competitiveness of South Africa and building regional capacity rather than regional divide



1. Introduction

While it is widely recognised that the number of health professionals currently operating in the South African public sector are inadequate to address the specific needs of the population without medical insurance (84 per cent of the total) (Department of Health, 2011a; Motsoaledi, 2013), there are disagreements among experts over the actual causes of and possible solutions to protracted human resources shortages. Nonetheless, the South African government has never enjoyed better access to broader sources that could feed the health workforce than it currently has, either domestically (from medical schools and nursing colleges) or internationally. The demise of apartheid, the influx of skilled refugees from the region and the reintegration of the country into the global market have resulted in an increase in foreign health professionals seeking employment in South Africa. While this is a seemingly growing phenomenon, it is one that has been poorly documented thus far with limited exceptions (Bateman, 2007a & b, 2011a & b; Johnston 2011; Johnston & Spurrett, 2011). Minimal data, qualitative or quantitative, have been systematically marshalled to document the conditions of recruitment and employment in the public sector, particularly in relation to the broader issues of skills shortages and structural transformation of health care in the post-apartheid period.

Expert opinions regarding the recruitment of foreign staff are divergent. As they were formalising policies on the recruitment of foreigners over the past two decades, the National Department of Health (DoH) and the Health Professionals Council of South Africa (HPCSA) have adopted a principled position against the recruitment of staff from developing countries (see Chapter 3) and increasingly reinforced restrictive measures. Meanwhile, many voices in the sector, particularly in rural health care, have called for increases in foreign staff, better coordination of their recruitment, targeted training programmes and incentives to their retention in the public sector (Bateman, 2007b). The recently articulated DoH strategy on human resources recognises the current challenges and the need for further recruitment without any concessions regarding the ban on recruiting from developing countries (DoH, 2011b). Currently the vast majority of foreign doctors employed in South Africa are from the Southern African Development Community (SADC) region¹. This report intends to document and address these various tensions and dilemmas.

A conceptual framework for the study of health professionals' mobility and employment

Conceptually, this study is situated at the intersection between four main fields of inquiry mobilising a range of conceptual tools:

- The historical making of the health professions in South Africa, in comparison with other regions of the world, and its transformation in the contemporary period;
- The national labour market for health professionals;
- The global and regional mobility of health professionals from developing countries; and
- Workplace dynamics in South Africa.

¹ SADC comprises Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, United Republic of Tanzania, Zambia, and Zimbabwe.

This section will synthesise each of these fields and indicate how each factors into the present inquiry. The section closes on a set of research questions guiding the study.

The making of the health professions in comparative perspective

Historians and socio-anthropologists of medicine have built an impressive body of work on the making of medical professions worldwide. This was initially largely biased in favour of the West before Africanist scholars began to address similar issues in relation to Africa. While historians and sociologists of the 1970s argued over the differences and similarities in the nature of professionalisation between the West and developing countries (see for instance Iliffe's critique of Johnson & Caygill, 1998), this polarisation seems to have subsequently given way to more nuanced approaches. Many called for a re-examination of the various paths adopted for professionalisation in the West where state intervention proved more prominent on the Continent (Germany, France) than in the United Kingdom (UK) and the United States of America (USA) (Iliffe, 1998). In developing countries, the degree to which professionalisation was similar or divergent to the trajectory in the West (Johnson & Caygill, 1972) has been revisited in light of more recent developments and the unprecedented impact of the HIV/AIDS epidemic (Iliffe, 1998). The nature of professionalisation itself was deconstructed. Largely modelled on some experiences in the West, 1970s historians assumed hastily the universality of key features in the making of professions (ibid). These were characterised by the assertion of autonomous power structures independent from both state and private interests, control over a distinct body of knowledge, and shared values. The trajectory of professions in African countries rarely offered similar developments without necessarily excluding the idea of professionalisation. More recent approaches have rather documented the trajectories of professions in their national contexts of emergence (ibid).

In this discussion, as a former settlers' colony, retaining strong but also tense relations with the former colonial metropole, South Africa stands apart. The trajectory of its medical professions is more complex and follows a different timeframe than most other African countries. On the one hand, independence from the former colony and the assertion of an indigenous, albeit overwhelmingly White, profession materialised much earlier than elsewhere (Digby, 2006). On the other hand, the question of the structural transformation of the medical and nursing professions, in terms of racial composition, size, level of qualification and training, and distribution, is much more recent than in other African countries. These two dimensions have profoundly influenced the making of the medical and nursing professions. While the South African medical profession developed its own standards of professionalism early on, it also remained strongly influenced by the standards set by the former colony, Britain, which it ambited to emulate and even surpass, as well as by medical progress in the USA where many South African specialists have been and continue to be trained (ibid). The first heart transplant performed by Professor Christiaan Barnard at the Cape Town Groote Schuur Hospital in 1967 was emblematic of this ambivalent relationship with the West.

Further, the standards set by the South African Medical and Dental Council (SAMDC), which became the Health Professionals Council of South Africa (HPCSA) in 1974, were for a long time modelled on the terms of validation of qualifications of the General Medical Certificate in the UK (Digby, 2006). Due to the very early provision of medical education to White students within the colony (starting in the 1920s), this reference to British standards later became less obvious than it was across the rest of former British colonies where training and validation of degrees continued to be directly under the authority of the British authorities



even after independence (for East Africa for instance, see Iliffe, 1998). However, the reference to British or British inspired norms and competence in the English language have remained particularly strong tropes shaping recruitment into the health professions in South Africa, as will be seen in the empirical analysis of this study.

Other issues are those of discrimination, resistance to transformation, and racism, which continue to divide the South African medical and nursing professions. The provision of medical education to 'Blacks' and 'Coloureds' was thus heavily contested, not only by the apartheid state but also by professional bodies (Digby, 2006; Monamodi, 1996; Noble, 2005). While much larger than medicine, the professionalisation of nursing in South Africa also goes back to the 19th century (Searle, 1991) and, as in other colonies, is very much a history of fragmentation along gender, racial and class lines (Marks, 1994; Mashaba, 1995). Its transformation post-apartheid has been particularly complex and required profound restructuring of education and training institutions (Breier et al., 2009).

The imbalances of professionalisation were only one side of the colonial coin. The other side, access to health care under colonisation and apartheid, was particularly discriminatory. State funding started being invested in care for the majority of the population only when the reproduction of the labour force became an issue for the mining sector (Digby, 2008). It is emblematic that professionalisation in South Africa originates in Kimberley in the 1890s (Gilder, 1983). The shift to democracy in 1994 marked the beginning of a more sustained discussion about universal coverage and a national health insurance system. Yet, it was only in 2011 that the move towards a state-sponsored national health insurance policy was confirmed (DoH, 2011a). Among its core challenges, South Africa is characterised by a quadruple burden of disease (HIV and TB; child and maternal mortality; non communicable diseases; injury and violence) as well as by a general scarcity and chronic poor distribution of human resources for health (HRH) with a huge imbalance between the public and the private sectors, rural and urban areas, large hospitals and lower level facilities, and a very substantive loss of trained workforce (drop-out rates in nursing colleges in particular, as well as loss to the private sector and emigration).

The discussion on professionalisation in South Africa is important to this study for at least two reasons. The first relates to the historical transformation of the medical professions, which enables us to understand the specific dynamics in which the current inflow of foreign professionals is taking place. Here, issues of transformation and human resources for health are critical to understanding the debate on the recruitment of foreign staff in the South African system. The second reason has to do with the question of standards and models governing the profession, their origin and the set of values attached to them. These two dimensions related to the discussion on professionalisation (historical transformation and standards and models) need to be understood in their historical depth in order to better situate current discourses on skills and qualification as well as competing models of HRH policy. These dimensions also shape the normative representations and prejudice to be found in actors' discourses across the sector.

Labour markets for health professionals

A second key dimension informing this study is the understanding of dynamics structuring the national labour market for health professionals. As indicated above, the South African public health care system faces major HRH challenges. First is the issue of the imbalance between the public and the private sector: 79 per cent of registered medical doctors and 40 per cent of nurses operate in the private sector for about 16 per cent of the population (Motsoaledi, 2013; Breier et al., 2009). As opposed to medical doctors who

are overwhelmingly trained at the medical schools of South African universities, nurses' education straddles the public and private sectors with increasing numbers of nurses trained at lower levels by private institutions (hospital groups and nursing colleges) while four-year comprehensive training programmes are offered by universities and colleges (Breier et al., 2009: 3). A particularly worrying trend, noted in the 2011 NHI Policy document, is the attrition of medical and nursing staff through the education process, emigration and shift to the private sector. DoH (2011b) assessments put attribution rates at an average of 25 per cent, but it is much higher in certain categories. While medical schools and nursing colleges are currently training more medical staff than ever, numbers of doctors and nurses effectively employed in the public sector have stagnated for the past decade (Breier et al., 2009).

The long awaited draft Human Resources for Health strategy document (DoH, 2011b) published in 2011 paints a bleak picture of the state of education, training and recruitment of health staff in the public sector. The diagnosis is surprisingly open. Importantly, it is one of the only government policy documents acknowledging the recruitment of foreign workers as a needed policy instrument in order to counter attrition and meet staffing targets over the next 15 years. However, this is nuanced by the strategy of the current policy of the DoH "to limit recruitment of foreign doctors to a maximum of 6% of the medical workforce and only to use country-to-country agreements" (DoH, 2011a: 36 section 3.1.12). The same document also states that the current share of foreigners in the total medical workforce (general practitioners) is 10 per cent based on HPCSA registrations (DoH, 2011b: 36). Our own data (see Chapter 2) from PERSAL 2013 provided by the DoH indicates huge variations per profession, with 13,1 per cent for medical practitioners or 11,7 per cent when vacancies are taken into account (See Chapter 2). This is less than figures cited in the early 2000s of 20 per cent of doctors on the South African Medical Register (Lehmann & Sanders, 2002) or van Rensburg & van Rensburg's (1999) claim that 25 per cent of all public sector doctors were foreign, or even more recently Stern (2008: 8) who estimated that the figure had reached about 50 per cent.

The factors behind the current state of affairs are largely blamed on a historical neglect of HRH, disparate provincial HR systems, and inefficient management and recruitment processes (DoH, 2011b: 32). Management deficiencies and their specific impact on staff shortages and attrition are confirmed by independent research (Von Holdt and Murphy 2006; Africa Health Placement, 2014). After a particularly debilitating period between 1996 and 2008, when growth stagnated and key categories of specialists and specialist nurses declined, the situation seems to have stabilised but remains critical. Target achievements for critical health professionals will only be met over the next 10 to 15 years (DoH, 2011; Bateman, 2011a). However, the proposed increase in enrolment in medical schools needed to meet those targets is massive and unrealistic: for instance, to produce the needed 1 053 extra MB ChB graduates annually by 2025, enrolment in medical schools would have to be increased from 8 589 to 15 549, which would mean doubling the current training platform (Bateman, 2011a: 702). In nursing, the situation is even more serious with massive attrition: a Human Sciences Research Council (HSRC) study based on South African Nursing Council (SANC) statistics shows, for instance, that there were only 349 more nurses in 2002 than in 1996 and that while numbers have increased since as a result of the output of auxiliary nurses in particular, they are far from meeting targets. According to the DoH HRH strategy document, the deficit across all categories of nurses except enrolled nurses stood around 38 000 in 2011 (DoH, 2011a: 134) whereas the output from all colleges is about 3 000 to 4 000 annually with an attrition rate of about 67 per cent according to Breier et al.'s calculations (2009: 78).



This is the national HRH context against which the current policy regarding the recruitment of foreign staff will be assessed in Chapter 3 of this report.

The mobility of health professionals from developing countries

In addition to the history of professionalisation and the current HRH situation, the context in which the recruitment and employment of foreign professionals is taking place should also be envisaged from the perspective of their global mobility.

Key findings from the existing international literature point to a number of characteristics that are also found in the South African case. The general global context in which the current mobilities are taking place is characterised by a trend towards the privatisation of healthcare in many Organisation for Economic Cooperation and Development (OECD) countries as well as in emerging economies causing imbalances in personnel supplies since wages and conditions of work in the private sector are often more attractive (Iredale, 2001). In several OECD countries, the crisis in health personnel has initially been sparked by ageing populations with increasing care needs. This is not the case in South Africa where the population age structure is still predominantly young; the flight of personnel to the private sector and emigration are the two dominant factors of change. To summarise, South Africa combines aspects of OECD countries, in terms of high standards of its historical health personnel and challenges of recruitment and incorporation of foreign personnel from developing countries, with aspects of developing countries, in terms of the ratio of personnel to patients dependent on public health care (see next section), skills pool and output, and disease burden.

Because of its mixed nature, the South African case also defies theoretical frameworks that have classically analysed the migration of the highly skilled as either a net structural loss ('brain drain') for sending countries resulting from unequal power relations between centre and periphery (Marxist-structuralist approach), or the outcome of individuals' rational choice in maximising their human & social capital (neo-classical theory). Networks approaches, which Meyer (2001) has applied to South African highly skilled diasporas, do not necessarily bring a convincing answer to the theoretical challenge posed by South Africa. While it may have broadened the understanding of the mobility of the highly skilled, the networks approach has not entirely shifted around the 'brain drain' claim of an immeasurable loss to sending countries, nor has it provided very convincing empirical evidence that diasporas could be efficiently mobilised and contribute to innovation through a constant circulation of skills and ideas. This is demonstrated by Crush et al.'s (2012) study of the South African medical diaspora in Canada and its progressive but steady disengagement from the country of origin.

From a global market perspective, the trends described above mean that South Africa competes with OECD countries in terms of the recruitment of the best professionals from developing countries. While South Africa has adopted a principled position against 'brain drain', the reality is that this position is not going to deter health professionals from the African region from leaving their countries in search of greener pastures. Professionals' mobility is highly versatile and flexible, with flows that can shift rapidly to better destinations. These global shifts pose challenges to both the state and national professional bodies. As Iredale (2001: 21) notes,

Both the state and the profession have had to respond to changes brought about by the market situation and the increased mobility of professionals. The examples have shown that in some

occupations professional practice is no longer defined and controlled solely by national professional bodies. Few professional labour markets can be described as truly international at this stage as training, accreditation, ethics and standards continue to be managed mostly at the national level. However, there are distinct trends in this direction. Professional practice has become a transnational matter, although the extent of internationalization varies with professions.

This is the international backdrop against which the South African situation will be assessed.

Healthcare and workplace dynamics

The last dimension informing this study conceptually is that of workplace dynamics, the milieu in which foreign staff have to insert themselves. This milieu is characterised by: the institutional arrangements governing the practice of medicine and nursing; concrete conditions of infrastructure and logistics; the country's socio-economic conditions and specific disease burden; and finally the discourses and representations attached to health care and professionalism (Breier et al., 2009: 3).

The various laws and policies regulating foreign health care staff's access to employment in South Africa is detailed in Chapter 3, as is the role played and positions held by national boards of professionals and unions.

In terms of conditions of infrastructure and logistics, and in addition to the staff shortages described previously, the situation is one characterised by at least two features: a stark contrast between rural and urban areas; and financial difficulties and poor infrastructure across areas. While there has been a shift in policy emphasis from past biases towards urban health, hospitals, physicians and high technology to a more equitable geographical distribution of health care focused on preventive and primary care (Breier et al., 2009: 3), huge imbalances persist. The gaps in quality of services between the public and the private sector, and between urban and rural areas remain huge (van Rensburg & Peter, 2004: 163).

South Africa is plagued by a quadruple burden of disease (HIV & TB; child and maternal mortality; non communicable diseases; and violence and injury). This poses a number of training and organisational challenges to medical professions. In 2013, Statistics South Africa estimated that 10 per cent of the total population were HIV positive, with a constant increase since the 1990s, including since the roll-out of free antiretrovirals from 2007 onwards. This puts the total HIV population in South Africa at 5,26 million (Stats SA, 2013b: 4). Child and maternal mortality have also risen, only partly as a result of HIV and TB. Like non communicable diseases (hypertension, severe obesity, diabetes, etc.), and violence and injury, child and maternal mortality are linked to socio-economic conditions. In spite of the roll-out of a social grants system and a degree of free access to health care (maternity, children under 6 and emergency), living conditions for the poor in South Africa have in fact deteriorated since 1994, in particular as a result of unemployment currently standing at 35 per cent of the working age population (Stats SA, 2014).

There are specific tensions in public health workplaces related to structural understaffing. Indeed, when only doctors practising in the public sector are considered (via PERSAL data), South Africa's national average stands just above the poorest African countries with a ratio of 2,24 doctors per 10 000 of the uninsured population in 2007 (Erasmus & Breier, 2009: 116). The staffing trend for doctors over the 2000s decade is indicative of a stagnation of the doctor to population ratio, with instances of regression occurring in the Free State, Gauteng, and Western Cape provinces. In some cases, as in Limpopo, the ratio (1,74) is



comparable to those of Zimbabwe or Congo (ibid.). Regarding nurses, international comparison seems to indicate that South Africa has reasonable numbers of nurses compared to its neighbours. However, if one looks at the numbers of professional nurses in the public sector only (and not both public and private as the WHO does), the ratio falls from 4,08 to 0,9 per 1 000 public sector-dependent individuals (ibid.: 26). Given the very low rate of practitioners to dependent population, the burden on nursing staff in rural areas in particular is thereby increased within a context where nurses' ratio to population is already very low.

In terms of industrial relations, the South African public health sector is organised in bargaining councils. Two of them currently regulate the sector: the Public Service Co-ordinating Bargaining Council (PSCBC) and the Public Health and Social Development Sectoral Bargaining Council (PHSDSBC). The latter's mandate encompasses all employers and employees pertaining to the Departments of Health and Social Development at national and provincial levels. Parties to the PHSDSBC therefore are the two government departments (Health and Social Development) and trade unions. There are five trade unions: the largest one is the National Education, Health & Allied Workers' Union (NEHAWU) (a Congress of South African Trade Unions - COSATU - affiliate); the Democratic Nursing Organisation of South Africa (DENOSA) (also a COSATU affiliate); the Public Servants Association of South Africa (PSA); the Health and Other Service Personnel Trade Union of South Africa (HOSPERSA); and the National Union for Public Service and Allied Workers (NUPSAW). In 2006, the voting weights within the PHSDSBC were as indicated in [Table 1](#) below.

Table 1. Trade unions' vote weights within PHSDSBC, 2006

Trade Unions	Membership	Vote weight %	Reps
NEHAWU	84 698	33,34	5
DENOSA	65 376	25,74	5
PSA	52 377	20,62	5
HOSPERSA	41 481	16,33	4
NUPSAW	10 080	3,97	3
TOTAL	254 012	100	22

Source: PHSDSBC website, 2014.

However, in 2014, DENOSA had become the largest trade union for nurses with a membership of 84 000. It is also the largest union solely dedicated to the interests of nurses whereas NEHAWU, which claims more members overall, caters for both health and education workers. Historically, the largest two unions have had different legacies. A COSATU affiliate with its roots in the struggle against apartheid, NEHAWU is aligned to COSATU's socialist agenda and mobilises specifically around wages and conditions of employment. DENOSA, created in 1996 following the merger of segregated nursing unions under apartheid, claims a dual union and professionalisation mandate but is also a COSATU affiliate. While no unions have a stand-alone policy document on the question of foreign health professionals' recruitment and employment in the South African health sector, NEHAWU devoted a whole section of the resolutions adopted at its 9th Congress in 2010 to the issue. Mostly inspired by a socialist and internationalist perspectives, NEHAWU's position encompasses the recruitment of health personnel both from and into South Africa. The union adopts a mixed position combining aspects of protectionist and universalist viewpoints. While it generally condemns migrant labour (as leading to 'social pathologies') and the looting of skills from developing countries by developed ones, it also asserts the need for foreign personnel to be informed about their union rights, and in general to be treated equally to their South African counterparts in all manners of employment (NEHAWU, 2010). NEHAWU does not, however, adopt any clear position on the relationship

between skills shortages in the health sector and the recruitment of foreign personnel as a policy tool; its positions generally seem largely disconnected from the DoH Policy on HRH (2011). Of note is the fact that the other two significant unions in the sector are not COSATU affiliates. The PSA is the largest public service union that is not politically aligned, and HOSPERSA, which is a Federation of Unions of South Africa (FEDUSA) affiliate. FEDUSA, unlike COSATU, is not aligned to the ANC. None of these unions have publicly available records of their membership profiles, let alone of the nationality of their members.

Doctors, whether in the public or the private sector, have a narrower choice of unions for representation. The majority union is the South African Medical Association (SAMA). The history of SAMA goes back to the nineteenth century when doctors formed their own associations as local branches of the British Medical Association. In 1927, these branches were brought together and constituted as the national Medical Association of South Africa (MASA). Under apartheid, medical organisations were particularly fragmented; state doctors' ethics were severely criticised as some of them were considered to have become accomplices with the system. After the end of apartheid, the reunification of the medical profession did not go unchallenged. It was not until 1998 that SAMA was formed. SAMA is a registered trade union affiliated with COSATU. Through its Industrial Relations Unit, SAMA provides members with advice and information on employment laws such as the Labour Relations Act, the Basic Conditions of Employment Act and Regulations that govern aspects of employment in the Public Service. In addition, SAMA is admitted as a party at both the PSCBC and the PHDSBC where collective bargaining takes place on matters of mutual interests, such as improvements in the terms and conditions of service for all public service employees. FEDUSA, the other union federation, does not have a doctors' association or union among its affiliates. Other, smaller organisations exist but without significant impact.

Scope of the study and research questions

While the study's main aim is to document and analyse conditions of recruitment and employment of foreign doctors and nurses in the South African public health sector, it does so by paying attention to the four conceptual dimensions presented previously (professionalisation and its impact on the production of norms, standards, and discursive patterns; the national labour market for health professionals; labour market dynamics regionally and globally, with a specific emphasis on mobility; and workplace dynamics).

Our key research questions therefore are:

- Who are the foreign health professionals currently employed or seeking employment in the South African healthcare system and what role do they play in the sustainability of the system?
- On what is the demand for foreign professionals based and what are the specificities of the medical and the nursing professions respectively in relation with their South African counterparts?
- How do foreign medical professionals insert themselves in the South African public sector? What are the respective roles of the state, professionals' organisations, and professionals themselves?
- How do foreign medical professionals fare in the public sector?



Research design

The conceptual framework described above arises out of a research methodology that has been developed for a series of qualitative sectoral studies of low- and highly-skilled foreign labour developed in the framework of the MiWORC project.

Data sources

The first step in these studies consisted in a desktop scoping study of existing literature and secondary sources as well as a series of pilot interviews with a few key informants in the sector in order to map out key trends in the field and identify a more comprehensive list of key informants. A second step consisted in securing ethics clearance from both the University of the Witwatersrand Ethics Committee for Non-Medical Research on Human Subjects and from the Gauteng Provincial DoH Protocol Committee. Thirdly, the team worked on securing access from managers within public health care facilities and obtaining staff lists from which to sample. Staff lists were eventually provided from two academic hospitals, Chris Hani Baragwanath in Soweto, Johannesburg, and Steve Biko in Pretoria. Teams of researchers then approached sampled staff to conduct interviews. Interview data was collected through audio recordings (when authorised) and transcribed. Transcripts were analysed manually, using thematic clustering and qualitative content analysis in an inductive way (Patton, 2002).

In total, eleven interviews with key informants in the sector and 61 interviews with professionals (nurses and doctors) were conducted (see **Table 2**). Most interviews lasted between 60 and 120 minutes. In total, over 62 hours of interviews were recorded and transcribed. Women represented over half of respondents and foreigners just over two thirds. Among foreigners, 17 were from the Democratic Republic of Congo (DRC), 9 from Zimbabwe, 2 from Botswana, 2 from Malawi, 5 more from other African countries (Chad, Côte-d'Ivoire, Ghana, Sudan, and Uganda), 2 from Europe (UK and Belgium) and one from Iran. All together Africans made up over 75 per cent of our sample of foreign professionals. In terms of professions, nurses were just under one third of respondents, doctors slightly over one third and specialists and others (radiographers, pharmacists, researchers) constituted the final third. In terms of employment status, 11 out of 61 respondents were unemployed with all the others currently employed except one who was studying. Regarding their workplace, 25 respondents were employed at Chris Hani Baragwanath Hospital, Johannesburg, 16 at Steve Biko Academic Hospital, Pretoria, and the rest at other facilities across Gauteng (Helen Joseph Hospital, Alberton Hospital, rotating in Gauteng, etc.). The overwhelming majority of interviewees was selected through random sampling at each workplace based on staff lists provided by HR departments. A major challenge was that only one South African nurse accepted the invitation to answer our questions. While we agree that this is a major bias in our sample, we have tried to compensate for this with the use of secondary sources as most surveys conducted among nurses in South Africa have not taken into account the specific situation of foreign nurses but overwhelmingly focused on South African nurses. We therefore think that sufficient quality information is available in the literature to compare the information collected from foreign nurses to the condition of South African nurses. It is unclear to us why South African nurses were specifically reluctant to respond. Most explained they had busy schedules and indicated they could not see why they should be interviewed in a study focusing on foreign health personnel. While South African doctors also raised similar issues, we managed to convince more of them (17) to respond.

Table 2. Summary of empirical study - Professionals

	South Africans		Foreigners		Total
	Female	Male	Female	Male	
Nurses	1	0	13	2	16
Doctors (including Registrars)	5	4	6	10	25
Specialists	0	2	1	3	6
Others	3	3	2	6	14
Total	9	9	22	20	61

Source: ACMS WP3 Interview Track sheet for Health Study.

In addition, statistical data (presented in Chapter 2) were provided by the Foreign Workforce Management Programme (FWMP) at the DoH drawing on the government's human resources database, the Personnel Salary System (PERSAL). Statistical data from Statistics South Africa's Labour Force Survey (LFS) does not normally provide indications relating to country of origin, except for one iteration of a migration module in the third quarter of 2012 (see MiWORC Reports N°5 and N°6). However, breakdowns per country of origin offer such small numbers that these data were considered statistically unsound to be extrapolated at the national level and are therefore not used here. Data from the OECD and from the World Health Organisation (WHO) are used for international trends. Wherever possible we tried to disaggregate the data per gender, population group, geographical location and level of qualification but this could not always be done due to gaps in data collection.

Document analysis consisted in reviewing the following sources:

- Available national and international policy documents and legislation;
- Books and journal articles on the history of the medical profession in Africa and southern Africa, on international trends in the mobility of the highly skilled in general and of health professionals in particular;
- South African professionals' publications; and
- South African media.

Key informant interviews

Preliminary discussions were held with key players in the medical and nursing professions, among university, union, and national and provincial government stakeholders, as well as with representatives of organisations of foreign professionals in South Africa. These discussions allowed us to map out a more comprehensive list of potential key informants who were selected on the basis of their ability to provide specific information on key aspects of the inquiry. Redundancy in information collected led us to reduce the list of informants initially drafted. The protocol to inform and obtain consent was similar for all interviewees. In spite of numerous attempts by email and telephone over several weeks, SANC could not be reached for interviews.

Interviews with health professionals

The research design for professionals' interviews consisted of a deliberate combination of purposive and random sampling at the workplace level. Due to challenges in getting ethics clearance and access to



facilities, the initial national scope for the sampling of professionals had to be reduced to the Gauteng province only. However, the work experience of most Gauteng interviewees (particularly due to the obligation to complete community service (CS)²), and that of a few additional interviewees attained through snowball sampling, ultimately reflected experiences of work in rural areas and district or clinic level facilities and across most other provinces in the country. In Gauteng, three facilities were contacted (Charlotte Maxeke Johannesburg Academic Hospital and Chris Hani Baragwanath Academic Hospital in Johannesburg; and Steve Biko Academic Hospital in Pretoria) and two (Chris Hani and Steve Biko) provided lists of staff per department with breakdowns per nationality and profession. We then sampled from those lists and contacted potential participants telephonically which ensured confidentiality in the initial contact. However, due to slow responses or refusals, we then decided to simply contact as many individuals as we could from the lists. South African professionals were particularly reluctant to respond to the interview requests hence their underrepresentation in our sample: they indicated that they had no time and since the focus was on foreigners they could not understand why they should participate.

In addition to Gauteng hospitals, we also approached the Refugee Nurses Association of South Africa, an association of refugee nurses based in Johannesburg that claims a membership of over 300 nurses of different nationalities across the country. The organisation provided membership lists and we sampled nurses randomly from those lists.

Interview guides

Both key informant and professionals' interviews were semi-structured qualitative interviews. All key informants were asked to provide background on their education and qualifications, as well as their professional experience in relation with the recruitment and employment of foreign staff. They were then asked specific questions in relation to their respective organisations. Professionals' interviews were structured around the following areas: demographic profile; education and skills; migration to South Africa / from place of origin; recruitment process; previous and current work experience; workplace environment; relations with employers, colleagues and patients; representation through unions; and perceptions about the employment of foreign staff. Guides for South African staff were similar to guides for foreigners except that questions relating to migration from the country of origin were shifted to questions relating to mobility from the province of origin or place of birth.

Ethics commitments

In the initial phase of the study, ethical clearance was sought from the University of the Witwatersrand's Human Research Ethics Committee (Non-Medical). Ethics clearance N°4443_001 of 15/04/2013 was granted. Then clearance was sought from the Gauteng Department of Health Protocol Committee following indications by the province that this was a prerequisite to accessing facilities and staff lists. Clearance N°070813 of 06/09/2013 was granted.

As previously indicated, most of the time initial contact was established telephonically. If the contacted person agreed to be interviewed, interviews were then conducted in a place and language of their choice. We had an almost equal number of professionals choosing to be interviewed at the workplace and at home

² Community service (CS) is defined as compulsory service time in the public sector for newly-graduated health professionals. CS was introduced in 2001 and is still in place. It lasts one year.

or in a public space. Interestingly, even when given the option of conducting the interview in a language of their choice (most South African and foreign languages were spoken by someone among our staff), most respondents chose to be interviewed in English. Interviews conducted in other languages were translated into English in the transcript. Potential participants were presented with the research and given time to go through the participant information sheet and then asked to sign the consent form and specify to what extent they were ready to be cited namely, recorded, and so on. Verbal consent was irrelevant given the level of education of interviewees.

Recordings and transcripts were saved to external hard-drives with coded access as well as on pin-protected researchers' machines. Coding was kept separately at all times ensuring the confidentiality and security of the collected data.

Research team

Research for this report was conducted by an international team of eight senior and junior researchers: Mpumelelo Cebekhulu, Miriam Di Paola, Aline Mugisho, and Janet Munakamwe from ACMS; and Martha Molepo, Xolani Simelane and Lethabo Thaba from the Department of Labour under the supervision of Tendani Ramulongo, Head of Research, Policy and Strategy; Véronique Gindrey, independent data analyst, on the analysis of the PERSAL data; research assistantship was provided by Upenyu Majee from the University of Wisconsin-Madison in the framework of his internship with ACMS; all under the supervision of Aurelia Segatti (ACMS). Aurelia Segatti drafted the report with scientific editing by Zaheera Jinnah (ACMS) and partners from the MiWORC project. While these various inputs were extremely valuable, ultimately the views and analyses presented in the report remain those of the author.

Limitations

While we have striven to be as rigorous as possible in documenting the conditions of recruitment and employment of foreign health professionals in the public sector, the study has been subject to a number of limitations.

Data limitations

Statistics supplied by the FWMP at the DoH only provided limited information as they: were not disaggregated by gender or population group; were only provided for one year; and contained errors in the capture of countries of origin. This being said, the advantage of PERSAL data over other sources is that it excludes inactive staff registered with the professionals' councils thus providing a more accurate picture of currently employed staff.

Emphasis on institutions and professionals

Since the emphasis of the study was to document conditions of recruitment and employment, targeted informants belonged overwhelmingly to two categories: firstly, officials from government departments, academics from medical schools, professionals' boards and organisations, and unions; secondly, South African and foreign professionals currently employed or seeking to be employed in the public sector. The scope of our study did not allow us to incorporate the perspective of patients in their interactions with healthcare staff. This is a gap that we acknowledge and which we hope can be covered in future studies.



Another gap comes from the focus on the public sector. This meant that we did not engage with the issue of the recruitment of foreign professionals in the private sector. However, many of our interviewees had experience in the private sector or aspired to pursue their careers there. Key informants were also systematically probed to comment on the relationship between the public and private sectors. This dimension was therefore captured and analysed without having been the primary emphasis of the research. Another central dimension of the current crisis of healthcare in South Africa is that of the quadruple burden of disease. Aspects of this discussion came through in the interviews, particularly around issues of skills in relation to medical protocols, but it remained peripheral to our inquiry.

Social sciences approach

All sectors studied in work package 3 of the MiWORC project have been conducted by researchers not specialising in those sectors, but instead with a multi-disciplinary background in the social sciences and specific expertise in migration issues. This is both an advantage and a challenge. On the one hand, this has allowed for more distanced views and a comparison of the condition of foreign health professionals to that of other foreign professionals or workers in other sectors of the South African economy and internationally. In addition, our approach has looked into the history of the formation of the professions in South Africa and beyond, and envisaged how the arrival of other African staff complicated the transformation debate in South Africa, a perspective largely missing from studies conducted by professionals or educators in the sector. On the other hand, not being intimate with debates in the profession may have led to some approximations and gaps. In order to address this challenge, this report was presented to stakeholders in the sector and their feedback was incorporated in the final version. We are grateful for their input.

Overview of the report

The report is divided into six chapters and a conclusion, in addition to this introduction. These chapters reflect key thematic areas that have emerged from the empirical data. Chapter 2 provides an **overview** of the current profile of foreign health professionals based on statistical and sociological data. Chapter 3 clarifies the state of **existing policy and legal frameworks** regulating the recruitment and employment of foreign health professionals in South Africa. Chapters 4, 5, and 6 then document three key dimensions of their situation in the country: Chapter 4 looks into the complexities of their **recruitment** into the system; Chapter 5 highlights key aspects pertaining to their **conditions of employment**; and Chapter 6 explores in further detail processes of **de-skilling (the loss of skills due to their non-utilisation) and remigration (migration to a further destination)** from South Africa. The conclusion then synthesizes key findings and points to a set of policy recommendations as well as further research dimensions.



2. Profile of foreign professionals ³

This chapter first provides an overview and analysis of statistical data provided by the National DoH, and then an overview of the sociological profile of respondents interviewed in the MiWORC study.

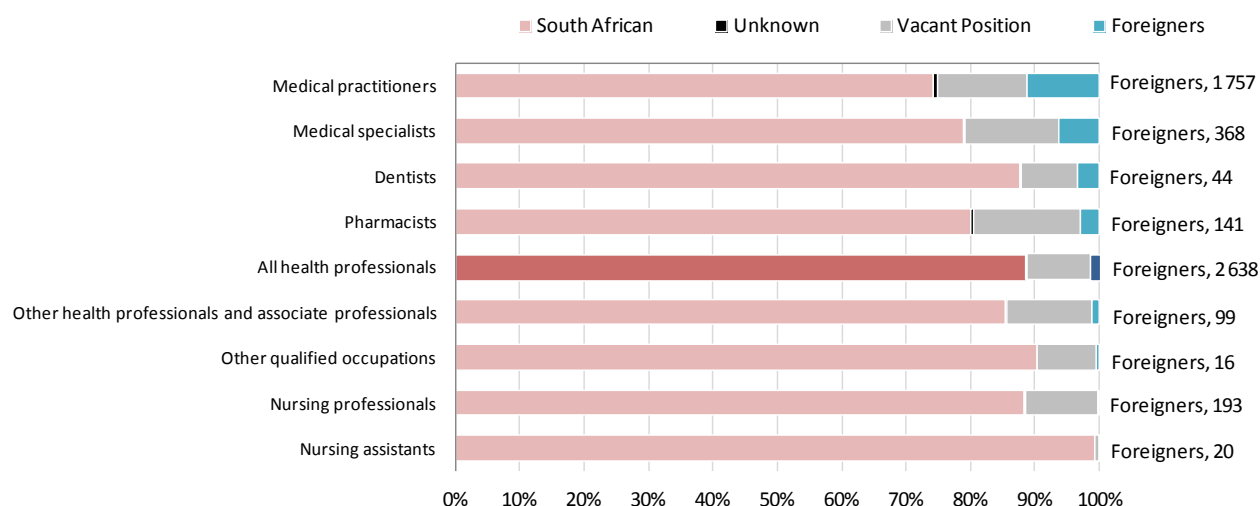
Trends and statistics from the Department of Health

The Foreign Workforce Management Programme at the National DoH (see Chapters 3 and 4) agreed to avail the following statistics drawing on the government's human resources database, the Personnel Salary System (PERSAL), as captured by the system on 28 February 2013.

Out of the total public health workforce, foreign personnel are about **1,5 per cent or 2 640 out of 173 080 qualified staff (Figure 1)**.

The situation varies widely between professions. Foreigners represent 13,1 per cent of the workforce among medical practitioners, 7,5 per cent among specialists, 3,8 per cent among dentists, 3,4 per cent among pharmacists and less than 0,3 per cent among nurses. Foreigners represent lower shares of the total number of positions per occupation if one takes into account vacant positions. When vacant positions are added, foreigners' overall share drops to 1,4 per cent of all qualified positions, 11,3 per cent of the medical practitioner positions, and 6,4 per cent of the specialist positions in 2013.

Figure 1. Foreign workforce as a percentage of total public health workforce by profession



Note: "Other health professionals and associate professionals" include dental therapists, dietitians, nutritionists, occupational therapists, oral hygienists, physiotherapists, radiographers, speech therapists, and audiologists. "Other qualified occupations" include biochemistry, pharmacology, zoology and life science technicians, life science professionals, medical research and related professionals, medical technicians and technologists, optometrists, opticians,

³ All data analysis in this section was undertaken by Véronique Gindrey, independent analyst, for the MiWORC. For a full analysis of PERSAL data, see Gindrey, V. 2014. *The position of foreign health professionals in the South African public health service: A statistical analysis of PERSAL data*. MiWORC Report N°7 bis. Johannesburg: African Centre for Migration & Society, University of the Witwatersrand.

pharmaceutical assistants, pharmacologists, pathologists and related professionals. Nursing professionals also include student nurses. Nursing assistants also include staff nurses and pupil nurses.

Source: March 2013 data from the Department of Health extracted by Ina Badenhorst, DoH.

The majority of the foreign workforce consists of medical practitioners (67 per cent), followed by specialists (14 per cent) and nurses (8 per cent) (**Figure 2**), a structure that is radically different from that of the South African workforce which is overwhelmingly composed of nurses (81 per cent), followed by medical practitioners (7 per cent) and other professionals and associate professionals (4 per cent) (**Figure 3**). These distinct structures are evidence to the influence of policy on the presence of foreign personnel in the workforce: while entry is possible and somehow encouraged for doctors and specialists, the limited presence of foreign nurses in the public sector could be a reflection of the specific challenges they encounter (see Chapter 4). This could also be a sign that there is a bigger attrition of the number of foreign nurses from the public sector to the private sector than of medical practitioners. However, more data would be needed to confirm this.

Figure 2. Foreign health workforce by profession, 2013

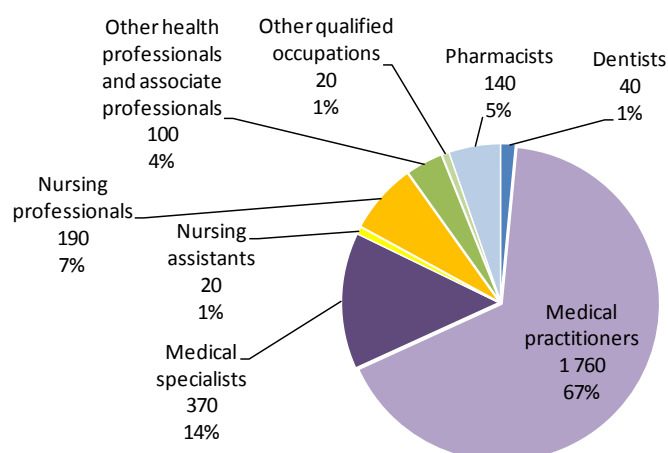
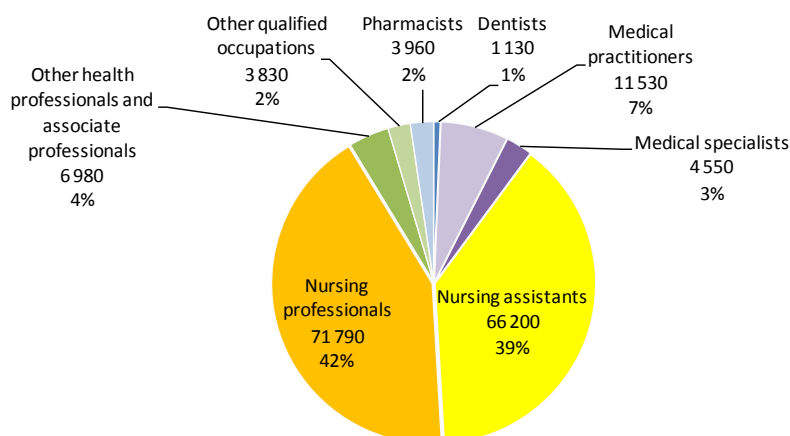


Figure 3. South African health workforce by profession, 2013



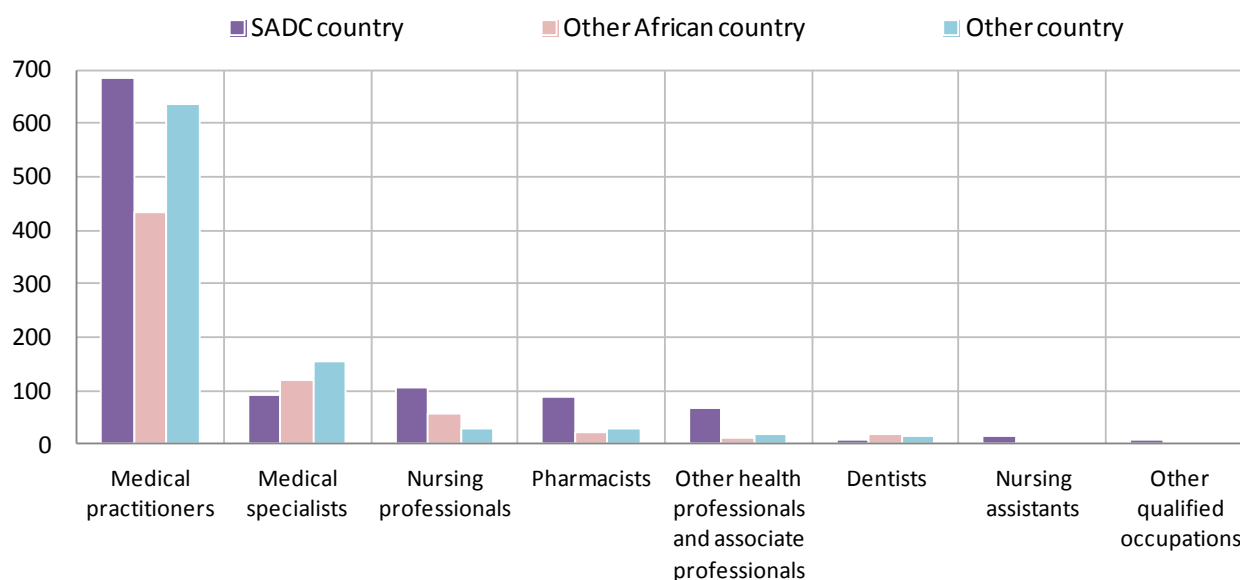
Note: The figures are rounded to the nearest ten.

Source: March 2013 data from the Department of Health extracted by Ina Badenhorst, DoH.



If one then looks at the origin of foreign personnel in the most qualified health professions, SADC countries are the origin of 38 per cent of the foreign medical practitioners, specialists, dentists or pharmacists, while 26 per cent are from the rest of Africa, and 36 per cent from the rest of the world (**Figure 4**).

Figure 4. Foreign health workforce by citizenship, 2013



Note: The professions are ordered by decreasing number of foreigners among health workers.

Source: March 2013 data from the Department of Health extracted by Ina Badenhorst, DoH.

Among SADC countries, the Democratic Republic of the Congo (D. R. Congo)⁴ is far ahead of Zimbabwe, Lesotho and Botswana (**Table 3**). Nigeria is the second largest African source country for the most qualified health professions in South Africa in 2013. Cuba, India and the United Kingdom are the main non-African source countries.

⁴ The capture of data for Congolese nationals seems incoherent in the DoH data base as they come under the label 'Republic of Congo' as well as 'Zaire' which no longer exists and probably corresponds to a few cases of older professionals who migrated prior to the change in the country's name. Empirical evidence shows that Congolese professionals working in the South African public sector are overwhelmingly from the Democratic Republic of Congo and NOT the Republic of Congo (Congo Brazzaville). We therefore decided to conflate the Republic of Congo and Zaire values into one single DRC category. This means that there may be a few cases of citizens from the Republic of Congo (Congo Brazzaville) who may be conflated into this category erroneously. There is currently no way to verify this in the PERSAL data set.

Table 3. Top 10 countries for foreign citizenship of medical practitioners, medical specialists, dentists and pharmacists, 2013

Citizenship	Number of health practitioners
Democratic Republic of the Congo	490
Nigeria	380
Cuba	150
India	150
Zimbabwe	140
United Kingdom	130
Lesotho	60
Botswana	60
Tunisia	50
Uganda	50

Note: The figures are rounded to the nearest ten.

Source: March 2013 data from the Department of Health extracted by Ina Badenhorst, DoH.

If one now turns to the distribution of the foreign workforce per type of facility, it is noteworthy that there is a balanced distribution across levels, with a slightly higher concentration in provincial or district level facilities (11 per cent), followed by clinics (10 per cent) and academic and tertiary institutions which only account for 7 per cent. Unsurprisingly, staffing in national and provincial offices is overwhelmingly South African (**Table 4**).

Table 4. Distribution of medical practitioners, medical specialists, dentists and pharmacists by type of health facility and citizenship, 2013

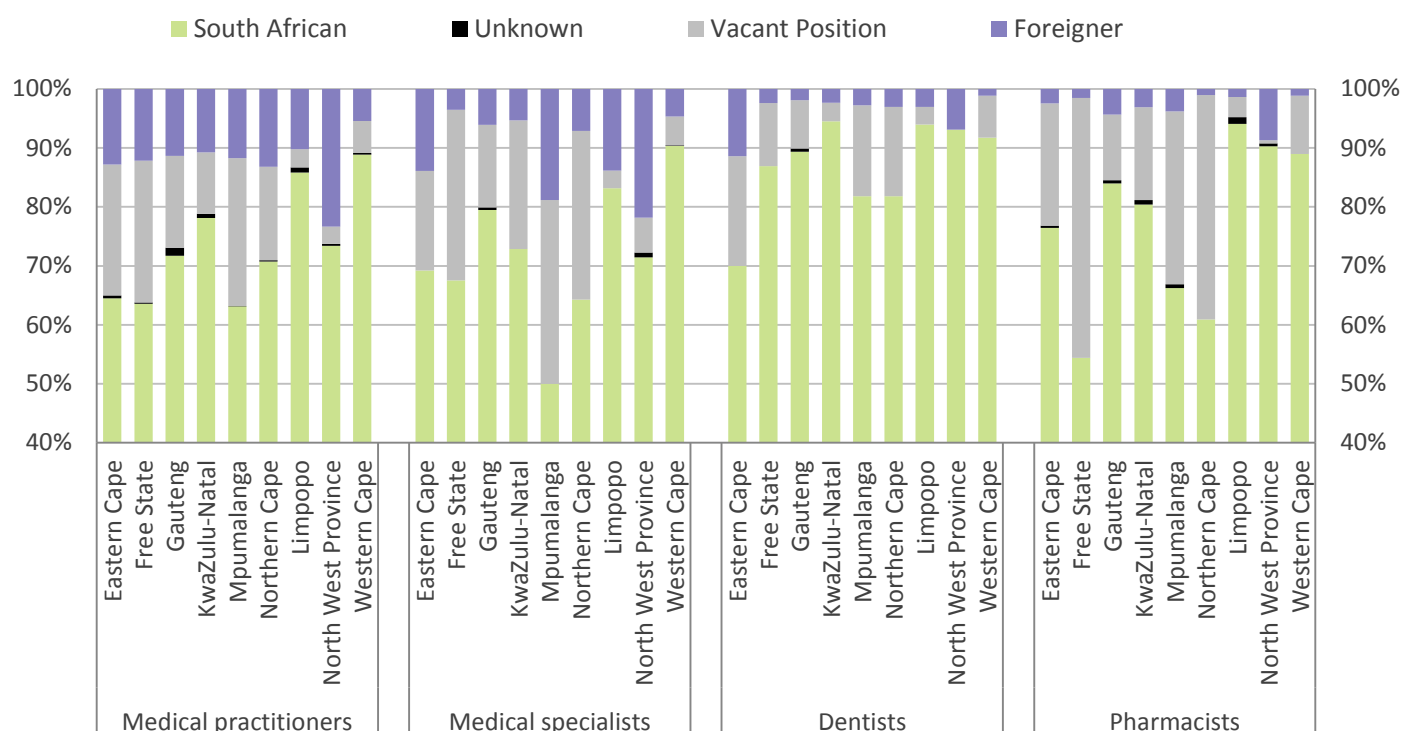
Type of health facility	Total highly qualified health workforce	Citizenship				Total
		South African	SADC country	other African	other country	
	<i>number of workers</i>	<i>percentages</i>				
Regional and District health facility	16 240	89	4	3	4	100
Academic, Tertiary and Specialised	6 230	93	3	1	3	100
Clinics	860	90	4	2	4	100
National/provincial Department of health head offices	150	99	0	1	0	100
Total	23 480	90	4	3	4	100

Source: March 2013 data from the Department of Health extracted by Ina Badenhorst, DoH.

The geographical distribution across the country's provinces reflects a different landscape (Chart 4). The proportion of employment by the South African workforce is highest in the Western Cape and Limpopo and lowest in the Free State and Mpumalanga with variations between professions. The relationship between high numbers of vacancies and foreign recruitments is not automatic. As shown in Chart 4, the Free State and Mpumalanga also have large vacancy rates while North West, with the lowest vacancy rate, records the highest share of foreign health professionals (19 per cent), mainly DRC citizens (25 per cent) and then citizens of neighbouring Botswana (12 per cent).



Figure 5. Distribution of medical practitioner, medical specialist, dentist and pharmacist positions by citizenship, in each province, 2013



Source: March 2013 data from the Department of Health extracted by Ina Badenhorst, DoH.

Gauteng and KwaZulu-Natal host the largest foreign health professional communities.

Error! Reference source not found. **Table 5** presents the three main countries of citizenship of the foreign health professionals working in each province. In most provinces, the main country of citizenship of highly qualified foreign professionals is DRC. Cuban doctors and specialist are mostly based in remote underserved provinces. The Free State health facilities employ doctors and specialists from neighbouring Lesotho, who may have been trained in the province. In contrast, Zimbabwean doctors in South Africa work primarily in Gauteng and not in Limpopo which neighbours Zimbabwe. British citizens represent one fifth of foreign recruitment by public health facilities in the Western Cape.

Table 5. Foreign medical practitioners, medical specialists, dentists and pharmacists in each province and top three citizenships, 2013

Number of foreign health professionals (all facilities)		of which, citizens of:	
Gauteng	590	D. R. Congo	36%
		Nigeria	12%
		Zimbabwe	8%
KwaZulu-Natal	510	Nigeria	16%
		D. R. Congo	13%
		United Kingdom	13%

Eastern Cape	310	Nigeria	25%
		India	14%
		Cuba	9%
North West Province	200	D. R. Congo	26%
		Botswana	12%
		Nigeria	11%
Western Cape	170	United Kingdom	31%
		D. R. Congo	12%
		Cuba	7%
Mpumalanga	170	Nigeria	31%
		D. R. Congo	12%
		Cuba	7%
Limpopo	150	Nigeria	23%
		Cuba	17%
		D. R. Congo	12%
Free State	140	D. R. Congo	41%
		Lesotho	17%
		Nigeria	8%
Northern Cape	70	Cuba	27%
		D. R. Congo	21%
		Nigeria	13%

Source: March 2013 data from the Department of Health extracted by Ina Badenhorst, DoH.

While still limited, these data show us that there are patterns of recruitment and settlement of foreign professionals in South Africa. While the distribution per facility seems homogeneous, the geographical distribution, particularly per profession and against vacancy rates, seems highly imbalanced and would deserve more targeted state intervention.

Sociological background of interviewees

Professionals interviewed were asked several questions about their place of origin, the occupation of their parents, their studies and who supported them, as well as their current household situation (marital status, children, ties with family in home country or home town). Our study was qualitative and therefore precludes generalisations. However, a finer understanding of the sociological background of our sample does help to contextualise the key thematic findings of our inquiry which will be presented in subsequent chapters. In particular, questions addressed in this section relate to the following:

- How was the decision to relocate to South Africa made and was the employment project central to it?
- Do South African professionals and their African counterparts share similar socio-economic backgrounds and educational trajectories or are there distinct patterns?
- How does this impact the ability to support their immediate and extended family and their career prospects?
- Are there different or similar patterns regarding state / private support for the primary investment in studies?



- Are there specific gender patterns cutting across nationalities and professions which impact the formative years of these professionals?

Nurses

Given the particularly skewed sample (only one South African nurse agreed to respond), our analysis is mostly based on foreign nurses and secondary sources for South African nurses. Among foreign nurses, while women were more numerous, male nurses were well represented. In the Refugee Nurses Association for instance (see Box 2 – Chapter 4), male nurses occupied most leadership positions. Apart from isolated cases, most nurses interviewed had parents who were civil servants, junior clerks, teachers, or even health professionals (nurses, pharmacists). In only two cases were both parents farmers. However, many, from the DRC in particular, indicated parents having passed away or being unemployed and no longer able to support them.

There was a clear divide among foreign nurses between Congolese and Ugandans on the one hand and Zimbabweans on the other in terms of education funding. Whereas the Congolese and Ugandan nurses had been supported by their families only (parents, uncles and aunts, or older siblings with an income) and never benefitted from state support, the Zimbabwean nurses were fully sponsored by the government throughout their studies. At nursing college, the Zimbabwean nurses even indicated receiving a salary which they considered decent at the time. In South Africa, while government support of historically disadvantaged students does exist in the form of subsidies for fees and tuition, it remains limited and does not cover all eligible students. Additionally, these subsidies were established fairly recently and did not exist for those who studied in the 1990s.

Overwhelmingly, foreign nurses came from urban centres in their country of origin (Kinshasa, Lubumbashi, Bukavu, Kampala, Harare, Bulawayo) and from families who had already been urbanised for one or two generations. For South African nurses, migration to an urban centre often occurs at the time of moving to a nursing college (Breier et al., 2009). Foreign nurses in our sample were also overwhelmingly trained at state university training colleges (Instituts Supérieurs de Techniques Médicales in Kinshasa, Lubumbashi or Bukavu, or Kampala Nursing College).

The sample of foreign nurses was almost equally divided between nurses whose migration to South Africa was part of a family project in which they had followed their partner or husband, and others, among the younger nurses, who had migrated to South Africa on their own, as single women, sometimes single mothers.

Doctors and Specialists

Even if skewed in favour of foreigners, our sample of doctors and specialists did contain a substantive representation of South African nationals. The comparison between South Africans and foreigners was therefore facilitated for these two categories.

In terms of parents' occupation, a clear divide emerged between foreign doctors and specialists (particularly Congolese, Sudanese, Nigerian, and from beyond Africa, British, Croatian, Iranian), and their southern African counterparts (South Africans & Zimbabweans). The former overwhelmingly come from

highly educated families of academics, engineers, top managers in state companies, or diplomats, while the latter come mostly from families of intermediary professions (teachers, medium managers, nurses, pharmacy assistants). In the case of South Africans, several were raised by single mothers (civil servants or teachers) particularly among Black interviewees.

A second clear divide, as in the case of nurses, is present with respect to education funding. Again the Zimbabwean, Botswana, and South African interviewees were sponsored by their respective governments (albeit unevenly sponsored in the case of South Africans). The Congolese and Nigerian interviewees were only sponsored by their families, not because they came from wealthier socio-economic backgrounds but due to a lack of any form of state support in their countries of origin. Malawians and Sudanese reported some access to international scholarships. A number of the Anglophone Africans (one Nigerian, some Zimbabweans, one Ghanaian, one Malawian) also reported coming to South Africa at a younger age to follow their parents and studying in South Africa albeit without bursaries. In the case of South Africans, some benefitted from support through the National Student Financial Aid Scheme (NSFAS), and others from private charities' sponsorships. This increased pressure on the students meant that they were not allowed to fail and sit for second sessions, but also that they were tied to government positions for longer than those not dependent on bursaries.

Unsurprisingly, most interviewees, whether South African or foreign, had been trained at large university hospitals and, as part of their internships, undertook training at a variety of facilities, both urban and rural.

More South African female interviewees than foreigners reported being single parents and relying on relatives, usually the grandmother, to look after their children while at work. Whether foreign or South African, those in relationships often had partners who were also in the medical professions. Several of the foreign interviewees were also single and without children late into their thirties or early forties, having entered the job market later.

In terms of gender patterns, more South African interviewees were single mothers and had been raised by a single mother themselves, reflecting dominant patterns across South African society where 39 per cent of children were raised by a single mother in 2013 (SAIRR, 2013). Some staff also insisted that female professionals in general tended to work fewer hours and opt for part-time work more than male colleagues in order to look after their families.

In terms of migration, as indicated, a small group of foreign interviewees had grown up in South Africa as a consequence of their parents' migration in the late 1980s and early 1990s. Interestingly, only two of these second generation immigrants had South African citizenship, while others had permanent resident or work permits.

For those who had immigrated, South Africa was often a second choice and one they had come to through relatives or alumni who provided them with information on immigration regulations and procedures. On average, doctors seemed to be better informed than nurses about the conditions of admission to the country prior to migration. Some doctors, from the DRC in particular, seemed poorly knowledgeable about immigration regulations, as did several nurses who arrived in South Africa without a work permit.

This report now turns to the policy frameworks regulating the recruitment and employment of foreign staff and documents how they have evolved over the past decade.



3. Policy frameworks

Foreign health professionals' recruitment and employment in South Africa are regulated by South African labour, immigration and health legislation and are also informed by the WHO's Global Code of Practice on the International Recruitment of Health Personnel. While the employment of foreign health staff is not new in South Africa, its regulation has become more stringent over the past two decades, particularly as a result of concurrent policy dynamics. On the one hand the DHA has imposed more and more restrictive legislation regarding the employment of foreign nationals which all sectors of the South African economy and government have had to align with; on the other hand, the HPCSA has striven to retain its independence regarding the assessment of foreign skills and competence and has gradually negotiated a more prominent role for itself in the issuance of immigration permits to foreign medical personnel. This section provides an overview of these dynamics over the past two decades and of the state of current legal and policy frameworks.

World Health Organisation

In 2010, the WHO issued a set of recommendations regarding the recruitment and employment of foreign health professionals. Titled "Global Code of Practice on the International Recruitment of Health Personnel", these recommendations are broad and cover most aspects related to the global mobility of health professionals. This code responded to the calls of the Kampala Declaration adopted at the First Global Forum on Human Resources for Health in 2008 and the G8 communiqués of 2008 and 2009 encouraging the WHO to "accelerate the development and adoption of a code of practice" (WHO, 2010). The politically sensitive nature of health professionals' mobility had already become prominent internationally as reflected in the May 2004 World Health Assembly which passed a resolution urging member states "to develop strategies to mitigate the adverse effects of migration on health personnel and minimize its negative impact on health systems" (WHO, 2004). As noted by Bach (2006), the WHO was not the only international organisation to pay increasing attention to the effects and implications of the international mobility of health professionals. The International Labour Organisation (ILO) and Physicians for Human Rights (PHR) also devoted resources to develop position papers on the issue (ILO, 2004; Friedman, 2004).

The debate is polarized along a continuum of positions (Bach, 2006) ranging from opposition to health professionals' mobility to support for their free movement. On one side, advocates of health professionals' mobility point to the rights of and benefits for individuals in enhancing their careers and income, their remittances to families in sending countries, and the position that free movement is an inalienable right of individuals and a fundamental principle of a market economy. This is a position defended by the World Trade Organisation (WTO), for instance. On the other hand, critics accuse the richer countries of plundering the resources of poorer countries unethically, depriving them of much needed health human resources which their education systems have trained. This is the position, for instance, of Physicians for Human Rights (Friedman, 2004).

The 2010 Code of Practice thus represents an attempt by the WHO to reconcile these contradictory positions around a consensus intended to assist states with the development of fairer policies. However, the Code was mostly drafted on the premise of mobility from developing to developed countries and thus

pays little attention to the regional mobility of health professionals within developing regions. The WHO recommendations particularly emphasise the development of legal and institutional frameworks for the international recruitment of health personnel; the development of bilateral and other international legal instruments; the non depletion of 'stocks' of professionals in developing countries; equality of recruitment and employment in host countries; and access to training. The Code also insists on the individual rights of health personnel to leave any country. In particular, the Code asserts equality of legal rights and responsibilities between migrant health personnel and domestically trained workforces in all terms of employment and conditions of work. One particularly innovative aspect of the Code is contained in its Article 5.1, which encourages destination countries to "collaborate with source countries to sustain and promote health human resource development and training as appropriate," and its Article 5.2, which suggests the Code should serve as a guide when entering into bilateral agreements (WHO, 2010: 5).

The South African frameworks have only retained certain features of these recommendations while ignoring others almost entirely.

South African policy frameworks

Up until the early 2000s, the recruitment of foreign health personnel was taking place largely on an ad hoc basis and while some institutional frameworks existed in the form of circulars and forms, no consolidated policy document can be traced prior to 2006. Throughout the 1990s the powers to authorise the practice of a health profession in South Africa was mostly in the hands of the HPCSA and the SANC, as well as the FWMP within the DoH. With the passing of the 2002 Immigration Act which introduced stricter rules for the admission of foreign workers into the country while South Africa was entering one of its worst shortage periods for health personnel, the HPCSA and the DoH felt the need to both ensure compliance with the new immigration rules and retain their independence from the DHA in the assessment of skills and issuance of authorisations to practise (20130214_DoHForMangtWorforce_MDPAS_HS). They also needed to guarantee that they retained control over bureaucratic processes in the case of urgent needs such as the hiring of much needed specialists. Lastly, South Africa had to align itself with the WHO recommendations which were being discussed at the time.

The 2006 Policy

To a large extent, the initiative taken by the HPCSA and the DoH in the early 2000s anticipated both the finalisation and passing of the Immigration Act of 2002 and the WHO's first resolutions in 2004. On 1 April 2006, the DoH issued a policy document entitled the Recruitment and Employment of Foreign Health Professionals in the Republic of South Africa which was developed by the FWMP. The aim of the policy was to "regulate the recruitment, employment, migration and support towards residency status of foreign health professionals in the Republic of South Africa" (DoH, 2006: 2). The Background section of the document clearly points to the policy priorities imposed by the profession:

2.1 The recruitment and employment of foreign health professionals in the South African Health Sector is viewed within the context of recruiting suitably qualified persons with proven skills and experience.



2.2 Preference is given to recruitment from foreign countries where the training and education meet the minimum requirements of training and education of health professionals in South Africa. The candidature of these applicants may be endorsed for registration with a relevant health professional council in the so-called 'non-exam' (fast-track) route, where it may exist. All other applicants will be subjected to formal testing by a relevant health professions council [...]

2.3 The primary aim of the Department to allow for recruitment from abroad is to deploy health professionals with the relevant skills and competencies to work in under-served / remote areas of South Africa. (ibid.)

The DoH asserted its preference for professionals from developed countries who were not only favoured but also proposed a fast-track route for their admission into the system. This is combined with a blanket restriction on “individual applicants from identified developing countries, in particular from another SADC country, [who] will not be endorsed by the Department” (DoH, 2006: 4) except in the case of refugees, who are exempt from restrictions on nationalities and of government-to-government agreements (GGA) (ibid.: 7).

What the 2006 policy document did was to clarify which categories of professionals were desirable and which were not, in which types of activities, as well as to clarify the various steps of the authorisation and recruitment processes. This is important as it formalised a range of processes which had thus far been left to the discretion of officials from the DoH and the various boards of professionals and had not been easily communicated to the public. As it is also required for South African health professionals, the document introduced the requirement of three years of community service (CS) for all foreigners recruited into the system before they could consider employment in other areas or move to the private sector. While recruitment of SADC nationals was discouraged, SADC students had preference at post-graduate level, provided their country of origin approved by their country of origin and that they could prove that the considered training is not provided in the country of origin. The policy also provided for several possibilities for foreign undergraduates, post-graduates, interns and exchange registrars. In all instances, the condition for entry was agreeing to return to the country of origin post studies. While exemptions from the developing country rule were mentioned in the cases of spouses of permanent residents and citizens, their employment was not guaranteed and therefore, again, left to the discretion of the DoH and boards. Finally, employment remained subject to the employer's job offer and provision of proof that no qualified South African citizen was available for the job, the granting of the appropriate immigration permit (a work permit in most instances) and a second endorsement by the DoH.

The 2010 Revised Policy

The 2006 policy was revised and a new policy issued on 5 February 2010, entitled Employment of Foreign Health Professionals in the South African Health Sector. In comparison with the 2006 Policy, the 2010 policy further restricts possibilities for foreign professionals to practise in South Africa, in particular for people from developing countries. The new document selectively aligns with the WHO 2010 Code of Practice, as well as SADC and African Union (AU) recommendations on recruitment protocols: it seems to have deliberately focused on the most restrictive aspects related to anti-‘brain drain’ positions while leaving aside the more collaborative dimensions in the Code about the building of regional partnerships. Its main aim is thus to: “promote high standards of practice in the recruitment and employment of health professionals who are not South African Citizens or Permanent Residents” as well as to “preclud[e] the

active recruitment of health professionals from developing countries unless there are specific government-to-government agreements” (2010: Article 1). The policy applies to public as well as private health care across the country. The second important framework within which the Policy is located is the Immigration Act of 2002 as amended in 2004 and the Refugees Act of 1998.

Regarding recruitment and employment, the 2010 Policy is both stricter and clearer on its requirements. It reiterates the need for foreign personnel to be employed within the ambit of the Immigration Act and therefore to be granted a work permit prior to hiring for recruitment outside government-to-government agreements (GGA) which require corporate permits. Furthermore, the policy specifies that only fixed term contracts not exceeding a term of three years shall be issued to foreigners; these permits can only be renewed provided the DHA grants an extension of work permit and the employer is able to continuously justify that the foreigner does not take away jobs from South Africans. This is reiterated in a separate article insisting on the need to avoid compromising employment opportunities for South Africans (Article 14). The DoH even reserves the right to issue quotas in the future. To that effect, the DoH has imposed the recording of separate statistics on foreigners employed by any employer across the country (Article 16). In articles 10 and 11, foreign personnel are placed on an equal footing with South Africans in all manners of conditions of employment, training, and service benefits; the articles also forbid the payment of any fees to DoH officials for completion of the registration process (Article 17). The list of categories of foreigners and their various rights and obligations are specified in more detail in the 2010 Policy than in the 2006 document (Articles 19 to 35).

In terms of qualifications, boards retain all powers, including the power to set requirements at their discretion. The policy also insists on a command of the English language, based on professional certification. Finally, the policy document, in articles 36 and following, sets out the role of the DoH : workforce management. While the FWMP largely predates the publication of the 2010 policy document, it is the first time the actual role of this Directorate is clarified in a public document. Interestingly, the mandate of the Directorate is framed by the Immigration Act to “ensure that the health sector as a collective comply with the Immigration Act” (DoH, 2010: 8). However, as clearly stated in Article 36 and confirmed by current officials from the Directorate (Hennie Groenwald and Phumelele Zulu, personal communication, 14 February, 2014), the intention behind the formalisation of policy by the DoH is for the DoH and the professionals boards to assert the specificity of their sector and retain discretion over the relevance of permit allocation.

As can be seen, and in spite of acute health personnel shortages in the mid-2000s, the policy codified by the DoH conforms to the constraints imposed on its recruitment of foreign personnel by the DHA. Immigration policy and its protectionist and securitarian drift in the 2000s (Segatti, 2011) seem to have shaped the DoH policy more than the concerns and daily preoccupations of hospital managers whose struggles to have sufficient staff in their facilities seem to have remained unheard (Bateman, 2007a). So while the HRH strategy document (DoH, 2011b), published a year later, acknowledges the need for the recruitment of foreign labour, it is only within a very limited scope since the policy which had preceded it is particularly conservative, especially for professionals from developing countries who are, ironically, the ones presenting themselves in large numbers to the Department. At the same time, while the foreign workforce policy document embraces the DHA’s conservative stance on immigration, the DoH also manages to obtain unprecedented waivers, positioning itself at the heart of the process and as the first and last port of call for foreign applicants, with precedence over the DHA. To date, this delegation of certain



immigration functions (such as the approval of recruitment) away from the DHA and toward professional bodies and another government ministry has no equivalent in South Africa and therefore constitutes a particularly interesting administrative innovation.

The policy debate

Interviews with key informants from within and from outside government revealed an unresolved policy debate, which largely explains the lack of a strong policy direction. Firstly, on the pertinence of foreign recruitment in general in terms of its impact on a national health system, the lukewarm position of the DoH is strongly contrasted by that of African Health Placements (AHP), the non-profit placement agency. When interviewed about this tension, Saul Kornik, CEO of AHP (see Chapter 4), had the following to say:

The US won a hundred Nobel prizes in the 1900s, over 30 of them were earned by immigrants. The National Health Service [NHS]⁵ is the largest employer on earth, 30 per cent of the NHS professional staff are South Africans. The US has a massive health care system, 25 per cent of their health workers are foreign qualified. If the richest country in the world relies on foreign skills, why shouldn't South Africa embrace and compete for those skills? So if we do develop a system where we rely on foreign skills I don't think that is a bad thing, it means that we have a good enough system to compete for and retain the skills that we need because we don't have the resources to train them and keep them internally. So, if that is the way our system is going to go, let's embrace it but I think to set quotas on the maximum number of foreign doctors that South Africa is willing to employ is naïve, we certainly don't have the wealth of some of the other countries who are proactively targeting foreign skills. We should be doing the same.

(20130603_S.KORNIK_MDPAS_HS)

In a 2011 report on reforming the public health sector, Johnston & Spurrett consider that the development of the foreign staff recruitment policy over the past two decades is emblematic of “strategic confusion” (2011: 37). The authors point to three problematic assumptions on which they consider the DoH policies to have been based: the aspiration and possibility of mid-term national self-sufficiency in the production of doctors; the precedence of controls and bureaucratic processes over efficient, fast-tracked recruitment processes; and finally, the aspiration to confine recruitment of foreign professionals exclusively to GGAs (Ibid). At the bottom of it Johnston & Spurrett see a nationalist form of protectionism:

In any case, to judge from the attitude of senior Department of Health officials, the motivation for restrictions appears to be protectionist rather than ethical. According to a senior Department of Health official, who was interviewed for a CDE-commissioned research paper in 2010: “The department has worked hard to improve salaries in the public health sector and must allow time for South Africans to fill these posts. No self-respecting country in the world prioritises foreigners over its own.”(Ibid.)

In 2014, several of these dimensions remained unresolved. The capacity of South African higher education institutions to scale up their output of medical graduates continues to be questioned. While deans of medicine would welcome increased capacities and budgets in medical schools versus sending South African

⁵ The National Health Service refers to the four publicly funded healthcare systems in the countries of the United Kingdom (England, Northern Ireland, Scotland and Wales).

medical students to Cuba, for instance (20130523_E.BUCH_MDPAS_HS; 20130521_DnWadeeWits_ASDF_HS), they also acknowledge the limits to enrolment currently reached by medical schools after recent increases:

As Dean, there is a sense that the costs of tuition, etc., [of sending students abroad] could be reinjected into the faculties here. There is a need to increase our intake in order to avoid losses. We have increased by about 400 a year [nationwide]. The question is: Should we not be investing more in our faculties? We've never been able to get the full detail of the costs [of sending students abroad]. Currently, the DoH policy is to say they are sending this number to meet current shortage and as medical schools scale up, we will reduce the Cuban training programme. (E. Buch, personal communication, 23 May, 2013)

We can accommodate a limited number of students. In my faculty we went from 165 in first year - two years ago to 250 that we now admitted, so we responded we can't go to 1000, we don't have the capacity or manpower or the hospital beds or the infrastructure to do any of ... we [are] graduating 250-300 a year now. Of course it doesn't help that the country is still underproducing medical doctors. What we're saying as Medical Deans is perhaps there is another way. ... That is very much in the cards of introducing another medical school and to perhaps increase the productions of health care professionals locally, which means injections of infrastructure money and all of that, so they would be major commitments from academia and the Departments of Health and Education. They are all involved in this and of course the community at large. (Dean Wadee, personal communication, 21 May, 2013)

However, the question of specialist training and output would remain unaddressed:

The specialty training is dependent entirely on the number of posts available from the Department of Health in the various hospitals and the clinics. It's not that we can train another 1,000 obstetricians or paediatricians. They're all gonna get posts with the hospitals in the public sector. ...specialists will only be able to train two or three at most legally, so they can do a 2:1 ratio, 2 registrars per consultant to train... because of the specialist training being so specific, focused and it requires very personal training. [...] We are at the limit of what we can train. (Dean Wadee, personal communication, 21 May, 2013)

While most interviewed government officials and some academics presented the recruitment of foreign staff as a necessary temporary solution awaiting the scaling up of medical schools, this position also attracted criticisms. Kornik (AHP's CEO), for instance, pointed to the dangers of seeing foreign doctors as a temporary workforce:

I don't agree with that point of view. I think that if we start viewing foreign doctors as a long term solution, then we will start treating them differently [...] For them to be a short term solution it means that we have to do one of two things, either we need to start training exponentially more health workers, more doctors than we are training at the moment and we just don't have the resources to do that. To do that the government would finally need to open up the doors to having private medical schools and partnering those schools in setting them up. Even then we would still struggle to train the doctors we need given the problems we have got with retention in public sector and retention in the country. (Saul Kornik, personal communication, 3 June, 2013)



Kornik's analysis further pointed to the existence of two lines of argument in the discussion: one genuinely arguing in favour of a shift towards primary health care and away from a doctor-centred approach; the other only preoccupied with job reservation or national preference for South Africans:

*The other thing we have to do is we have got to change how our system works, so we have got to change from a doctor-focused system to one which is run by your nurses or your clinical associates who are lower-level health workers, then we may not need as many doctors, in which case recruiting foreign doctors becomes a temporary solution. But I think probably the latter is not necessarily a bad way to go and I suppose that is kind of the direction the government is moving through primary health care, community health workers and making primary health care by nurses. So, if that is what they mean by a temporary solution then okay, **but that is often not what I think they mean, I think that what they mean is that we should be having South African doctors working in the place of foreigners and I just don't see how South Africa can do it if the richest country on the earth cannot do it, how are we going to do it?** (Saul Kornik, personal communication, 3 June, 2013)*

In actual fact, Kornik's suspicion of xenophobic undertones hidden behind official support for increased outputs was confirmed in one interview with a senior executive official from a national government body commenting on issues of discrimination and xenophobia:

There has been a build up of events that brought up xenophobia in South Africa including an upsurge in crime due to the openness of the gates, the fact that foreign nationals are using our legal systems for that. Also I don't think what happened in South Africa is xenophobia. It's not xenophobia as we always had foreigners but now foreign nationals rape old people and overcrowd areas. Multiple factors influenced the fact that people reacted against them, including the unemployment levels and the managers' preferences for foreigners. Whites are still punishing us for our struggle. Child trafficking and prostitution are also linked to foreign nationals. Anyway, xenophobia does not affect hospitals unless managers are foreigners and they start recruiting only their fellows. HPCSA collects complaints about hospitals and universities, about foreign professors who only recruit among their fellows. In UP there is the same problem with Whites who only hire Whites. Complaints are brought in to [our organisation] but mainly in relation to Whites, because we share the same colonial past as many African nationals and only a few complaints against them. (Senior official, personal communication, 17 May 2013)

The grossly negative as well as inconsistent stereotypes conveyed about foreigners (and African foreigners in particular), combined with the unresolved colonial legacies of racial resentment, expressed openly by this senior official are emblematic of the kind of attitudes reported by several foreign applicants in their interactions with government staff. The informant's fear of cronyism, which foreign managers could instill into the system, is of particular note. Even if it is seemingly irrelevant given the minuscule numbers of foreigners in the system overall, let alone in managerial positions, this fear expresses sentiments informing the relationship between the national and provincial administrations and foreign professionals.

To add to the complexity of the discussion, some key informants pointed to overlooked points in the debate around the shortage of medical doctors. Alongside processes of attrition of the number of staff in the public sector and emigration of qualified practitioners and nurses, these informants indicated that abuses of the Remunerative Work Outside Public Service (RWOPS) system were aggravating shortages.

Commenting on a case which had been reported in the media in 2013 (Thom, 2013), one informant explained:

You must have heard on the radio and newspapers of the overtimes and non-payment and the difficulties people are having in Joburg hospitals. It doesn't in fact say that [...] there is a shortage of doctors throughout the country because they are going to the private sector. That is not true, many people, many professionals work in hospitals in the public sector and then engage in what we call RWOPS (Remunerative Work Outside Public Service) in the private sector, so meaning that after hours they are allowed to do a limited number of private practice hours, which is acceptable to the department. The issue is currently the fight between abuse and non-abuse. [...] It's not a workforce story in that sense, it's a departmental personnel versus employer-employee relations issue. (20130521_DDW_HS)

While more stringent regulation of RWOPS abuses may remedy the situation in the future, or result in more doctors leaving the public sector, these abuses currently aggravate shortages.

Conclusion of Chapter 3

Expressed by key informants in critical positions within national departments and organisations, the above views reveal the polarisation of positions on the contentious issue of foreign personnel recruitment. This polarisation in turn explains the limited sense of policy direction reflected in the latest documents adopted by the DoH. In particular, the long-term strategic thinking conveyed by the CEO of AHP appears isolated from the approaches presented by other stakeholders who rather appear in favour of increases in locally trained personnel outputs. However, simple statistical analysis of current and planned outputs, as well as attrition rates, point to the caveats of the dominant approach. The reluctance to prioritise foreign recruitment and the very limited efforts undertaken to develop GGAs even with countries that have surplus personnel indicate that policy approaches are currently governed by a combination of nationalist prejudice and incapacity to strategise beyond the current specific challenges of disease burden, limited output capacity and definitive and temporary attrition; the government has been grappling with these challenges over the past decade, without decisive success. The development of the DoH policy position throughout the 2000s and current polarisation in the debate are some of the dimensions informing practices governing the recruitment and employment processes. The report now turns to an in-depth empirical analysis of the latter.



4. Making one's way into the system

This section accounts for key aspects governing foreign professionals' journey into the South African public health system. The section will first envisage the making of the current system, its key features, and the perspective of foreign professionals, and then deal with more specific, technical aspects, such as asylum, skills recognition, and challenges specific to nurses.

Designing and reforming the recruitment system

In spite of the acute shortages and the presence of large numbers of applicants, there was little sense of urgency in any of the interviews we conducted with top officials from the national and provincial DoHs, the HPCSA, or the organisation Africa Health Placement. As indicated earlier, while the 2011 DoH document on HRH does refer to immigration as a policy instrument, by the time interviews were conducted in mid-2013, there was no specific reference to emergency measures or a radical scaling up of programmes in place. While informants acknowledged the seriousness of shortages, there was also a sense that this situation had prevailed for decades and was not going to change overnight. In other words, the system's poor performance has come to be considered as the 'norm', or merely the outcome of a 'context' the administration needs to deal with.

Officials from the FWMP at the DoH related that, since the mid-1990s, different processes had to be developed incrementally within the Department and then between the Department, the HPCSA and the various boards. A similar effort was conducted externally with the DHA in order to align the DoH policies with those of the DHA while maintaining standards set by the professionals' boards. The development of these processes took years, almost a decade, and largely consisted in a trial and error process as no particular model was followed (Hennie Groenwald and Phumelele Zulu, personal communication, 14 February, 2014). Challenges were at least threefold. They came from:

- the diversification of professionals' origins and therefore the range of qualifications to be assessed (emerged in the 1990s);
- the diversification and formalisation of immigration and asylum permits following the reform of South African immigration policy in 2002; and
- South Africa's new obligations and commitments following its reintegration in international and regional communities.

In this context, new procedures had to be designed. These were prioritized as follows:

- boards' requirements;
- immigration and asylum policies; and
- and WHO and international commitments.

In addition, the DoH had to assess degrees, qualifications, and work experience from across the world against South African standards. For this, like most OECD countries, it outsourced the assessment activity to the Educational Commission for Foreign Medical Graduates (ECFMG - www.ecfm.org), a US based company in Philadelphia, in the mid-2000s, except for nurses who continue to be assessed by the South

African Qualifications Authority (SAQA). Finally, the DoH needed to put in place procedures regarding the recruitment and occupational mobility of foreign staff, ensuring compliance with WHO and DHA recommendations. These were sometimes contradictory: for instance, while the WHO recommends equality of treatment in all manners of employment between foreigners and locals, South African immigration policy had adopted a national preference position regarding employment giving absolute priority to local staff and forcing employers to demonstrate the unavailability of locals for any recruitment of a foreigner. Foreign health staff are also restricted to fixed-term contracts until they become permanent residents, which can take years and is regulated by the DHA. This places foreign staff in a much more precarious position than local staff, and this while there are thousands of vacant permanent positions according to the PERSAL 2013 data reviewed in Chapter 2.

The DoH found itself caught in its own dilemma. Its own prohibition on the recruitment of doctors in a list of 77 countries, later extended to 110 countries, considerably reduced potential countries of origin (in principle and even more so in reality given the actual origins of applicants) and the administrative statuses under which applicants could be recruited. The system therefore developed through the identification of loopholes in the rules government had set for itself. Three were identified which offered unequal merits and unanticipated consequences:

- asylum (and specifically refugee status);
- spouses of South African citizens or permanent residents; and
- GGAs with countries willing to export their health professionals as was made possible through Treaty permits, a specific category of the Immigration Act of 2002.

Further possibilities of recruiting from developing countries were offered on a case by case basis through university scholarships for visiting professors and international military agreements, for instance between the South African National Defence Force and the USA. The late 1990s and the 2000s saw the gradual formalisation of a system which was thus far largely ad hoc and, in terms of its recruitment target numbers, largely remains so (Hennie Groenwald and Phumelele Zulu, personal communication, 14 February, 2014). According to officials, the FWMP currently appoints about 1 300 foreign-trained personnel a year to CS (ibid.). However, given that the 2013 overall foreign workforce in the public sector was 2 640 according to PERSAL data (See Chapter 2), it is unclear whether there is a particularly high attrition rate among foreigners or if contracts are very short-term.

The actual intentions behind the system in place are more difficult to pin down but some key informants openly stated that the system was developed in order to keep applicants from developing countries out as much as possible and that the system is not meant to be friendly to foreigners in general. Professor Eric Buch, Dean of the Faculty of Medicine at the University of Pretoria, was clear that the “whole system is geared against foreign professionals” (E. Buch, personal communication, 23 May, 2013). While officially this is about South Africa’s principled anti-‘brain drain’ position, informants also alluded to the fact that less avowable aims were also pursued. In particular, there was a sense that African professionals, particularly from Francophone countries, are not as qualified and experienced as Europeans, Americans or Cubans, that their qualifications cannot be trusted (forgery was clearly mentioned as a possibility), and that they have more limited skills, particularly when it comes to electronic equipment, command of the English language, and understanding of the legal aspects of medical practice which are specific to South Africa. Some South African officials and professionals interviewed indicated that the recruitment of non-Anglophone Africans



into the system was seen as counter-productive but unavoidable given that they were the most numerous applicants.

Part of the explanation for these preferences is based on historically constructed biases in favour of UK trained doctors. Several informants confirmed this. Professor Buch explained:

Sometimes we have applications from very skilled doctors who are willing to go to the rural areas and we make it difficult for them. [...] then there are complex problems with the registration of medical specialists. Part of the difficulty is that historically there was some form of dual recognition. For instance with the UK but now it's become difficult. For instance we had the case of a highly experienced neurosurgeon from Germany [who experienced challenges getting accredited in South Africa]. (E. Buch, personal communication, 23 May, 2013)

A senior official from the HPCSA insisted on this bias, giving it a racial twist in addition to its colonial dimension:

There is an attitude from British professionals against African professionals. People from the UK working in the South African public health tend to recruit other people from the UK. This is mainly done on a racial basis. (senior official, personal communication, 17 May 2013)

And a British surgeon indicated he had had a clear sense of being treated with more deference than others while applying for the recognition of his degrees and trying to get endorsement from the FWMP:

When I went into the exam, it was me and two guys from Zambia [...] but I did obviously have an advantage because when the examiners [...] knew that you were a foreign graduate and you're coming to work in South Africa, they do view, this is just my opinion, they do view me differently than they view other graduates [...] They [Zambians] come to South Africa and are seen as economic migrants. [...] Maybe it's me but I just really felt like they [FWMP staff] hadn't expected someone like me to be there and therefore they kind of treated me nicely whereas they had a very jaded approach to other foreign nationals whom they were doing a favour to let into the country [...]. (20130807_DrSR_AMAS_HS)

On the other hand, GGAs are very limited. Currently only two agreements are ongoing with Cuba (medical officers and specialists) and with Tunisia (ophthalmologists). The Cuban experience, born out of historical solidarities between the Cuban government and the ANC, started in 1997. It was, however, initially a fiasco as several Cuban doctors either applied for asylum, or married South Africans in order to avoid going back to Cuba (20130214_DoHForMangtWorforce_MDPAS_HS). Currently there are 147 Cuban doctors in the South African public sector (PERSAL, 2013). Tunisians are even fewer at 57 (ibid.). This is clearly too limited to have a decisive impact on the shortage situation even if the HPCSA indicates another intake of Cubans is being prepared (20130517_BM_MDP_HS).

Pro-active or 'aggressive' recruitment is not part of government strategy. However, various initiatives launched by non-profit organisations emerged in the mid-2000s to facilitate the recruitment and retention of foreign health professionals in South Africa (for a detailed description of these, see Box 1 below). Saul Kornik, the CEO and founder of AHP, currently the largest NGO offering placement services to foreign professionals, indicates that his organisation has placed over 2 800 health personnel in underserved areas and facilities in the public sector since its creation in 2005. In 2008 alone, the organisation claims to have

made 448 placements, a figure which, according to their website, “translates to over five times more doctors placed through AHP than produced through all eight South African medical schools annually”. Given those figures and the extent of the work performed, AHP has become a very critical component of the South African public health human resources management system, albeit a non-governmental one.

Working closely with the South African DoH and HPCSA as well as with the Lesotho and Swaziland governments, AHP and its teams of consultants perform a number of the recruitment and assessment tasks which public health administrations at national, provincial or facility level are unable to perform. With branches in the UK and the USA, AHP follows an administrative business model and applies it to the delivery of non-profit services of recruitment, retention, work planning and human resources assessments. AHP consultants thus assist applicants throughout the application process by streamlining all steps and ensuring the full compliance of applicants prior to applications in order to speed up processes. Through a range of communication tools and HR management systems, they perform basic informative, advisory, and administrative support tasks which the DoH or the HPCSA cannot afford to do, due to lack of HR capacity and systems in place. In addition, some of the AHP staff are sent to directly assist the FWMP and HPCSA with the processing of foreign doctors’ applications therefore also improving their reception at the other end of the system. When asked to explain the origin of this symbiotic relationship with public administrations, Kornik clearly pointed to the need to run parallel systems that were not subject to the same degree of bureaucratic heaviness and political interference as those of the DoH and HPCSA:

We saw the competitive advantages and at the same time we saw the barriers, there were definitely regulatory and bureaucratic barriers to getting into the system. There was a degree of opacity to what needed to be done and there were different bodies that needed to be gone through. I’m talking about early to mid 2000’s. And also there were issues around management, there were issues around understanding where health workers can make the biggest impact... [A]s an independent organisation we are not bound by the politics and we are also not bound by things like the restrictions on how positions can be marketed, we can use graphics and adverts and emotive language whereas the DoH is forced to use their standard template, black and white adverts with logos and such [...], we kind of see ourselves as facilitators where we bring the process together, we provide some professional expertise, we have got electronic process management systems, we try to speed things up, [...] everything we do though, is absolutely aligned to what the DoH’s priorities are, we don’t go out and decide for ourselves what the health system should look like, we make sure we help the government to implement their own policies around HR.
(20130603_S.KORNIK_MDPAS_HS)

While complementary, innovative, and seemingly effective, this arrangement between a government department, professional boards, and a non-profit organisation raises questions of political leadership and administrative sustainability. To a large extent, AHP was born out of service delivery failures, policy gaps and political weakness. Its careful and particularly strategic positioning seems to have ensured maximum complementarity of its activities with those of government as well as a degree of lesson drawing in the form of policy advocacy. Yet, current shortages and administrative challenges a decade after its inception should encourage its managers and government officials to look more thoroughly into the long term implications of the arrangement and a more systematic lesson-drawing from AHP’s expertise and work methodology to inspire a reform of the FWMP within the DoH.



Box 1: The Rural Health Initiative and Africa Health Placement

In May 2005, the Rural Doctors' Association of South Africa (RuDASA) launched the Rural Health Initiative (RHI) Recruitment Project under the auspices of the South African Academy of Family Practice (SAAFP). The initiative was prompted by the waiver obtained from the DHA by the FWMP of the DoH for foreign-qualified doctors. The RHI was started thanks to funding secured from the Discovery Group (a major South African health insurance company) by Professor Steve Reid to start recruiting foreign-qualified doctors in KwaZulu-Natal.

In 2006, the Foundation for Professional Development (FPD) founded The Placement Project (TPP), a non-profit recruitment agency funded by Atlantic Philanthropies, an American funding organisation. RHI and TPP entered into a collaborative relationship for the recruitment of healthcare professionals for the South African public sector: TPP focused on active placement of local doctors, RHI on the recruitment of foreign doctors. In 2006, over 100 doctors were placed. In 2008, the initiative was rebranded African Health Placement, as it is still known today. In 2012, AHP launched as a separate legal entity with two companies: AHP Recruitment Foundation NPC (whose name was changed to Africa Health Placements NPC), the donor-funded arm of what AHP does; and Africa Health Placements (Pty) Ltd, the for-profit entity, with one 'feeding' the funding needs of the other.

Currently, AHP works in the following areas: workforce planning assessments and human resource recommendations for selected facilities; retention programmes in rural areas; and placement of local and foreign staff. In 2013, AHP placed more than 400 healthcare professionals and support staff, including 234 doctors, in rural and underserved public healthcare facilities in South Africa.

See more at: <http://www.ahp.org.za>

The current administrative process

The administrative process, which has incrementally been put in place for the assessment and recruitment of doctors and nurses into the South African public health system, entails no less than ten different steps and seven institutions: the FWMP at the DoH, the HPCSA or SANC, SAQA for nurses, the ECMGP in the USA for doctors, a Test of English as a Foreign Language (TOEFL) accredited language centre, a provincial Department of Health or a district level authority, and the HR services at facility level. In addition, various documents need to be certified by the embassies of applicants, the medical or nursing bodies of their countries of origin, their universities and colleges of graduation, recognised notaries and sworn translators. The process differs depending on the applicant's country of origin, status regarding immigration, type and level of qualification, and position applied for in the system. To simplify, one can distinguish between four main processes applying to four main groups of foreign applicants:

1. General medical practitioners and specialists trained in OECD countries applying for a job;

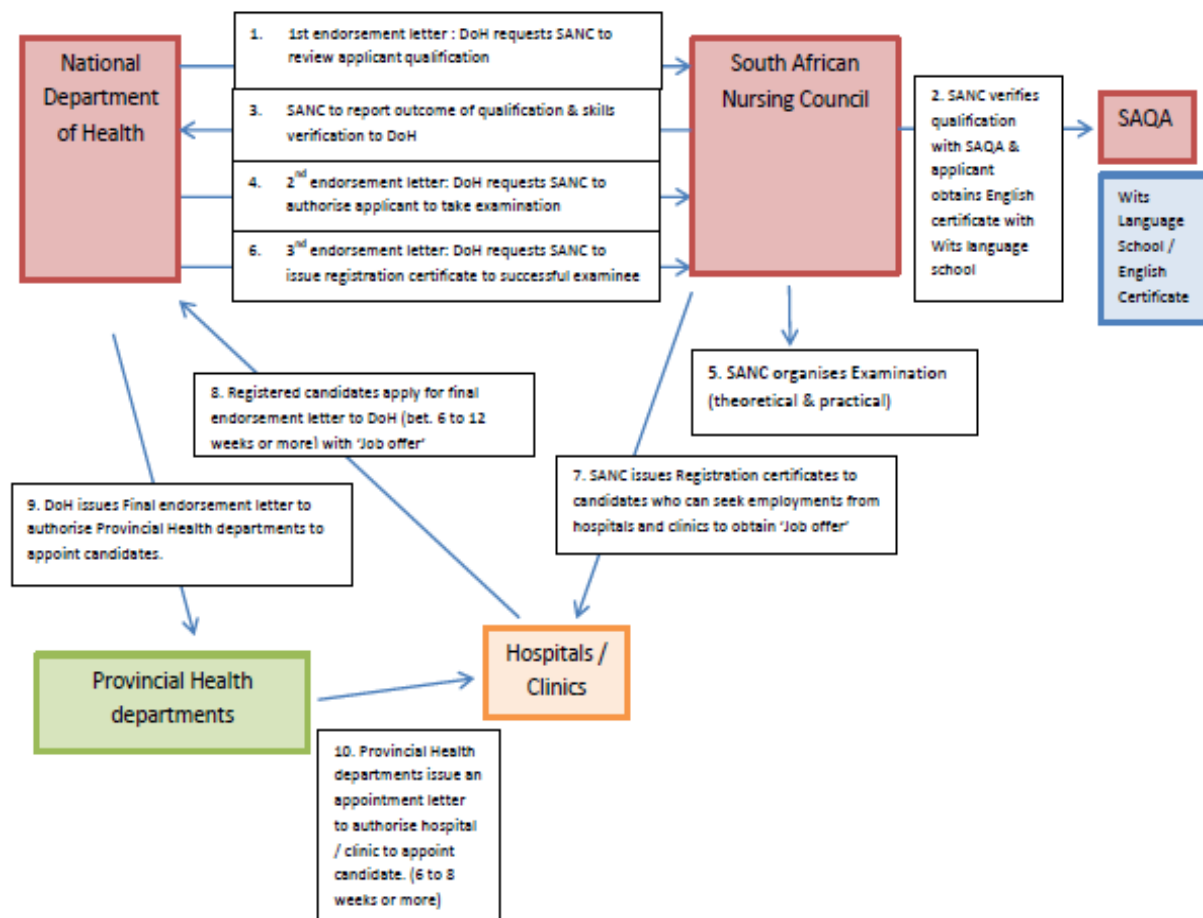
2. General medical practitioners and specialists trained in developing countries applying for a job but exempted from the anti-‘brain drain’ veto;
3. Nurses (all countries); and
4. General medical practitioners applying as supernumerary registrars to undertake specialisation.

Group one (medical practitioners trained in OECD countries) is the only group which may be exempted from taking an examination and whose admission into the system can therefore be fast-tracked. However, in many instances, specialists’ boards within the HPCSA require the completion of additional modules or tests or months of practice to validate fully the applicant’s registration. It varies from applicant to applicant and board to board as each case is specific. Groups two and three need to sit for an examination in order to determine their compliance with South African standards of medical or nursing practice. However, nurses need not have a level of English proficiency as high as that requested of doctors (officially International English Language Testing System (IELTS) Level 6 for both doctors and nurses, but in practice, a local language school certificate is accepted for refugee nurses). All three groups, once approved, lead to employment in remunerated positions in public health facilities. The fourth group is in a different situation: foreign general medical practitioners who apply for clinical specialisation in South Africa do so in positions of supernumerary registrars which are not remunerated throughout their period of study (three to five years depending on the specialty). While they are not requested to sit for the board examination, they also commit in writing not to apply for a position in South Africa following their graduation. While South African registrars and senior registrars (those doing a further sub-specialty) are remunerated (at an entry level salary of R 455 634 or USD 42 670 per annum) and employed on a contractual basis, international supernumerary registrars are mostly privately sponsored.

Figure 6 below provides a graphic illustration of the process to be followed for and the institutions involved in the recruitment of foreign nurses, which is an example of one typical administrative journey into the system. Each of these steps implies several micro-sub-steps consisting of telephone calls, emails, visits in person to the FWMP, the HPCSA or the SANC (all in Pretoria), and to the other organisations. Like many South African public administrations, loss of documentation and inefficient or counter-productive telephone enquiry services were commonly reported in our interviews (see next sub-section) and resulted in repeat physical visits to the offices which in turn mobilised staff away from the processing of applications.



Figure 6. Foreign nurses' registration and recruitment process - South African public health sector (2013)



Source: Author's own analysis from interviews and policy document, 2013.

The processes described above exclude the immigration or asylum permitting process itself, which predates and then runs concurrently with the registration process, the boards, and the DoH. Initial applications for a specific permit and renewals can take anything between three months to years (in some asylum adjudication processes). The Home Affairs permitting process conditions access to certain steps in the DoH process. For instance, the initial endorsement letter is conditioned upon the applicant being in possession of a valid and relevant immigration / asylum permit; similarly, the final endorsement letter for employment is also conditioned upon the applicant holding a valid and relevant work permit. While separate, the two processes are therefore intricately linked and almost symbiotic.

Theoretically, the recruitment process (understood as the total process from submission of application for the first endorsement authorising the applicant to pursue his/her attempt to register until the first day of work in a public facility) is presented as something that can be completed within nine months (as, for instance, on AHP's website). However, our evidence shows that this is hardly ever the case and that recruitment takes much longer in actual practice. This is especially so since recruitment runs parallel to and is dependent on the immigration permitting process. Unfortunately, the FWMP does not seem to keep or to be in a position to avail records of application processing times or approval rates. Empirical evidence presented in detail in the next sub-section shows that most candidates seem to have spent a minimum of

two to three years and sometimes over ten years to gain access to a job in the South African public health sector. African professionals and particularly African nurses applying from within South Africa experience the most challenges and protracted processing time. When interviewed about these aspects, staff from the FWMP pointed to a major challenge pertaining to the unpreparedness of applicants from developing countries in putting together their application or taking the examination and the poor quality and often lack of official documents from the administrations of their states of origin (Hennie Groenwald and Phumelele Zulu, personal communication, 14 February, 2014). While none of the documents required in the application forms seemed unreasonable and met international requirement standards, their issuance by least advanced countries did appear unlikely in some cases (for instance, in the case of applicants having studied in the 1990s requiring detailed curriculum descriptions of modules per year of study validated by university authorities).

By any international standards, such a process would be considered inefficient, or even counter-productive. This does not mean that progress has not been recorded. The registration and recruitment processes have reached a higher level of formalisation and transparency than was the case a decade ago without losing the necessary possibility for flexibility in the instance of highly specialised and urgently needed professionals. Another aspect of practice seems positive and was actually welcomed as such by many interviewees: the examination system, at least in the case of doctors, in addition to reassuring the South African boards that they are not lowering standards, strengthens the legitimacy of successful African professionals whose qualifications are subject to a lot of speculation and prejudice. Yet, in terms of the system's output (number of professionals hired) and turnover times, it seems obvious that it has not become an efficient recruitment instrument able to fill in shortages effectively over a reasonable period of time. The scarcity (absence of statistical data over the past decade) and opaqueness (no upfront processing time and approval rate) of data provided by the FWMP is in itself evidence of outstanding challenges and of the administration's lack of confidence in its own performance. The question which then arises behind this underperformance is why new efforts are not put in place to increase its capacity and efficiency to meet its official targets. Part of the answer lies in the ambivalent policy direction highlighted in Chapter 3 and the many unresolved dilemmas that dominate the recruitment of foreign health professionals. Other aspects to be envisaged are specific administrative bottlenecks affecting some categories of applicants as well as the conservative attitude of certain boards (the SANC in particular), which the next sub-sections address in turn. Beyond the measurable outputs and turnover times, which are the end result of a long and complex process, understanding poor performance requires a deeper inquiry into the technical and human dimensions informing recruitment. This is what the next sub-section does on the basis of our interview material.

The perspective of foreign professionals

As indicated, the complexity of the admission system is such that each single case is almost specific. However, we have regrouped our interviewees' experiences under the four groups mentioned in the previous sub-section and tried to distinguish what constituted the common features of their respective tribulations from what was specific to a special category, and then to individuals. We will be focusing here on the general and category specific findings.



General impression: Cumbersome processes and hostile administrations

While South African professionals almost systematically skipped the question of their recruitment after graduation as not presenting any particular challenge, strictly none of our foreign interviewees indicated having gone through a smooth process, except for one specialist who settled in South Africa over thirty years ago. When probed to clarify their grievances, our interviewees pointed to recurrent patterns focusing on at least four aspects in order of importance:

1. The extremely lengthy turnover times of the administrations in charge (FWMP at the DoH, HPCSA; ECPMG; SANC; provinces);
2. The unnecessary multiplication of administrative steps and duplication of tasks or poor coordination between institutions, particularly between the DoH, the HPCSA or SANC, and the provincial / facility level, and then between these and the DHA;
3. The sense of hostility, disrespect and absence of a customer care culture experienced in interactions with staff in some, if not all, of the administrations involved; and
4. A sense of opaqueness and discretion characterised by poor communication and information given to applicants, policing rather than support, and limited mediation or appeal mechanisms.

The following quotes provide illustrations of the numerous and recurrent patterns described above. In a number of instances, interviewees became emotional when recalling the process they went through.

Nicole, a nurse from Zimbabwe who arrived in South Africa in 2007 with all her documentation, degrees, and transcripts, recollects:

*Actually the processing here is very long, like I said, when I came here I came in with my certificates, my transcripts of training and my passport, so after we have applied to the Foreign Workforce then we went to the department – the SAQA where we evaluate our certificates, then we paid for our evaluation, but still with our certificates evaluated, we were turned down [after six weeks] because we didn't have work permits; but then how can you have a work permit when you are not working? [...] **Ja, it has been a nightmare.** So between 2008 and 2010 I have tried to obtain a work permit, of which maybe I lost close to maybe fifteen thousand paying people for the work permit which never came out ... [The participant became emotional, started crying and stood up to get a glass of water, and cool down.] (20130523MC_NIC_HS)*

A female specialist from Sudan who arrived in South Africa in 2002 relates her experience getting registered and then getting her specialisation recognised:

So because being a foreigner, as I came, the first year of registration took so long because your documents have to be sent to the USA for verification. The USA then sends letters to whoever trained you to verify the documents that you have submitted like proof of internship and what and that took more than a year, so one year and half or one year three months - something like that. So I did the medical council exam in 2003, September, but only managed to start work in March 2005. All this time I passed my exams straight away no problems, all this time I was just waiting for what? For my documents to come from the USA to be verified to get registration, even the job offer

was there and the vacancy was there. So then I worked in internal medicine [...] but I was not allowed to specialize; [...] and then the policies changed while I was there. Initially it was if you are foreign you have to work for three years then you can apply to sit the six-year exam and then get the independent practice registration. [...] They changed it to make it five years, [...] so now I had to wait for five years to get to do the six-year exam. Then, they told me no until you get your permanent residence. I waited for permanent residence for two years before I received it, I applied in November 2010 and I got it September 2012. So meanwhile [...] I continued to pursue my specialization in the UK. I finished that still waiting for permanent residence, did even a certificate in [specialty] in the UK, passed it in November 2012 but I am still working as medical officer here. (20131106MC_DrWMD_HS)

The same doctor, in her interactions with the HPCSA and the DHA, reported having been shouted at, and spoken to with open disrespect, which she found particularly shocking:

Every time I go there I am in tears from the way they treat me. You are scolded at, you're told that you are coming at the wrong time, you are shouted at when you are a professional expecting to get better, and then no response, no response to email, you travel all the way from Johannesburg to Pretoria to get one response. (ibid.)

While not specific to the DoH, the layers of administrative checks which often duplicate a specific action, seems to considerably increase turnover time. The greater formalisation of the assessment and recruitment system has unfortunately resulted in the multiplication of bureaucratic steps. In addition to the formal indications, there is often internal miscommunication between departments, almost invariably resulting in applicants having to provide (and apply for) similar documents misplaced by the administrations several times. Winnie, a Zimbabwean nurse, has been in South Africa since 2005 and had been trying to register since 2008 until the time of the interview (May 2013):

I should have registered some years back but they keep ...– like I said it's frustrating. I went there, the Foreign Workforce Management gave me a letter of – I don't know whether its confirmation or approval or whatever, which I took to the Nursing Council, the Nursing Council therefore accepted me, they gave me all their requirements which I submitted to them and then later on, they wrote me a letter and said one of my transcripts they could not find in my file so they wanted that transcript. I went back to Zim, I paid like a thousand rands for that transcript, it was DHLed [couriered] to them, I called them and they confirmed that. In about three weeks or so they wrote another letter and said my transcript was not there. [...] It was not there, it was not in my file, so I went back to Zim, paid another one thousand two hundred rand for the transcript, came back. I have been there again three weeks back and they told me they cannot find my transcript; which tells me that someone there is not doing their job properly because they don't want you to hand-deliver it to them, they want to receive it via courier or DHL or any other means – which is money – you pay for those things, you travel you pay, you get those things, you pay for them and then you post them; and then at the end of the day someone somewhere just sits on them and then tells you that they can't find it; and then you have to restart the process again. As it is they gave me another form for transcript which I have at home and I just kept it in my laptop bag there, because I am like this that is not working for now. (20130528_MC_WIN_HC)



Dr. WMD, the Sudanese specialist, cited previously, expressed extreme frustration and fatigue with the way in which she had been sent from pillar to post resulting in precious time being wasted and opportunities missed:

*The letter they gave me said that I am not exempted [from the six-year exam] and the second point says you have to sit for the exam. So when I took that letter to the University now to register for the exam, they said: 'No this is not the letter we get.' So I went back to the medical council to ask which letter. They said I have to apply yet to another committee to give me that letter. I am now waiting for that, and sometimes it can come out after the closing date for registration so you wait one whole year for that. [The College of Medicine of South Africa] then transferred me to another committee as the initial committee couldn't answer, that's why the transfer to the education committee who refused for it to be accepted and now I have to go to the six-year exam. **How long? 18 years after graduation! So I might cry if I talk to you because this is really what frustrates me.** (20131106MC_DrWMD_HS)*

A few of our interviewees (about 15 per cent) did not report major challenges or only reported challenges during one step of the process (usually the recognition of degrees) related to the qualification and recruitment. Shadrack, a Congolese medical officer who arrived in South Africa in December 2009, explains how his qualification and recruitment went relatively smoothly:

I got my refugee status I think seven days later, that was the main thing I was waiting for to start the process. Once I got the refugee status I came back because I got it in Durban because I had to travel to Durban, people say that it's most easier to get it in Durban, it's less corrupted than other places. So I had to go there and I got it there, then I submitted all my documentation to the foreigner workforce management and [...] there it was three months or four, they sent me a letter, an endorsement letter allowing me to pass the HPCSA exams, so I was supposed to submit that letter to the HPCSA with all my documentation. [...] I got replied, I took the paper to HPCSA for the test and then I think I was late, my submission came late so they told me that I had to wait for the next exam, so I had to wait for the next exam and meanwhile I went to MEDUNSA to do some course there and then I came back, those are clinical courses that help you, they give a broad view of the South African medical practice, so I came back, I prepared with other friends for the exam, meanwhile. And then there this agency called African Health Placements I think, so I went to submit my papers there, they told me that things get easier when they are submitted through that agency, so for my following exam I had to go to them, so you submitted your papers, they submit to the HPCSA, they call you and tell you how the processing is going, how far it is, what documentation you need to submit if there is any on top of what you have submitted already. So they helped me that way until I passed the test and I passed as I said the first time I succeeded to clinical part, I failed the practical so I had to redo everything. (20131102AM_DocSHA_HS)

Dr. Shadrack sat again for the practical test and passed (he had in fact only failed Emergency the first time) but it then took him until December 2012 to finalise his recruitment process into a public hospital. Overall, his recruitment into the system took three years. It was among the shortest we came across.

Coping strategies and organisation

Faced with those numerous bureaucratic hurdles and with often unreachable public servants, applicants are not passive. In addition to navigating those systems individually, they reported resorting to various organisations. However, because they are not yet employed at that stage of their integration process, they cannot (and would be unlikely to) resort to unions but rather seek help from national or status specific associations of professionals. For these reasons, interviewed nurses who had not yet been recruited into the system mostly cited the Refugees Nurses Association and the Zimbabwean Nurses Associations (See Box 2 below) and a few others, already employed, indicated referral to DENOSA. Doctors did not seem to rely on any association, but some of them reached out to AHP and a few of those already in employment cited SAMA.

What these professionals essentially sought from these organisations was a confirmation and clarification of the indications provided by the FWMP and the boards and councils as well as assistance with compiling the application, certifying and translating documents, preparing for the examination, assistance with immigration permits at the DHA, and then exchanging information on job opportunities.

Box 2: The Refugee Nurses Association of South Africa and the Zimbabwean Nurses Association of South Africa

The **Zimbabwean Nurses Association of South Africa** was formed in 2004 as a loose network of Zimbabwean nurses living in South Africa after the Zimbabwe Global Network encouraged professionals to form their own associations. No formal structure runs the activities of the association. The role of the association is to convene meetings for the nurses to share information and opportunities and to work together to further their socio-economic activities. The association has a database of about 150 nurses and there are no membership fees. The leaders usually contribute from their pockets. Meetings are called per rising need. The activities of the association essentially consist in providing members information and guidance on the registration process; moral support when facing challenges; referrals to individuals or organisations that can help in certain situations. The association's main objectives are:

- To mobilise the nurses to contribute to South African society while they are practising using the four year permits;
- To mobilise the nurses to return to Zimbabwe to serve the communities back home;
- To mobilise nurses to develop their skills and prepare for a better Zimbabwe where they will return with more skills;
- To link nurses with scholarship-offering organisations; and
- To help nurses with any of the challenges facing them now and in the future by being proactive.

The organisation reports having a poor relationship with the SANC which is reluctant to deal with the organisation and insists on only dealing with individuals. In 2009, a member of the organisation decided to organise a group of over 100 Zimbabwean nurses and approached the DoH and the DHA in order for them to benefit from the South African Government's Documentation Project for



Zimbabweans. 105 of them obtained four-year work permits on that basis. (Source: Interview with representatives of the association; 20130519_B.NYATHI_MDP_HS). The **Refugee Nurses Association** was created in 2005 following challenges encountered by refugee nurses with the SANC and support offered by lawyers from the South African Human Rights Commission (SAHRC) for the association to register with the Department of Social Development (DSD). The association is organised around a Board Committee, the decision-making organ, composed of the Chairperson, Secretary, and Board members; and then the General Assembly of all members who are qualified refugee nurses from a range of countries. The association claims a membership of about 150 active members although they indicate having had up to 500 members. The association's main objective is to get members registered with the SANC and assist them throughout the registration process. The association assists members putting together their documentation and conducts pre-screening to detect fraudulent qualifications which they reject for membership. Through negotiations with the SANC, they have now achieved a positive working relationship, which helps RNA prepare their members for the SANC examination. They indicated having seen a dramatic increase in pass rates thanks to better understanding of the examination process and training of their members. With limited support, the association has conducted an interpretation programme across hospitals and clinics in Gauteng on a voluntary basis. It sits on the City of Johannesburg Migrant Advisory Council (JMAC) Health Committee.

(Source: Interview with representatives from the association (20130508_RNAsso-AS-HS))

Specific issues: Asylum, skills recognition and de-skilling, and foreign nurses policy

This sub-section explores three specific areas posing additional challenges to the broader question of foreign health professionals' recruitment into the South African system: asylum; skills recognition and de-skilling; and the policy on foreign nurses.

Asylum: The back door to the immigration of African health personnel

Firstly, as envisaged earlier, asylum is one of the loopholes which have been used both by the South African government and applicants to circumvent the anti-'brain drain' principled position on importing skills from developing countries. Because of the numbers of African health professionals applying for endorsement (they are a majority of the applicants), accepting recognised refugees became a convenient way, for both government and applicants, to accommodate them into the system.

However, little thought seems to have been given on the side of the DoH, FMWP, or the HPCSA regarding the consequences of this use of asylum as a loophole in at least three ways: first, the sustainability of these recruitments; second, the prospects of those professionals under refugee status; and third, the asylum system itself at a systemic level. The (unintended) consequences of this make-shift approach are many. Firstly, at the individual level, refugee staff are restricted in their regional mobility: as refugees, they are not immediately given authorisation to travel internationally, and once given a passport, they are restricted from travelling to their country of origin. They are also exposed to the possibility of cessation of status: the

South African government in agreement with the UNHCR can pronounce the end of refugee status for certain nationalities (Angolans are the latest example). When this happens, shifting to a work permit or permanent residence is not guaranteed and entails a whole new immigration process. Since asylum has come to be considered the easiest way into the system for practitioners from the region (and in law there are not many others), it is also very likely that refugee status is often acquired fraudulently (see further in this section). Since acquisition of refugee status is systematically recommended by colleagues or the FWMP, in the absence of other options, sooner or later individuals are vulnerable to complaints related to fraudulent documentation. This could lead to their barring from the HPCSA and SANC and dismissal from their jobs. This means that the use of asylum as a 'loophole' in the system is placing a substantive number of applicants in very uncertain conditions and creating unnecessary vulnerabilities and risks in terms of the sustainability of these recruitments. It exposes not only the fraudulent applicant but also the credibility of a public health system which has encouraged professionals in this direction.

Secondly, and perhaps more seriously, the major unintended consequence of the positions of the HPCSA and the DoH is to have created space for an additional economy of corruption within the already corrupt asylum system (Siegfried, 2013). Several of our interviewees, under conditions of anonymity, admitted to having had to pay substantive amounts of money (from R 5 000 to up to R 20 000) in order to fast-track asylum applications and obtain final refugee status within a few weeks or days. Clearly, health professionals, because of their social and financial capital (having saved substantial amounts to sustain their migration project), have a higher purchasing power than most asylum seekers. As refugee status is presented to them (including by staff from the DoH) as the only way into the system, paying to obtain refugee status is considered to be one additional cost in a long list of costly registration processes (translation and certification of degrees, language tests, etc.). It is an 'investment' they are ready to make in order to be able to move on with their lives and careers. Doctors, who are usually socio-economically better-off than nurses, are accused of making 'prices' increase for the fraudulent issuance of refugee status (see Box 3 below).

Within the already complex context of asylum, further complications were recorded for asylum seekers who arrived in the early 2000s. They seem to have faced much longer periods of inactivity or underemployment than those who arrived in the 2010s, once the system was already in place. In the late 1990s and early 2000s, systems to evaluate degrees were not properly in place and the DoH was grappling to adopt consistent policies. This was concurrent with the early stages of the asylum regime managed by the DHA. Combined the two resulted in a whole generation of refugee nurses from Africa who remained unemployed or underemployed for sometimes over ten years (See Box 3 for examples of life stories). Bureaucratic indeterminacy is not restricted to the asylum system and seems to characterize a great number of public administrations in South Africa. However, in the case of categories of professionals who are particularly scarce in the country, it is surprising that no integrated screening was put in place to fast-track applications of health professionals from the pool of refugees. This major bureaucratic failure of the 2000s directly resulted in 'wasting' a generation of refugee nurses who, in the meantime, joined the ranks of the largely exploitative care-giving and domestic work industries.

While turning a blind eye on the current 'system' of fraudulent asylum practices may accommodate both government and applicants' needs, it is also putting substantive numbers of highly-skilled professionals in potentially vulnerable situations and therefore exposing the institutions they work for to future crises. It also clearly impacts very negatively on the asylum system by using it as a backdoor immigration instrument,



which it was never meant to be, and is aggravating its endemic corruption. This situation is certainly not working towards consolidating foreign health professionals' position in the South African public health care system.

Box 3: Trajectories of refugee health professionals

Carol is a registered nurse from Bulawayo, Zimbabwe, who arrived in South Africa in 2007 due to economic hardships. Despite four years professional experience in her country of origin, running a family and community health department in a local clinic, she had to wait until 2011 before being able to apply for registration in South Africa. While she had first applied for asylum on arrival in 2007, she later realized that not having fully recognized refugee status was barring her from being recognized by the FWMP. However, as a Zimbabwean, she stood few chances of becoming recognised as a refugee. Rather than persisting with asylum, she used the Zimbabwean Documentation Project to opt for a work permit in 2010:

2008 yes I did South African Qualifications Authorities (SAQA) and then we did apply with the Foreign Workforce when we were having the asylum and we never got any reply and we got to know that they didn't recognize this document for professional registration so we forgot about it, we just thought oh well life goes on, as long as we can get something it's fine—until heavens comes. Until this permit thing started in 2010. In 2010 people applied for permit; that was in September [...] I applied also during that first group, there is was difficult because of the queues, we could go and sleep there like you saw in Harrison Street in Johannesburg—Home Affairs. I think I slept in Market Street twice and you couldn't go in, it was very risky to sleep there but you had no choice because you wanted to say at least if I am between number one and fifty I will go in, but there are these corruption things, you sleep there [...] you don't know how the queue pushed, you can't even go in but you see people are going in, but you were just close to the door and you think I will go in today, you can't go in until maybe the next day [...]. Then when the permits started coming in then we applied to the Foreign Workforce—I think mine came in it was February 2011, so I applied, I don't know when I got the letter from the Foreign Workforce but then I went to the Nursing Council to submit my letter and my application, then I got a response sometime in July. (20130531_MC_Carol nurse)

It then took Carol another 20 months to sit her examination and finally get registered with the SANC in early 2013.

Robert, a Congolese nurse, who arrived in South Africa in 2006 and then struggled to obtain refugee status, was still awaiting registration with the Nursing Council in 2013. He particularly resented corruption in the asylum system:

I don't know if other people they are facing the same situation but I can see, you go to Home Affairs you see all the doctors are running up and down having R 10 000 or R 5 000 just to get a status for him to get access to go and write the test. [...] When you come they give you

asylum and asylum doesn't give access to do nothing and you need to spend maybe R 5 000. [...] You need to spend R 5 000 to get a status. (20130601_AM_ROB_HS)

Two further cases illustrate extreme situations but which seem to have affected many refugee nurses who arrived in the early 2000s. **Bibi and Valentina, two Congolese nurses** who arrived in South Africa in 2000, could not register before 2012 and only started employment in 2013 (20130512_AM_Bibinurse_HS and 20130425_AM_Valnurse_HS). A combination of factors explain this situation: obtaining refugee status was not necessarily the most difficult as it was granted after two years in both cases. However, they then faced the moratorium on the evaluation of all refugee nurses imposed by the Department of Health between 2004 and 2007. For three years, no examination was organised. Once the moratorium was lifted, refugee nurses were made to start the registration process from scratch leading to these extended periods outside formal employment or employment outside their field of training. Even once they obtained employment, only short term contracts were issued to them, as the DoH aligns on the length of permit issued to refugees by the DHA (about three years in general).

Skills recognition: When migrating means losing out on experience and qualifications

A second serious issue raised by many respondents is that of incomplete or unfair skills recognition. Compared to a decade ago, there has been great progress made by both the DoH and the HPCSA in clarifying the qualifications recognition process. The process is now formalised through official information documents and forms, and validation of degrees is provided by an independent organisation (ECMPG). Regarding skills, the only further validation that takes place is through the examination organised by boards which are only waived in the case of world renowned specialists with excellent credentials.

While it is beyond the scope of this report to provide an assessment of the examination system itself, what the examination does not take into account is additional skills acquired through short training courses or periods of service in specific units or departments. This results in either mere frustration, or in underemployment within the system. For instance, the equivalent of a registrar abroad will be hired at the entry level of a medical officer or the equivalent of a specialist nurse will be hired as a general nurse. The case of Dr. WMD, cited previously, a specialist from Sudan with degrees from the UK, illustrates this particular challenge:

*They even call me every now and then to assist as a registrar but yet I can't be recognized, and can't have specialized registration here with all this, so this is the frustration that you get from ... so that's my story. So now [...] I have been registered as medical officer [and am] working here as medical officer. **Then when the OSD⁶ came they didn't recognize my previous experience, they***

⁶ OSD stands for Occupational Specific Dispensation. The result of a collective agreement, the 2007 OSD reform introduced a revised salary structures per identified occupation. Its objective was to cater for career pathing, pay progression, seniority, increased competencies and performance with a view to attract and retain professionals and other specialists in the public service. Many errors were recorded in its implementation and resulted in numerous frustrations. Skilled nursing staff are said to have left in large numbers to the private sector (Ditlopo et al., 2013).



only recognized my experience as of 2005, so I only got translated to Medical Officer Grade 1 and since then I am still in the same place - Medical Officer Grade 1, not even moving notches.
(20131106MC_DrWMD_HS)

For nurses, this lowering of actual skills in the skills recognition process has even been built into the foreign nurses' recruitment process as a result of initial tensions (and following the mid-2000s moratorium referred to earlier). Members of the Refugee Nurses Association indicate: "When we negotiated with the SANC, (we said:) give us the means to succeed. They said: We reduce your qualifications and you take a test like South Africans" (20130508_RNAsso-AS-HS). South Africans take the test upon completing nursing college; some already qualified foreign nurses, who may have completed one to two years of specialisation at MA level, are also required to take this compulsory test. However, this additional experience, which may be confirmed by degrees and certificates, etc., has been written-off within the process. Once they have passed the test, foreign nurses need to undertake specialisation again, if they so wish, in order to graduate from a South African institution. Foreign nurses are subjected to conditions that include more conservative screening processes than doctors.

Foreign nurses not wanted here

The SANC's policy position on the recruitment of foreign nurses was formalised in 2009 in a policy document which has been revised several times since its publication. The "Policy Guidelines regarding Registration of Foreign Nurses and/or Foreign Qualifications with the South African Nursing Council" (2012) is a technical document providing the legal framework within which the policy operates. It also presents the procedure for foreign nurses' recruitment, including the forms and documents to be provided at each stage. Interestingly, it is a sub-section of the Services section of the SANC website and it is not visible from the home page. From a policy perspective, SANC's approach differs somewhat from that of the HPCSA. The SANC does not make reference to the WHO guidelines and makes no mention of its position on the recruitment of nurses from developing countries. Eligibility conditions seem to apply across all groups with a distinction only for refugee nurses. In practice, the SANC position has proved very conservative over the years and in general, foreign nurses are not considered to be welcome into the system. While this is not official policy, this can be seen from the observation of recruitment practices and was confirmed in several key informant interviews.

The 2000s decade was particularly chaotic with a three-year-long moratorium on recruitment between 2004 and 2007, exactly during the peak of shortages in the public sector. When the moratorium was lifted and examination resumed, the SANC and the FWMP took two years and much legal pressure from the Refugee Nurses Association to publish the results of the first batch of students who were eventually allowed to take the theoretical examination in 2007. Following this, the SANC decided that the theoretical examination was not enough and imposed a practical examination. However, it took another two years of coordination between the SANC, the nursing colleges and the FWMP to decide on the modalities of this practical examination. One successful applicant, who passed the theory in 2007, only finalised her practical test in 2011 (20130512AM_BIB_HS). With the formalisation of its policy in the late 2000s, and the publication of guidelines in 2009, the SANC has undeniably worked towards greater transparency and improved communication towards foreign applicants, an effort readily acknowledged by the Refugee Nurses Association. However, considerable bottlenecks in turnaround times seem to persist within national and provincial DoHs:

There is no corruption [at the SANC], etc. so we can't complain. To renew our license every year, there is no problem too. The real difficulty is with the DoH: that's a headache. Our members sometimes wait up to six months. We can't touch [complain about] the SANC, but the DoH. At an individual level, members may have issues with the SANC, but as an association, we have an understanding. But the DoH, things drag on. [...] At the provincial level too, it drags on forever. At the Provincial DoH, the hospitals have already accepted but the process there can take you another six months. We don't understand why. (20130508_RNAsso-AS-HS)

In addition, in its 2012-2017 "Strategic Plan for Nurse Education, Training and Practice" the DoH asserts the need to have effective and efficient policy and procedure for the recruitment of foreign nurses as one of its objectives. Within this, it indicates the need to "keep records such as training records, examination results, and criteria for registration" (DoH, 2012: 112). However, while the Department acknowledges the need for the recruitment of foreign health staff in its 2011 HRH strategy document (DoH, 2011b; see Chapter 3 of this report), this is not translated into a clear policy direction in the subsequent quinquennial plan, pointing to some internal policy inconsistencies. The SANC does not express any priority given to the recruitment of foreign nurses.

The reality of recruitment procedures, particularly when seen over the past decade, rather seems informed by an inimical approach to foreign nurses. The policy impasse of the mid-2000s, leading to the three-year moratorium, the initial unwillingness to incorporate refugee nurses then followed by their acceptance under the condition of a downgrading of their qualifications, the current low profile of their recruitment in policy frameworks, together with the challenges reported by applicants, all point to a prevalent and persistent negative approach. Related to this, particularly for those stuck in protracted waiting periods, de-skilling has become a source of added anxiety. Joyce, a Zimbabwean primary health care nurse with 15 years experience in rural Zimbabwe, has been in South Africa since 2007 but was still awaiting authorisation from the SANC to sit the examination:

I have never practiced as a nurse [in South Africa], I am even forgetting what I have learned, what is nursing, etc. I don't know - the time I will be going back into the health system, I don't know, I'll have to read books. (20130517MC_JOY_HS)

Although the SANC could not be reached for an interview, other key informants were asked about the SANC rationale on the recruitment of foreign nurses. Saul Kornik, from AHP, indicates that the compulsory examination for foreign nurses regardless of their level or the origin of their qualification, works as a deterrent, particularly for nurses from developed countries but also, given the requirements and nurses' much lower salaries, as a higher barrier to recruitment (20130603_S.KORNIK_MDPAS_HS). Kornik explains:

We have spoken to the nursing council about it. They say that the job description for nurses in South Africa is so particular to the South African situation that they need to make sure that these nurses are qualified or sufficiently trained to work in South Africa and they are not willing to compromise on that. The nursing council has to maintain a certain standard for nursing in the country but I have heard a lot of people argue that what they are saying is probably a bit too protectionist and that actually the level of nursing in South Africa is not that good and that is pretty much the experience we have got. The doctors who work in rural hospitals often work with fantastic nurses but a lot of the time say that nursing staff work ethics and some other issues, well often it's not that great. So, I don't know, we have a good relationship with the nursing council now



but it would be great for someone to challenge the nursing council on this exam requirement because we know there are a lot of foreign nurses who want to work here who just can't get in.
(20130603_S.KORNIK_MDPAS_HS)

An official from DENOSA, the largest public sector nursing union, explained that DENOSA did not have a specific policy or mobilisation strategy on foreign nurses in the public sector. This was acknowledged as a gap that needed to be addressed (20140819_M Phapo DENOSA_AS_HS). On the issue of recruitment, the DENOSA official interviewed insisted on clarifying the union's position for it to be fully understood in the current context of the challenges encountered by government to meet its training targets:

We don't have a problem if foreign nationals are being recruited with scarce skills. Before the OSD, people with skills moved to the private sector (midwife, ICU, trauma). As DENOSA, we don't have a problem if people with scarce skills come into the country; but we have a problem when government recruit ordinary nurses because we have so many who are not placed. If you look at the HRH, government is not even close to where they are supposed to be in terms of training targets. [...] When a foreigner works in the public service, if that foreigner has scarce skills, we know at which level that person is supposed to be paid. The problem is when the private sector sources nurses out. We are not sure about the Mediclinic agreement with India. In government-to-government agreements, there are a lot of loopholes.(20140819_M Phapo DENOSA_AS_HS)

While concerns about qualification and employment standards are important and legitimate on the side of the SANC and the unions, clearer, evidence-based policy positions would assist in reaching a working consensus that avoids the development of segmented nursing markets with fragmented and disparate conditions of employment.

Conclusion of Chapter 4

On the policy side progress in terms of formalisation and information about processes seems to have been recorded in comparison with the unacceptable waiting times which characterised the early to mid-2000s. However, the **actual mechanisms and rationale behind the recruitment process of foreign health professionals remains the weakest link in the broader South African policy framework**. Turnaround times in the processing of applications by the DoH FWMP, as well as the provincial administration in particular, should constitute a priority area for improvement as those impact all other aspects of the process: de-skilling and demotivation of personnel as well as their socio-economic prospects (underemployment and exploitation) while awaiting the outcome of their applications; and shortage crises and vacancy situations at facility level.

Specific aspects can be identified as in need of urgent attention. Among others, one can cite the **interdependency of the FWMP and the DHA** (the fact that the issuance of letters of endorsement is conditioned upon immigration permits). This situation seems to delay processes considerably and it is unclear what independence was gained by the DoH vis-à-vis the DHA since so many steps in the process remain dependent on assessment by the DHA, a department notorious for its administrative inefficiency in the processing of immigration matters, regardless of applicants' level of qualification (Segatti, 2011; Amit, 2010).

A second dimension is the **outsourcing of credentials verification** to the American International Accreditation Services of the ECFMG. On average, applicants reported waiting periods of about one year and a half and indicated having had to contract people in their countries of origin in order to fast-track requests from the ECFMG. We can assume this, in turn, creates spaces for corruption. While the concern for independence of evaluation is a valid one, outsourcing to the ECFMG is not necessarily a better guarantee of assessment. It is also extremely time-consuming and costly for applicants. Given South Africa's needs and the fact that most applicants are from SADC, developing international professional expertise within the FWMP should be studied. It could also contribute to build on current initiatives regarding skills recognition within SADC.

Urgent improvements in basic administrative tasks should be prioritised by the DoH, the FWMP, the HPCSA and its various boards, as well as the SANC. These include: welcoming and informing the public, providing accurate and up-to-date information, avoiding by all means multiple visits due to poor information, ensuring secure tracking and recording of documentation; and reducing administrative steps to a minimum across processes. All of these technical items seem to be within the reach of institutions in charge provided management takes a strong leadership position. This may mean increasing staffing in some instances but could essentially be addressed through a reduction of unnecessary and duplicate steps, improved systems management and interdepartmental coordination.

The **use of asylum as a backdoor to recruitment** is a particularly contentious and complex issue. From a state perspective, the fact that some sections of public administration directly or tacitly encourage their public to exploit loopholes in public legislation seems short-sighted and irresponsible, particularly with such consequences as increased corruption and long-term precarisation of part of the workforce. It also points to a lack of political courage to undertake the necessary reforms to facilitate the intake, stabilise, and retain such a workforce. In the short-term, and in order not to aggravate the already seriously dented reputation of the South African asylum system on corruption matters, the creation of specific immigration permits for medical and nursing staff should be considered. Those permits should offer prospects of settlement in the longer term in order to progressively separate entirely asylum from skills import and therefor stabilise the workforce as early as possible.

In general, several of the shortcomings documented in the report are linked to the **broader ambivalent position adopted by the HPCSA, SANC and the DoH on the longer-term role of the foreign workforce in its policy design**. A complete rethink of this dimension, focusing on the need to shift policy efforts towards regional development rather than regional antagonisms and isolation seems urgent 20 years after the end of apartheid. This rethink could encompass the following: regional GGAs; support to professionals from the region to retain linkages with their workplace or university of origin; twinning of facilities; and a shift to a system of recruitment quotas managed on the basis of known regional outputs and surpluses.

Finally, as **the performance of nursing colleges** does not seem to match current expectations with attrition rates that remain particularly high, the lack of initiative and at times blatant reluctance of the SANC to be more flexible, particularly vis-à-vis applicants with high credential levels, seems difficult to understand and should be revisited in the face of urgent and medium term needs. The shift towards higher education nursing training could well aggravate the gap between needs (with higher standards being adopted) and output capacity. There again, the identification of a clear strategic plan, with skills targets, is needed in order to actively recruit missing skills.



5. Holding one's ground within

This chapter explores the most salient aspects of foreign health professionals' experience of employment in the South African public health sector. This experience is contrasted against respondents' previous work experience in their countries of origin or transit, and, for some of them, to experiences of employment in the private sector. Foreign respondents' accounts were also systematically compared to those of their South African counterparts. In a sector characterised by overtime, understaffing, and occasionally unsuitable infrastructure and hostile environments (remote areas without public transport; crime-ridden spots; volatile communities), conditions of work in the South African public sector are challenging for all. Our analysis tried to distinguish what pertains to those generally challenging conditions of work from what can be attributed to specific challenges encountered by foreign staff (nationality, race, geographical origin, gender, etc.). Our guiding questions were:

- Do foreign staff experience conditions of employment (contracts, duties, remuneration) and work (performance of their job) which differ considerably from those of their South African counterparts and if so, why?
- In what ways do their distinct conditions of recruitment impact their induction into the public health sector?
- In what ways do their distinct conditions of employment, particularly the precarious nature of their contracts, impact their status and ability to perform their job?
- Is there a formal / informal division of labour with concentrations of foreign doctors in certain medical and nursing occupations, geographical areas, or types of facility?
- What are foreign staff's overall experiences in the system?
- Are there learning patterns and emerging forms of collaboration at the workplace?
- What protection mechanisms do foreign staff who are victims of discrimination resort to?

Positive experiences: Skills acquisition, experience, and good practice

Very spontaneously in the course of the interviews, foreign staff pointed to positive dimensions of their South African work experience. Beyond general, and at times extreme, frustration around turnover times during the recruitment phase, interviewees were more positive when it came to their work experience. Among a range of aspects, they listed the following as the most rewarding dimensions of their employment in South Africa: sense of usefulness in serving patients and contributing to the country's growth and well-being; acquisition of additional medical or nursing knowledge; furthering of English language skills to professional proficiency for the non-Anglophones; work in diverse, multicultural settings and teams; familiarisation with specific diseases and conditions; training with state-of-the-art equipment; familiarisation with complex legal aspects and protocols; team management; and, last but not least, pay.

One first source of satisfaction resided merely in becoming active again after often long periods of either forced inactivity or underemployment in other occupations. Linked to this was a sense of skills adequacy: even though several interviewees indicated challenges in terms of language or knowledge of medications and protocols, several expressed pride in having found themselves well prepared for their current jobs. In several instances, this came mostly from previous work experience in the country of origin.

In other instances, the change in work environment resulted in the need to adapt, which was perceived as an opportunity. This applied to staff from developed as well as developing countries. The former indicated having had to adapt to working in challenging, underserved and under-resourced environments, forcing them to make do with less (equipment, staff, direction). They also pointed to familiarisation or sometimes retraining regarding specific diseases. In particular, the high prevalence of TB and HIV as well as maternal mortality, and related pathologies were considered 'attractive' from a practical, clinical perspective. For those coming from developing countries, and perhaps more so from the least developed countries such as Côte-d'Ivoire, the DRC, Malawi or Sudan, the use of electronic equipment, modern technical sets, and a broader range of medicines was particularly attractive. Several, who had worked in the private sector, also expressed satisfaction with learning efficient coordination protocols from patients' admission to discharge.

These immediate gains were also often presented as part of longer term goals within a broader migration project in which accumulating globally marketable qualifications and experience in South Africa could help professionals move on to an OECD country. Among the most cited ultimate destinations were the UK, USA, or Australia (see Chapter 6). In some instances, the longer term plan was also to move to the private sector, but this was not very widely indicated.

Finally, many respondents expressed their intentions to remain in the public sector and work their way up the ladder making use of all possibilities for internal promotion including additional training, specialisation, and diversification of one's profile. Many expressed aspirations for managerial responsibilities. Some had already acceded higher responsibilities, either through promotion or as trainers of trainees. There was a broadly shared sense of appreciation for these possibilities for promotion even though respondents expressed apprehension about the discrimination or preferential treatment exercised in accessing those limited positions and opportunities. Yet, a strong belief in the potential to be promoted on merit and through hard work seemed to prevail among foreign staff. For those coming from developing countries, this seemed to be particularly valued.

A positive, emerging pattern, which came across in interviews with both South African and foreign staff, was related to appreciation of the international, multi-cultural work environment, both in terms of patients and teams. Several of our interviewees expressed appreciation of the diversity encountered in their current teams in large Gauteng facilities. They contrasted this to the parochial, ethnic or racist behaviours and attitudes found in smaller facilities, particularly in rural areas or, for the foreigners, in their countries of origin. This came across as a strong incentive to remain in such teams, departments and facilities.

Conditions of employment: Division of labour, precarity and exploitation

In general, conditions of employment in the public sector, while worse than in the private sector (for those who had experienced both), were not described as being particularly bad; a majority of interviewees, whether South African or foreign, expressed a kind of resigned frustration but ability to get by. Common factors of frustration were unpaid overtime, especially among nurses; poor equipment and infrastructure in peri-urban and rural areas in particular; gross understaffing resulting in overtime but also in administrative overload; and poor organisation and communication between different departments within facilities, particularly on procurement issues for equipment renewal or medicines. Across nationalities, many also expressed a sense of powerlessness in addressing those issues which, they said, were demotivating and counter-productive. When it came to differentiating foreign interviewees' perceptions from those of South



Africans, we essentially came across three prominent and interlinked dimensions which will be outlined here:

- An emerging division of labour with foreign staff more often ascribed to less attractive or more difficult occupations, facilities, or types of work;
- Greater precarity of employment status among foreign staff; and
- Exploitation understood as the performance of an occupation either remunerated well below standards or not commensurate with one's qualifications & experience but which one is forced to accept due to one's precarious situation.

Regarding the **division of labour**, as our study mainly drew on random sampling at the level of three large facilities in Gauteng, we cannot infer strong evidence pointing to specific concentrations in certain occupations, departments, or types of facilities across the country. However, our interviewees and key informants pointed to the following trends which they were drawing from their own experience. Firstly, they indicated they had a sense African doctors and nurses were overwhelmingly appointed in underserved and rural areas; and second, that they tended to concentrate in some departments such as Intensive Care Units, casualties, pharmacy and radiography. One South Africa educated intern of European origin explains how the division of labour has gradually become formalised in the appointment system of medical officers:

During the course of my sixth year, final year, I had to apply with all the other interns for a post to the various hospitals around the country. I was lucky enough to get allocated a post during the first round as they call it but currently all foreign nationals even if they finished in South Africa are automatically second round which means they get much less desirable internship posts throughout the country, they [foreign nationals] get put in hospitals where most of them [South Africans] don't want to be put in. (20131005AM_DrRIA_HS)

In terms of division of labour within facilities, the 'difficult' departments are filled by and large with foreign staff. A Central African medical officer currently working in the emergency unit at a large hospital in Johannesburg made the following comment:

Those who are in that department, those who are looking after that department, it's only foreign doctors, we are having only two South African doctors. The kind of job that we are doing there, it's only foreigners who can just, you know, accept and carry that burden. Others they do resign in days, months just like that because they can't take it. (20131114AM_DBD_HS)

The second dimension which characterised the position of foreign staff employed in the public health sector was **precarity** understood here as the fact of being maintained into poor conditions of work characterised by short fixed term appointments, low salary scales, positions left to the discretion of a few HR officials, and protracted uncertainty about one's future employment situation. While it took multiple forms, which will be presented further, its general features were: a combination of indeterminacy linked to one's contract renewal and conditions attached to being foreign; and the subaltern positions staff were confined to, depending on colleagues and superiors, as well as a chain of officials regarding the continuation of their employment. Contract types, in turn, triggered a whole new round of indeterminacy at a personal level (accommodation, access to credit, family life, etc.). Several of the employed interviewees were unsure about the continuation of their employment as this was dependent upon the renewal of their work permit or refugee permit by the DHA. Even though the DHA was said to follow

recommendations from the DoH itself based on indications provided by the employer (the CEO or HR head), several interviewees as well as key informants experienced suspensions due to the DHA's delays in renewing permits. These suspensions imply non payment of salaries and are not retroactive: when permits are issued, salary is then paid again starting on the first day of work. This also means that contracts are discontinued resulting in the loss of benefits during suspension and sometimes penalties when salaries are resumed.

Lastly, **exploitative conditions of work** were very common across a broad spectrum of situations with foreign health professionals not always fully aware of being exploited as a result of a limited understanding of their actual rights. Exploitative situations were first a direct result of waiting periods during the recruitment process (from initial submission to the DoH to the final registration with the board). Given the extensive periods of time (in most cases several years) and for most applicants the double need to access some income and to ensure the legality of their stay in the country, they needed to identify an additional (and immediate) economic activity. For many nurses, this activity was care-giving through placement agencies which seem to specialise in the recruitment of non-registered African nurses awaiting registration. For these placement agencies, this workforce is almost captive: for extended periods of time they are available and ready to work in poor conditions and well below their qualifications, yet they are considerably more qualified and experienced than local labour in the same occupation bracket and therefore appreciated by clients. Since these agencies have labour broker status, they are in effect not bound by labour laws and operate in a sort of grey area where labour and immigration legislations are almost inoperant. This parallel economy of care-giving relies at least partially on the impossibility of a section of the qualified workforce entering the labour market in occupations commensurate with their qualifications due to waiting times and the uncertainty linked to the outcome of their registration process. Several nurse interviewees also indicated having resorted to other activities even further from their sector of qualification: domestic worker, child-minder, waitress, hairdresser, etc.; occupations not requiring any registered qualification and often in the informal sector. Sharon, a Zimbabwean nurse, who arrived in South Africa in 2007 and currently works in the private sector as an HIV counsellor, explains how being foreign can become a comparative 'advantage' in otherwise exploitative conditions of employment:

*Well they say we are hard working so they book us more and when we have travel events they will put Zimbabweans first because we can go into a bush and we live there, you know what you can book us in a shady place unfortunately we won't mind as long as we are getting money, but you can't book a coloured or a white South African or some black South African who thinks she is up there and you book her in the shady place where she would be sleeping in a BnB and whatever, scary things moving around, you can't do that, so for us it becomes an advantage if we are travelling because they will book us more, **they know that we would take any kind of nonsense.***
(20130515MC_SHA_HS)

While some **doctors** indicated having worked in low-skilled occupations to make ends meet, there is a different parallel economy for doctors in the form of **illegal locums**. A *locum tenens* is the name given to the process of hiring the temporary services of a medical practitioner as a replacement: a registered medical practitioner hires a replacement for a period of time not exceeding six months while he or she is prevented from working (maternity leave, increase in workload between different practices, etc.). While locum tenens is a standard practise regulated by the Health Professions Act, its illegal practices seems to be mostly confined to lower end private practises in underserved areas. From a legal perspective, the activity



is regulated by Section 9 of the Ethical Rules of Conduct for Practitioners registered under the *Health Professions Act*, 1974. Section 9 determines the following regarding locums:

A practitioner shall employ as a professional assistant or locum tenens, or in any other contractual capacity and, in the case of locum tenens for a period not exceeding six months, only a person –
(a) who is registered under the Act to practise;
(b) whose name currently appears on the register kept by the registrar in terms of section 18 of the Act; and
(c) who is not suspended from practising his or her profession.
(Cited by Slabbert & Pienaar, 2013: 97).

This was renewed almost unchanged but except to be further restricted (see emphasis) in 2006 in the *Ethical and Professional Rules of the Health Professions Council of South Africa as Promulgated in Government Gazette R717/2006*. These guidelines indicate that:

9. (1) *A practitioner shall employ as a professional assistant or locum tenens, or in any other contractual capacity and, in the case of locum tenens for a period not exceeding six months, only a person –*
(a) who is registered under the Act to practise in independent practice (emphasis added);
(b) whose name currently appears on the register kept by the registrar in terms of section 18 of the Act; and
(c) who is not suspended from practising his or her profession.
(HPCSA, 2008: 12)

This means that those who cannot be hired as *locum tenens* include: interns in medicine, whether South African or foreign; South African medical officers who have not completed CS; and foreign practitioners still awaiting registration with the HPCSA and not registered to practise in independent practice (something foreign practitioners residing permanently in South Africa can only apply for this after five years of practice in the public sector). The reality is that this legislation seems to be often breached. Different newspaper articles and reports have documented the seemingly widespread practice consisting in using South African interns in *locum tenens*. An article by Slabbert and Pienaar asserts, "The *locums* are often appointed without consideration of the legal consequences or requirements" (2013: 94). In 2010, the case of a South African doctor, formerly chairperson of the Junior Doctors of South Africa, hit the news and ended with definitively barring from medical practice the practitioner who had engaged in illegal locum as an intern three years earlier (Comins, 2010). The practitioner claimed that this practice was in fact common and could concern 60 per cent of final year South African medical students (ibid.).

During our fieldwork for this study, we came across several foreign doctors who, under conditions of anonymity, indicated being currently or having previously engaged in locums without being registered fully: they were either in the process of registering or, having registered, had not obtained authorisation to practise in independent practice. The interviewees were unclear whether this was done in breach of the law: they made no reference to the *Health Professions Act* of 1974 or the *HPCSA 2008 Guidelines*. When asked if they had been informed, some insisted they had been told by their employers or contractors that it was 'okay'. However, others were very clear they knew it was illegal and were ready to take the risk. Some even explained the kind of precautions they would take (or be told to take) while in the practice room in order to avoid government officials or police passing for patients in order to check on their employment

status. Interviewees also described that the situation varied from employer to employer, some giving them written agreements (but hardly ever contracts it seemed), others only agreeing with them verbally. In several instances, interviewees reported being told one amount and then given a lower one at the end of the month or replacement period. Dispensing of drugs was mostly done under the principal doctor's name and licensing number with basic forged signatures. Dr. J., a young Congolese doctor, currently studying for the examination, explains:

R) You can do the, what they call it, volunteer, in the hospitals but they won't pay you.

Q) Are you allowed to do that though?

R) You need to have some authorization most of the time but it's a waste of time because you need to survive, you need to eat, you need to pay rent, sometime there is some locum you can do, even though you are not allowed to do it. [...] It's to work under someone in the private practice but it's not allowed by the law. [...] It is illegal, [...], you need to be registered to do a locum. [...] and it's not secure because if one day the inspector comes, you understand...

Q) You are going to be arrested?

R) Not only but it won't be nice, they will put you away.

(20130811AM_DrJ_HS)

Motivation for locums was essentially two-fold: economic sustainability and clinical practice. Doctors indicated they could make up to R 20 000 or even R 25 000 a month and sometimes were reimbursed for other expenses such as travel or accommodation. Some, however, indicated having received much smaller amounts for a full month locum. The need to maintain their level of clinical practice and, for some, familiarise themselves with medical English, drugs dispensed in South Africa, and so on, was an incentive which seemed preferable to sitting at home working from books. Often, locums were accepted during the period leading to the examination. Locums were taken mostly in small private practices such as small clinics or dispensaries either in impoverished urban neighbourhoods (typically Hillbrow, Berea, Yeoville in Johannesburg; Sunnyside in Pretoria), or in remote, equally impoverished peri-urban or rural areas (Atteridgeville, Diepsloot, Hammaskraal, Tembisa, in Gauteng, and other parts of the country such as rural Limpopo, Kwazulu Natal, North West, etc.). Several respondents feared conditions of insecurity in those areas but indicated they had to put up with them in order to fund their studies, specialisation or simply recruitment process. Lastly, there seemed to be a degree of ethno-national connection in accessing locums. For instance, younger doctors indicated being offered locums by established practitioners from the same country of origin running several medical facilities in South Africa. Some of these facilities also received large numbers of patients from the same country coming to South Africa for medical treatment.

The prevalence of locums is a consequence of the de facto inactivity of foreign practitioners applying from within the country who still have financial needs. Yet, the practice seems problematic on several grounds. Firstly, it is exposing South African and foreign patients, and particularly the poorest among them, to inappropriate and below standards healthcare practice. While according to Slabbert and Pienaar (2013), there have not been cases of malpractice exposed thus far, this could very well happen in future. In addition, the new dispositions of the Consumer Protection Act of 2008 create the possibility of locums, not just principals, being held directly responsible should such a case arise (Slabbert & Pienaar, 2013). Secondly, these doctors are in breach of the legislation which means that in case of control, both the locum and his/her principal are liable to fines, suspensions by the HSPCA and barring from the profession. As seen in the 2010 case, this can even occur several years later if evidence is collected by plaintiffs. While financial



needs are not specific to foreign applicants, their immigration status often bars them from remunerated activities (except in the case of refugees). It is evident that extended waiting periods for recruitment, qualifications recognition, etc., exacerbate the incentive to engage in such informal and illegal type of work. The fact that regulatory institutions such as the HPCSA and the DoH seem to turn a blind eye to such widespread practice implicitly allows it to spread further. Beyond concerns for patients exposed to these practices, this situation clearly aggravates the vulnerability of those medical practitioners (South African and foreign) coming from underprivileged backgrounds and whose financial situation while studying or awaiting registration is precarious. These practitioners are mostly found among African South Africans and African foreigners. Rather than simply envisage this issue from a normative legal perspective, we must take its systemic dimensions into account in order to minimise risks for patients and avoid aggravating the vulnerability of an already precarious section of the workforce.

Support mechanisms deterring such practitioners from entering into illegal locums should be considered. Three measures could be explored:

1. Decreasing waiting periods and processing time should be a priority;
2. Advertising the possibility to volunteer in the public health sector while awaiting the outcome of one's recruitment would assist in terms of clinical practice (while the possibility exists, it seems very few applicants are aware of it) and working with facilities to determine the best use of this volunteer workforce (interpreters, administrative assistants, etc.); and
3. Creating specific temporary work permits for a limited number of hours to allow applicants to engage in remunerated activities not requiring an HPCSA registration (private tuitions in science subjects, care-giving, etc.).

Lastly, another space for exploitation is that of **supernumerary registrars (SNR)**. SNRs are foreign registrars who obtain authorisation from heads of academic departments and the HPCSA to train in South Africa. Registrars are positions made available by the DoH and provincial DoHs on an annual basis in academic hospitals for the training of specialists. While registrars are remunerated by the DoH as well as authorised to practice a quota of additional hours in private practice throughout their specialisation, supernumerary registrars are not remunerated and therefore fully self-supported, or, in some instances, supported through scholarships from their government of origin and they are not allowed to work in private practice. While issues remain related to supervision loads (as registrars all need to be supervised closely and supervisors are only in limited numbers), the no-cost availability of SNRs has played a role in their increase over the years. In several instances, interviewed SNRs and even South African doctors indicated that SNRs were asked to perform multiple administrative tasks. In clinics and rural facilities, some were even in charge of entire units. This cheap, very highly-skilled labour is said to play an increasingly critical role in underserved areas and overburdened units in urban areas. While our evidence is too thin to confirm this, this trend deserves future research attention.

Coping with discrimination, xenophobia and prejudice

Interviewees were asked about their relationships with their colleagues and superiors at the workplace and about any particular challenge they faced. As indicated earlier, overtime and understaffing were overwhelmingly cited as the most negative aspects characterising their current experience in the public sector. Without being primarily characterised by discrimination, xenophobia and prejudice, interviewees'

experiences regularly reflected these dimensions. In this sub-section, we define discrimination as unfair treatment in comparison with another colleague with similar qualification, experience, and in the same occupation. Xenophobia is defined as the ostentatious or overt dislike of foreigners based on preconceived ideas, i.e. prejudice about their intentions or their effect on one's environment. In our fieldwork, these three dimensions (discrimination, xenophobia and prejudice) could only be envisaged through interviewees' perceptions of their manifestation (and the interviewee's willingness to disclose them). It was beyond the study's scope and methodology to establish the reality of acts of discrimination and xenophobia. However, the patterns which emerged from our empirical material converged regularly enough to point to trends that are likely to exist in real life. Beyond this, interviews reflected directly how interviewees felt about the way they were treated by colleagues and superiors, a key aspect of work relations.

Firstly, it seemed that nurses experienced these three dimensions more often and in more acute ways than doctors. They also indicated having had such experiences more frequently in the public sector than in the private sector, when they could compare the two. Discrimination would typically translate into additional allocations of night or week-end shifts without compensation, obstruction to promotion or access to training, accumulation of unpaid overtime, appointment in difficult departments, wards, etc. In some instances deliberate actions intended to undermine the interviewee, including with the threat of legal consequences, were reported to us in the interviews. These took the form of: retention, omission, or communication of critical information during take-overs between shifts regarding patients' behaviour, medication or the functioning of equipment in a language not understood by foreign staff; deliberate set ups incriminating foreign staff for malpractice; and refusal to partner in team situations or obey orders for nurses in managerial positions. In some instances, the behaviours and actions described could have had serious consequences for patients. Here is one example we came across:

A Congolese nurse who started working at a large Johannesburg hospital in the early 2010s explained how difficult her induction was with South African nurses openly refusing to partner with her for night shifts on the ground that she could not be trusted with emergency cases. After weeks of hostile attitudes from most nurses except a few, a serious incident happened. As the Congolese nurse arrived to take her shift one night, the departing South African nurse gave her medicines which were passed directly into her hands for immediate injection to the patient. However, the Congolese nurse decided to check the patient's file and the doctor's prescription first and realised the medicines passed on by her colleague were not only not on the prescription but could also have been lethal. She administered the prescribed medicine as per doctor's prescription and decided to report the incident to her manager. No further action was taken against the South African nurse. (20130508_RNA_AS_HS)

Doctors reported less overtly xenophobic attitudes or behaviours from their colleagues but regularly indicated being confronted by prejudice, particularly in the attitudes of staff from the HPCSA, or discriminated against in accessing promotion or registrar positions. They also regularly experienced resistance to their authority in their interactions with nurses. One Central African medical officer at a large Johannesburg hospital who initially refused to comment on discrimination then lowered his voice and declared:



[In this hospital] it's not that obvious but discrimination is all over my dear. I don't want to describe but discrimination is all over. We want to focus on the little positive that we get but discrimination is all over. (20131114AM_DBD_HS)

South African staff interviewed sometimes confirmed openly the **pattern of prejudice** foreign staff had reported, either by denouncing it themselves or by being xenophobic and prejudiced in their own comments. An African South African pharmacist from Chris Hani Baragwanath explained:

I will be honest: we have a lot of people from Congo, people from Zimbabwe, most of it I know of those two countries. I am not too sure of everything else. They are actually quite good, they are lovely people, I honestly have no complaints, they are hard working. Obviously I understand the language barrier is there, but they get sworn at, screamed at [...] The pharmacist [...] she is actually from the DRC and [...] the patient was screaming at her and then he told her 'You must go back to your country: we don't need you here'. You know I felt for her and I told the guy, I said: 'That's wrong, that was uncalled for'. (20131106MC_PhczKR_HS)

While some were welcoming and hospitable, other South African staff interviewed confirmed that prejudice was also deeply ingrained among them. Asked about his interactions with foreign colleagues, a South African registrar from Steve Biko Academic Hospital in Pretoria stated:

Doctors from the DRC are weak, they are worse than doctors from South Africa. And there is no doubt about that, any doctor will tell you that. [...] There is the test that they write from HPCSA. I have seen one of those tests, and the questions in those tests can be asked to a fifth year medical student in South Africa. (20131126LJ_Doc3_HS)

South African professionals did not always seem to be aware of the standards and protocols in place to screen foreign doctors and recruit them into the system. A South African specialist at Steve Biko was commenting:

There must be standardised exam boards. Don't just take everyone who practice somethings in our patients. If there can be the board of standardised entry board exams. Just like now, I can't just go to the USA, come and say I'm here to work or even study. So there must be standardised South African board of exams for this level, like a general doctor or a specialist, and that must include practical work like even when I have to go there I have to do practical. (20131106MM_OT_HS)

A South African intern's (at Chris Hani Baragwanath) suspicions of difficulties were far from the reality:

I don't how but I think their registration is a bit more difficult compared to what we go through. They have to go through 1001 things before they finally get a certificate. I remember there was one guy who came in, he actually was even laid off work for... whilst he was fixing his permit - this and that, so if they could just try and see if they can make it easier for them in terms of registration you know because I don't think it's fair. (20131009MC_DRBBN_HS)

Tensions also arose from the **differences in protocols and training**. While one would have expected those differences to have been ironed out at induction, they seemed to go largely unaddressed, whether by the HPCSA or the FWMP, leaving staff to their own devices in often strained situations. A South African radiologist who completed his CS in Mpumalanga Level 1 and 2 facilities recounts:

When I finished, before I registered, I wanted to go to Canada. But along the way I changed my mind and stayed when my colleagues were all going. Then I decided to go and specialise. Cause I worked in the rural places, it was strenuous for me. We learn about so many defects in the medical field, where they put mainly these medical officers from outside the country. Like from nearby countries, DRC, Congo, Ghana, Nigeria. Those ones, they run the hospitals, the Cubans, and sometimes, you know... and what made me realise that I needed to go back to school is that I realised that I'm not learning anything as a doctor. Some of the way things were done were not done properly the way I was taught undergraduate. [...] Our training is different. I remember there was always a disagreement on the patient. They were saying (Cubans): 'Patients with breast carcinoma must be seen by the obstetrics and gynae'. But we know that here it's a problem of surgery. (20131106MM_OT_HS)

Hostility was not only experienced at the workplace but also in the vicinity of the workplace, in communities. One Central African doctor specialised in HIV management received death threats for having exposed management corruption in the programme he was running in a North West hospital and had to resign (20131114AM_DBD_HS). In another instance, one interviewed doctor reported being victim of a serious assault in which he was injured and could have been disabled for life. While this assault was perpetrated by members of a community and not by fellow health professionals, it is worth recounting as it illustrates another dimension of xenophobia to which foreign doctors are confronted with, particularly when operating in underserved, impoverished and volatile communities. During one locum in Hammanskraal, a township twenty kilometres to the north of Pretoria, this Central African doctor was assaulted and remained particularly affected by the incident:

I got off the taxi. I was going on my way to the surgery. [...] I saw that guy he was just following me, he asked me something in Xhosa or Zulu I don't know, as I couldn't respond him, I just smiled and kept on walking to where I was going. Then he came and started to beat me, all his friends came, they came all around me, they start to beat me, they took everything I had with me, they took my tablet, my phones, my wallets, everything, people was around watching them beating me like this, nobody came to say something like to try to get me out of that situation. When I woke up I wanted to check my pocket to see what they took from me, I realized my arm was broken. (20130814_AM_DrF_HS)

Dr. Francis was transferred to two hospitals over a period of three weeks but was not attended to. Once he had regained some strength, he was eventually able to call on a surgeon he knew to undergo surgery successfully but had he not taken the initiative of organising his own operation and transfer, he could have lost the use of his arm. He retains anxieties and is reluctant to accept new locums in similar neighbourhoods.

Even in instances of people who indicated not having experienced any overtly negative attitudes and who 'got along with everyone' at the workplace, interviewees overwhelmingly referred to the difficulty of **inserting oneself in an extremely fragmented society**, divided along racial, ethnic, and language lines palpable in their work environment, and in a particularly **strained health system**, that has yet to come to terms with its own **transformation**. **Language barriers** were cited by most interviewees as a major obstacle to communication with colleagues and patients. While such barriers were surmounted in relation to patients with interpreters or local nurses interpreting for doctors when necessary, interactions between



staff were said to be made difficult by a range of factors. Firstly, all interviewees indicated that they were confronted in multiple languages of which they had no or very limited command, and the mere diversity was a disincentive to one's investment in learning one of them. Francophones felt particularly challenged and self-conscious about their limitations in English but insisted on their constant efforts to improve themselves. Second, foreign and Anglophone South African staff resented (and experienced as exclusionary) the deliberate use of a single language other than English, whether Afrikaans or a South African African language, and refusal to interact in English. There, different factors played out. South African staff seemed to be in a better position to demand information be communicated into English whereas similar requests from foreign African staff, particularly nurses, were said to be easily ignored. Those with experience in the private sector noted that English was more in use there than in the public sector. A racial dimension played out: South African African nursing staff seemed to strongly expect African medical and nursing staff (but more so the latter) to be able to express themselves in a South African African language. Besides language barriers, foreign staff pointed to their difficulties grappling with **South Africans' own divides**, putting them in impossible situations in which they had no idea who they should side with. Perceptions collected from South African staff confirmed those impressions. A South African registrar from Steve Biko Hospital explains:

The aim is to just tolerate in order for you to get the papers that you need; and then you go. [...] We know what happened. We know what Mandela died fighting for. We know, that's how it is. It's not gonna change as much as we try to hide it. It's just that now, like we call medically, its subclinical. It's not as obvious as before. Now it's subclinical. It's there; it's just trying to hide it. But some make it obvious. But some most of the time try to hide. But you can see, let's say you are Zulu and I'm Zulu, you can see the difference. Because we know each other's languages; we are comfortable around one another. So when a Pedi comes, then in Zulu you say 'Ufunayin lomuntu?' (what does he want this Pedi?). So it becomes like that if you speak Afrikaans and I speak Afrikaans; then the black guy comes, it's like 'Wat soek jy?' (what does he wants?). (20131209MM_MEM_HS)

Fragmentation also resulted from extreme demotivation felt by South African medical staff, in the face of generally low management standards, poor equipment, staffing, overtime, but also **lack of racial transformation**. It is against this background that foreign health professionals have to position themselves often ignoring entirely the South African politics of the workplace. The experience of this African South African surgeon in an ICU unit at a large Gauteng hospital points to dynamics that are well beyond the issue of foreign staff but may explain how they are, in some instances and indirectly, perceived as emblematic of the system's failure to transform (even though this particular surgeon was sympathetic to foreign staff):

I think the only reason [I am still here] is because I have recruited the first four black registrars to do this, what I'm doing. I'm the first black to qualify from here. [...] I even told them that I'm focusing. That's why I'm here every day from morning; teach them, try to do this. If I'm working in private, there is a case, I ask them to come, see how it is so that they can add to the logbook. As soon as they are there; they are finished, I'm out of here. I'm not racist but I think we deserve to have blacks in the institution like this. But we are pushed out by whatever is happening. That's the only reason I'm here. I promise you. It is frustrating. [...] And then in that manner, the profession won't die out; won't be extinct. [...] Essentially, what I'm trying to say is when I qualified, we were making about 109 cardiothoracics in the country; and less than nine, most of them about six, they

came from Medunsa; trained by a Black professor there. So I'm the first one to come out, pure Black, to come from here. So I want to see another Black come from here. [...] Two of them should qualify next year. And that's when you won't see me anymore. I have no options. Unless if something else changes. I have no options. It's a difficult one. (20131219MM_SMS_HS)

Confronted and grappling with these inner race and ethnic politics, the foreign interviewees reacted either by withdrawing and limiting interactions to a minimum or, in some instances, played the role of intermediaries.

Fending for oneself: Limited trust in the unions

How did those affected by poor conditions of work or, more specifically, discrimination defend themselves and in general what was the relationship of interviewees to existing labour organisations in the sector? These questions almost invariably elicited responses along the nationality divide: South Africans were affiliated to existing organisations (SAMA for doctors; DENOSA and HOSPERSA for nurses) whereas foreign respondents were mostly not, although a few indicated affiliations with DENOSA (among refugee nurses) and SAMA. There was generally a negative attitude towards unions among foreign professionals, which was essentially explained around two points: firstly, as foreigners, they considered that they were not welcome or allowed to join the labour organisations (many had no clarity and had never been approached by any organisation); secondly, for those coming from African countries, unions had a bad reputation of being trouble-makers. The better-off specialists also indicated preferring to handle disagreements themselves, or if need be, with the assistance of a specialised lawyer. In one instance, a foreign specialist was seeking redress for unfair treatment in the assessment of her qualifications by the HPCSA through SAMA.

In spite of multiple and repeated attempts by our research team to conduct interviews with their representatives, neither SAMA, nor NEHAWU were responsive. While NEHAWU's policy document was referred to in Chapter 1, DENOSA and SAMA do not currently have publicly available policy documents or position papers on the question. The DENOSA official cited earlier acknowledged that DENOSA does not have a comprehensive position and also lacks a strategy to sensitize and recruit foreign nurses employed in the public service (20140819_M Phapo DENOSA_AS_HS). DENOSA's approach seemed to be largely conditioned by a narrow principled understanding of the WHO anti-'brain drain' position and of the broader skills shortage issue:

It's a problem because the HRH plan says we need to produce at least 3 000 nurses per year. But if our colleges and universities are producing less than 1 500 per year as they do currently... and if we up the level, we'll have a bigger challenge. [...] I don't think importing people is the solution. There are laws that you can't poach nurses from Lesotho, Botswana, within SADC. We see an influx of nurses that come from Nigeria but most of them fail to register because South Africa's standards are actually superior to most other countries. Our nurses are rounded and comprehensively trained. [Importing skills] must be a temporary solution for part of the skills not available in the public sector as long as government is going to ensure they are going to generate those skills internally. If we allow for certain skills to be only imported, that's where the problem starts. We need our own people who understand our own problems. (20140819_M Phapo DENOSA_AS_HS)



Self-defence mechanisms therefore dominated the responses of interviewees who, depending on their experience and age, had different approaches. Invisibility and passive resistance were the preferred options. Some indicated preferring to take up the issue with their managers even when knowing that this would never result in reporting or sanctions. Others indicated always being on their guard and warning newcomers about the need to constantly look behind one's back and never trust South African colleagues. Knowing how to avoid being set up or diffuse the attempt were soft skills which were cited as good protection tactics.

Different attitudes to poor conditions of work were also noted. Not only were South African staff more often unionised but they (including doctors) also tended to have participated in industrial action, whereas foreign staff had not. In general, there were contrasting attitudes in terms of reactions to overtime and understaffing. While the foreign doctors indicated being more committed to work and having better work ethics because of the poorer conditions of work in their countries of origin, South African staff tended to consider that accepting poor conditions only encouraged government to exploit staff further. The following quote from a Zimbabwean pharmacist employed at a large Johannesburg hospital lends itself well to this double reading:

This is my experience, I could be wrong, but I have worked even in the private sector in this country and in the public sector, and I have worked with locals and foreigners and I think it is because South Africans in general are not exposed to the rest of the continent so they do not know the hardships out there, so there is no appreciation of how good things are and how hard you should work. Because I am telling you the first people to walk in are the foreigners, the last people to walk out are foreigners. [...] Knock-off time is 16:00 but there will be overtime. By 15:30 the South Africans will put their pens down and leave, and then I know it is usually with me and three other Congolese people usually – all the time, sometimes we would leave at 19:00 when we were supposed to knock off at 16:00, but not to say that everyone who is a foreigner has a good work ethics. It's just a general thing of work ethic because I think the government system, there is no punishment, no punishment for absconding work or not pulling a weight as in the private sector. In the private sector it's almost – it's a military style, enforcement of things you should do and which is always better for the person because you then learn what you need to do and you learn to be proactive and a lot of people here are reactive. (20131107MC_PhCPMC_HS)

However, in the absence of engagement forums for staff to express various perceptions of work ethics and expectations, these views remained largely repressed. Because of their subaltern position in terms of precarity and general hostility, foreign staff turned their victimisation and acceptance of discrimination into a sense of moral superiority. In turn, this acceptance of exploitative conditions further widened a lack of understanding between them and their South African colleagues.

Conclusion to Chapter 5

Our enquiry into the lived work experiences of South African and foreign health professionals reflected the general context of **a very strained public service seriously affected by under- and inadequate staffing and attrition of staff to the private sector and emigration**, and faced with a quadruple burden of disease. Within that context, our **foreign interviewees reported more positively on their work experience than on their registration and recruitment experiences**, which was insignificant for South Africans as their

induction was greatly facilitated by their nationality. However, several challenges continued to render their experience in public service particularly difficult as a direct result of their nationality. Firstly, their conditions of employment were characterised by: a seemingly growing **division of labour** between locals and foreigners; contract **precarity** due to their immigration status and a lack of policy direction; and **exploitation**, particularly in the period leading to registration, with employment in illegal conditions (locums) or in occupations well below their level of qualifications. Different **parallel economies** seem to be thriving as a result of foreign health professionals' precarious position. We saw in Chapter 4 that a parallel economy of asylum 'benefitted' from the ban on African nationals. In Chapter 5, we documented the interconnection between the caregiving economy and of illegal locum networks and the availability and extended waiting times imposed on foreign health personnel. The interdependency between employment in the public service and immigration permitting seemed to impact very negatively on foreign staff's morale, and their relationship with HR services at facility and provincial levels.

Interviews with South African and foreign health professionals also revealed **discrimination** at the workplace. Reports of **xenophobic attitudes** were common, particularly among nurses, and they sometimes led to illegal acts, endangering patients. A general sense of **hostility**, which at times manifested beyond the workplace in surrounding communities, impacted very negatively on interactions. South African staff interviewed either confirmed the abuse to which their foreign colleagues were subjected or themselves reflected high levels of prejudice. Many were misinformed about the realities of their colleagues' recruitment. Even in places where people did not report major problems, the **level of fragmentation** characterising the milieu, with tensions along language, ethnic, racial, gender, hierarchical and professional lines, was adding to foreigners' difficult integration. Foreign staff in those situations tended to withdraw and adopt invisibility strategies. While some were unionised, many expressed **distrust and defiance in the unions** or indicated having never been approached by them. South African staff, while often demotivated and despondent about unions, reflected a very different organisational culture in which union protection played an important role. Diverging attitudes were blatant between foreign and South African staff in terms of responses to overtime, understaffing, etc., but mostly repressed for lack of engagement space where such incomprehension could be discussed and addressed.

However, some positive aspects were identified which could serve as the **baseline for a more inclusive approach to foreign staff's integration into the South African workplace environment**. The formalisation of administrative recruitment processes, in spite of continuing hiccups, was considered as positive as it gave a firmer footing to foreign staff once they were employed. Foreign staff valued the South African experience for many reasons: some were particularly interested in the acquisition of clinical experience with pathologies they were unfamiliar with; others liked the quality of technical equipment compared to other developing countries; yet others were interested in the organisation of health care and the systems management experience. Many, whether local or foreign, valued the international and multicultural dimension of the teams they worked within at large Gauteng facilities. Finally, pay was considered reasonable, except in the case of high level specialists.



6. Remigration and retention

As seen in Chapters 4 and 5, conditions of recruitment and employment are lacking on many fronts and sometimes could even be considered as a disincentive to one's commitment to work in the South African public health sector. Some of the challenges described are general and shared by all health professionals; others, as we have shown, are very specific to foreign professionals. The question animating this last chapter is two-fold:

- Given the mobility of health professionals globally (Bach, 2006) and South Africa's attrition rates through emigration, is South Africa a final destination or a temporary stop-over for those foreign professionals currently there?
- What are their views regarding current policies and practices and what would be decisive in their decision to stay?

Remigration

For a majority of our foreign interviewees, including those from SADC, South Africa was initially a second choice, identified by default and through networks. Interviewees would have preferred to go to Europe (Belgium, France, UK), North America (Canada, USA) or Australia. This is a classic trend for the highly skilled migrant who gathers information about employment opportunities through networks, other nationals or relatives already in South Africa (Iredale, 2001). South Africa, with its specific policies and practices, then has to be integrated into a migration project in which it did not initially fit. While there was a strong appreciation of South Africa's generally high medical and nursing standards as described in Chapter 5, the hostility and incoherence of the recruitment system were pointed to as strong deterrents to pursue one's experience further or encourage others (alumni, relatives) to join them. We acknowledge that the study was by nature biased towards foreign health professionals who were either trying to be recruited or had succeeded and were currently employed in South Africa. We could not actively look for those who had failed to be recruited and had decided to leave, go back home, move to a different country, or change occupation. Therefore, the views presented here simply point to certain trends that could be explored more systematically in further research.

Several interviewees indicated South Africa was a good place to get trained at and registered in because of the global recognition of South African standards of education and medical profession. For interviewees coming from less developed countries, the length of the registration process was worth it as it was seen as a passport en route to greener pastures. This does not necessarily mean that interviewees will eventually leave South Africa but simply that this kind of rationale does exist among foreign staff alongside the view that South Africa is a final destination, meeting professionals' long term life expectations. Officials from the FMWP also indicated that for some professionals in GGAs, in particular it seems for Tunisian doctors, experience acquired in South Africa with specific pathologies such as TB, HIV/AIDS and trauma, was considered valuable because it could be marketed in other contexts (Hennie Groenwald and Phumelele Zulu, personal communication, 14 February, 2014).

Several interviewees were also following in the footsteps of relatives, often an older brother or sister, who had been registered and recruited in South Africa, and had remigrated after a few years to Canada, the UK,

or the USA, in most instances. If and when they take the decision to move on, remigrants can mobilise these transnational networks of relatives and co-nationals. For instance, a number of Congolese doctors and specialists indicated having relatives also in the health professions who had settled in French and English speaking Canada over the past ten years and with whom they were in regular contact via email, telephone or instant messaging. Like South Africans, several foreigners aspired to work in the private sector, a trend more pronounced among nurses.

Within our sample, we also came across several interviewees who were in the actual process of **relocating**. They were either awaiting the outcome of visa applications, new registration with medical councils in the proposed country of remigration, or the end of a contract in South Africa. In one instance the connection between successive bureaucratic challenges and the hostility of the South African system and remigration was direct. Here is the conclusion of our interview with the female Sudanese specialist cited earlier:

So it [administrative challenges with the HPCSA and the DHA] chases you away and I might be leaving actually. I reached a certain stage when I thought like: Is this going to be my life onwards? I have been patient for like almost 10 years. Now how long more can you be patient before... I got the experience, I got the qualifications, why can't I just go and work in the UK? Now on Friday I am traveling to finalize my registration. So this chases you away, so really that's the thing that frustrates one, which is one of the reasons I am leaving. (20131106MC_DrWMD_HS)

Others were unsure, exhausted by their bureaucratic ordeal, tempted to return home but also perhaps to move on. Dr. S., a Medical Officer from the Middle East who currently works at Chris Hani Baragwanath and has to renew her immigration permit every six months, explains:

You know I asked Home Affairs. I have to stay for five years here, with general work permit and then I can apply [for permanent residency], so you know I'm not sure about my future because my husband is supernumerary and doesn't get paid now. I don't have any plan, to stay in South Africa. I have a plan to go back to [country] because of the economic situation, because my husband now doesn't get paid and now I'm the only one working, life is very expensive in South Africa so I'm not sure. It might be if my husband is employed here, I can stay. Now I'm not sure. [...] Sometime I'm thinking immigration to a developed country because of my baby, because I want to keep him in high education but it depends because we are old, it's not an easy decision, I didn't apply yet. (20131008_AM_DrSPR_HS)

Others had given up. One Congolese nurse, having failed the examination three times, was considering moving back to Congo as he could not make a decent living in South Africa. Another Congolese national, who had attempted the medical examination twice and had failed, continued to accept illegal locums and did not have any other plans, as long as locums would work for him. Yet others, who had also failed the examination had decided to stay but had changed occupation or started a new degree.

Retaining people: Some hints

Retention of all staff, South African and foreign, specifically in underserved areas, is as critical as the recruitment of larger numbers at intake. While we tried to show that foreign staff suffer specific types of discrimination in addition to being exposed to similarly challenging conditions of work as their South



African counterparts, there is no reason to think that foreign staff are less affected by attrition. As a somewhat captive workforce, statutorily and socio-economically, they remain nevertheless free to leave as shown in the previous section. Retention of foreign staff into the system should therefore be part of the broader policy focus on staff retention in the public sector but with a specific emphasis on eliminating those particular factors leading foreign staff to consider exit options. This sub-section envisages the possibilities to turn around specific disincentives to foreign staff's continued employment in the public sector as well as policy directions for improvement.

In spite of the serious challenges described earlier, the administrative and workplace contexts in which foreign staff are recruited is not hopeless. Not only are systems in place, even though they may be greatly dysfunction and need fixing, but there was also broad consensus among the majority of the South African staff we interviewed around the need for their skills and presence. Most South African staff considered that shortages were such that 'foreign doctors were better than no doctors at all', and that they allowed the public health system to survive. Some went further by insisting on their appreciation of foreign staff's hard work, and ability to cope with difficult conditions and publics. Others appreciated their high level of specialisation, particularly for first world doctors. In addition, those who had positive reflections sometimes pointed to African staff's added ability to sympathise with the hardships of the African population of South Africa and to learn African languages.

This consensus constitutes a critical baseline from which the current policy can be expanded and should be better explained. We saw earlier that there is limited knowledge on the side of South African staff of the bureaucratic challenges and professional tests and verification of credentials which foreign professionals have to go through to make their way into the system. This can be addressed by better informing South African staff. In addition, the need for foreign staff from other African countries also arises directly from a more profound structural transformation at play within the South African medical profession. A young South African registrar from Steve Biko Academic hospital pointed to the emergence of a new class of practitioners with different aspirations in terms of lifestyle, standard of living, etc.:

You see what happens, sometimes I don't blame the department. I don't blame them. They do this because they are desperate. [...] Let me tell you about the South Africans, at least from my point of view. It's not from everyone. I think South Africans are spoilt. So those guys they come here, they work hard; they know how it is back there. So here, we are spoilt. If you go to the rural areas; you wouldn't find South African doctors. What they want, they want a good life. Rural areas, there are no malls. There are no cinemas. So who would want to go there, they don't. We end up not having doctors in the district hospitals. So what must government do? They go out there, they get guys from Africa, the foreigners. They place them there. Because those guys for them, it's better than where they are from. So they are willing to sacrifice. They are not used to all these things that South Africans are looking for. So South Africans you find them in the cities. Hospitals in the city, that's where you find them. That's how we are. We are spoilt. (20131209MM_MEM_HS)

Beyond the normative and at times patronising undertones of the excerpt above, what is fundamental in this quote is the fact that even increased numbers of South African medical and nursing staff will not address this profound and irreversible change in aspirations of the younger generation of South African health professionals. Well known in other parts of the world, the replacement of local doctors by foreign ones in socio-economically challenging areas, whether urban or rural, calls for systematic policy responses.

The traction offered by tax incentives and subsidies to rural based practitioners in Europe seems limited in South Africa, except perhaps if combined to the announced shift towards an increase in primary health care units. Yet, it is unlikely current South African outputs will meet those needs. On the other hand, the current concentrations or clustering of foreign African doctors and Cubans in some of the most underserved areas with limited supervision and coordination, seems undesirable as it creates a sense of a system based on double standards: South African doctors for the better off and the urban, African foreign doctors and Cubans for the rural poor. The position of a majority of South African practitioners was to recognise the need for more doctors and generally the import of foreign staff but under certain conditions of monitoring and management which they considered were currently not met. The following quote points to the complexities and nuances of the longer-term incorporation of foreign doctors and the need for support for re-training and specialisation:

Foreign migrant doctors play a very important role. You find that there are those that have been there for years and they are doing very well and do their work diligently. However, I have noticed that some doctors, once they start to do a speciality, very few of them cut it, which is very sad because they have to keep on increasing their knowledge. Secondly, having worked with a lot of them, I also notice that they have a very high level of practice which is good but only at a lower level. When it comes to high level decision making, it is quite frightening some of the decisions they make. (South African female registrar, Steve Biko Hospital, Pretoria 20131210_XS_LAT_HS).

To build confidence in the screening and selection system put in place by the FWMP in collaboration with the HPCSA, the SANC, and AHP, these stakeholders should consider better publicity sensitizing South African staff, managers and students, in order to formalise, embed and enhance the efforts produced along with their policy rationale. Currently, however, this sensitizing work seems to be completely lacking, as does a more systematic and transparent assessment of spatial and skills distribution. In other words, the foreign workforce component of the general workforce policy cannot be done behind closed doors and in the secrecy of government-to-government talks but should be owned and supported as a positive policy measure by all concerned in the public health sector. This requires political leadership.

Another key dimension of the retention of foreign staff, as underscored in the WHO's Code of Practice (2010), is equal treatment between local and foreign staff. We have seen, however, that there were multiple instances of differential treatment. There are at least two critical areas that could be reformed in order to ensure earlier and longer stabilisation of staff in the South African system:

- The first is a **drastic simplification of their registration process** with a view to decreasing all waiting periods and **aligning the foreigners' hiring process with that of South Africans**, once the former have been registered with the HPCSA; and
- The second critical area is working towards the gradual **elimination of uneven and precarious immigration statuses** among all foreign health staff whatever their origin through the creation of a simplified but specific work permit of a minimum of five years, leading to permanent residence.

Some of the interviewees came up with different suggestions based on their experience. On the simplification of the recruitment system, one foreign specialist encouraged a concentration of services under a one-stop shop model of service:



It's a whole change of policy, I think it should be a one stop thing; it should be a one stop thing but not meaning to go from this place to that place and everyone has got their rules and regulations that are completely different from the other. So if it should be a one sort of agency that will deal with your registration, with your work permit rather than going to Home Affairs, probably the job offer itself I am not sure. (20131106MC_DrWMD_HS)

The complexities, delays and precarity associated with immigration permits were almost unanimously resented by foreign interviewees as well as South African administration managers. In particular, interviewees suggested the creation of SADC cooperation agreements allowing all SADC nationals who would have satisfied admission criteria to benefit from specific arrangements, in particular in relation to mobility across the region. For those with refugee permits, this was impossible and while some admitted to travelling back home with false documentation (particularly to bury relatives), they felt these limitations spoke poorly about the state of regional integration: “They speak about SADC but we don't see it!” stated Bibi, a nurse from Congo, who arrived in South Africa in 2000 (20130512AM_BIB_HS).

Finally, whether before registration or during employment, some, echoing Saul Kornik's call for better training of foreign staff (see Chapter 3), expressed incomprehension and dismay at the level of skills waste in a country so affected by shortages. Adaptability and maturation of skills were regularly referred to, as in a poignant call from Joyce, a Zimbabwean primary health care nurse with 15 years of experience in rural Zimbabwe. Joyce migrated to South Africa in 2007 and has not managed to finalise her application for recognition of her degrees. She currently works as a child-minder. When asked what she thought of the management of foreign health staff by the South African government, here is what she had to say:

*I feel bad actually, its' so bad. I see someone who is not even professional, is working as a nanny or she is working as a housekeeper. **I am myself a domestic worker and yet I have got my documents, they are just packed in the bag!** [Very emotional]. I feel – if I become angry then I would just sit down and cry: 'Why are they doing this to us? We are Africans, we are trained, why can't they just accept us?' **If they want us to be trained again here in South Africa why can't they arrange something - to go for training or for workshops so that we can know what they are doing in their South African system. Unlike just to come here and sit and say 'Ey I've come here to look for a job.'** [...] There's nothing you can do only to wait and the people in the health sector or the minister: **I haven't even heard the minister himself speaking on behalf of the foreign nurses** or the foreign workers as professionals, I haven't heard him. Maybe he hates us, I don't know, maybe he doesn't want us to be in South Africa, I don't know but we are Africans. (20130517MC_JOY_HS)*



7. Conclusion

The South African public health sector faces numerous challenges, some historical, some contemporary. Twenty years into democracy, it is now evident that South Africa will not by itself meet its health staff shortages with its current policy instruments. While the government's sustained policy efforts in tertiary education have, of late (since 2012), reversed the dramatic decade-long decrease in outputs in medical schools and nursing colleges, other structural (disease burden, educational output of secondary schools) and systemic (attrition to private sector and emigration) factors remain largely unchanged. In the face of these challenges, the South African government has chosen to prohibit immigration from developing countries, including from its own region and sub-region (SADC). This has been done in spite of the fact that large numbers of African professionals, mostly from SADC, are already employed in and keep arriving to South Africa. While the dependency of the South African system on African professionals claimed by some (Stern, 2008: 17) seems exaggerated given foreigners' small share of the total workforce, it is also clear that in certain facilities, specialities, and rural areas, they have become a vital component of extremely fragile and vulnerable systems. Yet, the government seems to remain caught in its own dilemma and unable to instill forward-looking policies. Instead, government officials should aim to mobilise their departmental skills to actively recruit available and excellent professionals, develop sustainable cooperative policies at the regional level, and generally improve their conditions of employment over the long term in order to stabilise a workforce pool adequately trained and prepared to address the specific health challenges that characterise South Africa. We hope this report contributes to working in that direction.

The South African cul-de-sac: Policy ambivalence and maladministration

At a policy level, the study found that the South African government is struggling to find a robust, pragmatic policy line and, subsequently, to implement it. On the one hand, the South African policy on the recruitment of foreign health professionals is informed by professional boards' standards and principled positions against 'brain drain'. From that perspective, South Africa can and should hire only the best and most needed staff from developed countries on short term contracts as well as use temporary labour within GGAs with surplus countries. Concurrently, the country should scale up its output of local staff, both medium and highly skilled. On the other hand, the reality South Africa needs to deal with is very different from those lofty aspirations. Scaling up medical schools and nursing colleges' outputs has its limits as it requires supervision capacities which are currently overstretched. Further, the majority of doctors and nurses willing and actually available to settle in the country are overwhelmingly from Southern Africa and are more interested in settling in rather than coming in temporarily. Their qualifications often do not match South African standards and there are language barriers. They encounter a lot of hostility from both colleagues and patients but overall make their way into the system and have now become vital to some of its most vulnerable sections. When they remigrate, they seem to perform satisfactorily in North American and Western European healthcare systems. Yet, at the policy level, government remains caught in its own contradictions and has resorted to 'loopholes' in its own system to incorporate those African staff. This policy ambivalence has dominated the recruitment and employment of foreign health staff for the past two decades and explains a number of the administrative shortcomings that were documented in this study.

Firstly, the reasons the South African government gives, apparently under strong influence from the HPCSA and the SANC, as to why it continues to espouse conservative policies that even exceed the WHO anti-‘brain drain’ agenda do not stand-up to closer scrutiny. A closer examination of WHO Guidelines reveals that ‘regional cooperation’ for the circulation of skills and ‘individual freedom’ to emigrate are granted as much importance as the ‘anti-brain drain’ position; this balance is ignored by South African authorities. Analysis of current staff to patient ratios and trends in staff training outputs reveals that plans to resort to migration ‘temporarily’ are at best naïve as the country is very unlikely to meet its needs in the close future, a critical point which is acknowledged by even the deans of Faculties of Medicine. Rather than admit the realities of the current situation, South African health authorities continue to entertain the fantasy that their system could / should attract the global medical and nursing elite. While this may happen in some rare instances and in some niche research initiatives, the majority of foreign staff is currently recruited as disposable labour deliberately maintained in precarious conditions of employment.

Before envisaging what the way forward could be, it is essential to try and understand which key factors have contributed to this policy ambivalence. Firstly, as with all policies, the foreign workforce policy of the DoH is the outcome of competing forces and interests. The weight of colonial legacy seems to continue to play a strong role within professional boards, in shaping standards and aspirations, modelling them almost exclusively on the ideals of the health professions as they have developed in the West, in particular the UK and USA. However, rather than understanding the political economy of those systems in terms of education, labour and financial models, the main emphasis seems to be on emulating their qualification and training standards. This results in continued and deeply embedded prejudice against African professionals who elicit suspicion and are policed rather than supported in their attempts to integrate into the system. As far as government and unions are concerned, the main preoccupation seems to lie in the employment of South Africans in a narrowly defined, and at times blatantly chauvinistic, understanding of staffing issues. In spite of very low numbers of foreign staff, which preclude any idea of them displacing South Africans on the health labour market, especially not in the public service, the argument is raised again and again and serves to defuse a more open embrace of skills import. While more research would be necessary to document to what extent these positions and attitudes are informed by xenophobic sentiment, it seems obvious that, like the rest of South African society, the public health sector is generally negatively predisposed towards migrants, and particularly so when they come from Africa. This points to the necessity to open a discussion between stakeholders and to educate and sensitize staff more.

Secondly, the current policy ambivalence is also the result of incremental administrative developments. The South African case is a particularly interesting configuration of devolution of certain immigration powers from DHA to professional bodies and to another government department (the DoH). However, this configuration has been very slow to operationalise with the direct result of having ‘wasted’ skills on a large scale at a time they were dearly needed. Currently, recruitment of the available pool of health staff (predominantly Africans) takes place to a large extent through the loopholes of poorly thought through and largely maladministered immigration and asylum policies, which are themselves a consequence of the lack of political leadership. The interdependency between the health policies and immigration & asylum policies has not worked well: interdepartmental coordination remains clumsy, at times deficient, continues to accord huge levels of discretion to the DHA, and maintains many staff in very precarious and vulnerable positions. The system in place neither manages to shut out undesirable staff (from developing countries), nor does it efficiently attract the global healthcare elite, let alone retain it. And it is unclear whether the ‘temporariness’ of the solution is working well since output targets will not be met any time soon.



While less nightmarish to foreign staff than recruitment processes, current conditions of employment are unsurprisingly not very competitive. Some aspects are undeniably valued, such as the generally high standards of theory and practice, excellent equipment, unique clinical experience, and competitive salaries, but these are counterbalanced by a range of general and specific challenges. The general conditions of employment in the public sector are poor in terms of staffing, overtime, coordination, and management resulting in huge stress and burn out in the workforce. Attrition rates are record high. Foreign staff also face specific challenges which the study has documented systematically. Discrimination, prejudice and overt xenophobia are common, particularly vis-à-vis nurses. Precarity of status because of the limitations built into the policy renders foreign staff's integration much more difficult. The administrative hurdles at registration also tend to continue throughout one's employment as the treatments of foreign and local staff constantly differ on contracting, access to training, grading of occupation, promotion, etc.

This unresolved policy dilemma seems less and less sustainable in the global context of competition for skills. It jars with the experiences of South African staff who work daily with foreign staff and, while unwilling to compromise on standards and management, seem inclined toward making their integration easier and more efficient. For the vast majority of foreign interviewees, South Africa was the default option. While most foreign staff declared they were in the country to stay, several referred to aspirations to move to the private sector, abandon their current project, or accumulate as much experience, qualifications and savings as possible to move on to greener pastures. Many already belong to global professional diasporas and are closely connected to transnational networks of relatives and co-nationals successfully settled elsewhere. While beyond the scope of this study, the possibility of remigration, that is, using South Africa as a stop-over, is real for at least a portion of those who have managed to register here. The questions then are: Why would South Africa (and Southern Africa for that matter) be unable to retain health professionals who are very likely to successfully resettle in developed countries in the same profession? What, in the South African administrative and workplace environments, makes those professionals less performant than similar professionals who operate in developed countries? Answers to these questions perhaps start by shifting around the current approach and discarding the vision of a temporary, disposable workforce in favour of a stabilised and valued pool of professionals placed in the right conditions to contribute to team South Africa.

From disposable to critical: Contributing to team South Africa

Drawing on all the empirical and theoretical observations made in the course of the study, this final section proposes a series of 21 concrete recommendations intended to enrich policy discussions and the reform of administrative practices. In places, it also identifies persistent knowledge gaps and charts the way for future research. Recommendations are formulated in the following areas:

- Policy coherence and harmonisation;
- Governance reform of registration and recruitment;
- Conditions of employment and retention; and
- Global market competitiveness of South Africa and building regional capacity rather than regional divide.

Policy coherence and harmonisation

National DoH, Boards & DHA

1. Policy development work needs to be organised in order to shift towards maintaining a stabilised workforce, including staff from developing countries.

DoH & DHA

2. Commission studies to assess output situations in the region and among the refugee and asylum seeker population already in South Africa.

DoH

3. Build support for policy among ministerial management staff and across medical and nursing staff (and include information on the purpose and standards of recruitment policy).

Governance reform of registration and recruitment processes

DoH

4. Commission an audit of the registration and recruitment processes with a view to simplification and rationalisation of its different steps, particularly after registration.
5. Use existing PERSAL data to improve statistical knowledge of the existing workforce and start building time series in order to observe trends over time.
6. Align recruitment processes of foreign staff with that of South African staff after registration.

HPCSA & SANC

7. Revise outsourcing policies on credential evaluation for doctors and build upon SAQA experience and skills, in particular across the region.

DoH & Boards

8. Professionalise administrative processing of applications, drawing on the experience of AHP and similar projects globally.

DoH, Boards & DHA

9. Explore the possibility of an integrated 'one-stop shop' between the DoH, boards and the DHA.

DoH & DHA

10. Amend Immigration Act of 2002 / 2004 towards the creation of a specific endorsement of a minimum of five years within the framework of work permits or exceptional skills permits.
11. Phase out staff under refugee permits and channel applicants from developing countries towards work permits within the scope of GGAs.



Conditions of employment

Hospitals & Provincial DoH

12. Professionalise human resources staff at facility and provincial DoH levels to develop expertise on employment of foreign workforce.

P DoH

13. Sensitize staff at the facility level on the need to promote integration and unity rather than competition and fragmentation.

P DoH & N DoH

14. Promote the use of English and one African language per province and fund staff language training.

Unions

15. Systematically adopt policy position papers on issue of employment of foreign staff in public service, sensitize members and mobilise and train foreign staff to South African labour conditions.
16. Work with existing foreign staff associations to exchange information and explore convergence of interests.

Global market competitiveness of South Africa and building a regional capacity rather than regional divide

DoH

17. Explore the possibility for bilateral cooperation agreements within the region including on circular migration schemes, twinning of academic facilities, twinning of internship and specialisation programmes.
18. Set up proactive recruitment programmes in developed and surplus countries wherever possible with set targets and regular monitoring.
19. Build on transnational networks of professionals residing in South Africa to advertise South Africa's competitiveness.

DoH, SANC, HPCSA & DIRCO

20. Work in the SADC Regional Qualifications Framework (RQF) in order to define common standards of qualifications for SADC medical and nursing staff rather than resort to overseas private qualifications verification organisations.

DoH & P DoH

21. Draw on AHP's experience in retention at the facility level and expand policies.



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Professionals

Information on professionals cited has been anonymised for confidentiality purposes. Context for each quote is provided in the report.



Abstracts

ENGLISH – MiWORC Report N°7. *A disposable workforce. Foreign health professionals in the South African public service.*

Based on statistical analysis of PERSAL data and over 70 qualitative interviews of key informants and randomly sampled South African and foreign health professionals, this report documents the recruitment, employment and retention of foreign health professionals in the South African public service.

The statistical analysis identifies patterns of employment per profession, nationality, geographical location and facility. Over two thirds of the professionals currently employed in the public health sector are from SADC and the rest of Africa. The qualitative analysis points to a lack of policy direction over the past two decades limiting the impact of progress achieved in formalising procedures. Government and professional boards support a protectionist approach based on the assumption of the possibility for national self-sufficient training. Rural health advocacy groups insist on the urgency of meeting shortages.

While verification of credentials processes were considered solid, conditions of recruitment into the system were found to be lacking in terms of administrative processes inducing unacceptable turnaround times, at times defeating the purpose of the system. The lack of administrative professionalism induced discouragement, de-skilling and exploitation of applicants in parallel economies. While less contentious than recruitment, conditions of employment were characterised by both negative and positive dimensions. On the negative side, an increasing division of labour and forms of discrimination against foreign staff were noted. On the positive side, a sense of pride in one's contribution to South African society, the learning of new skills and self-achievement characterised foreign staff's perceptions while their South African counterparts were overall embracing their presence albeit in sometimes qualified ways. The current policy impasse calls for comprehensive policy reform particularly in the current global competition for scarce skills. The report ends on a series of 21 targeted recommendations.

العربية: - تقرير MiWORC رقم 7 . قوة عمل جاهزة و مجانية. المهنيين الصحيين الأجانب في الخدمة العمومية بجنوب أفريقيا.

بناء على التحليل الإحصائي لبيانات PERSAL وأكثر من 70 مقابلة و استجابات مع مخرين رئيسيين و مهنيين جنوب افريقيين و أجانب من قطاع الصحة مختارون بطريقة عشوائية، هذا التقرير يوثق طرق التوظيف و العمل والاحتفاظ بالمهنيين الصحيين الأجانب في الخدمة العمومية بجنوب أفريقيا.

يحدد التحليل الإحصائي أنماطاً للعمل لكل مهنة، و جنسية، و موقع جغرافي و مرفق. أكثر من ثلثي المهنيين العاملين حالياً في قطاع الصحة العمومي هم من منطقة دول مجموعة التنمية لأفريقيا الجنوبية (SADC) و من بقية أفريقيا. يشير التحليل النوعي و منذ العشرين سنة الماضية إلى انعدام وجود اتجاه قانوني مما حد من فعالية التقدم المحرز في إضفاء الطابع الرسمي للإجراءات. تدعم الحكومة و المجالس المهنية الطريقة الحمائية المبنية على أساس افتراض وجود إمكانية لتدريب وطني ذاتي كافي. تصر مجموعات محامين الصحة الريفية على الضرورة الملحة لتلبية النقص.

بينما تعتبر طريقة التحقق من المعلومات صلبة، ثبت أن هناك نقصاً في شروط التوظيف بالنظام من حيث الطرق الإدارية، مما تسبب في إطالة المدة المتطلبة لهذه الطرق و بالتالي تحدي لمردودية النظام. أدى إنعدام وجود مستوى عالي للإدارة إلى الإحباط و فقدان المهارات و استغلال للمرشحين بالمقارنة مع الاقتصادات الموازية. بينما تعتبر ظروف العمل أقل إثارة للجدل من التوظيف إنها تتميز بأبعاد سلبية وإيجابية. من الجانب السلبي، تم ملاحظة الزيادة في تقسيم العمال وأشكال التمييز العنصري ضد الموظفين الأجانب. ومن الجانب الإيجابي، شعور الموظفين الأجانب بالفخر لمساهمتهم نحو المجتمع الجنوب الأفريقي، و تعلمهم

لمهارات جديدة و تحقيقهم لإنجازات ذاتية ، كما أن نظرائهم الجنوب الأفريقيين كانوا يقدرتهم و لو في بعض الأحيان لمساهماتهم المهنية. يدعو هذا التوقف أو الحاجز القانوني الحالي لإصلاح شامل للقانون خصوصا في نطاق المنافسة العالمية الحالية للمهارات النادرة. ينتهي ختم التقرير على سلسلة من 21 توصية مستهدفة.

ESPANÖL – Informe Nº 7 de MiWORC. *Mano de obra desechable. Profesionales de la salud pública extranjeros empleados en los servicios públicos de Sudáfrica.*

En base al análisis estadístico de la información de PERSAL y de más de 70 entrevistas realizadas a informadores claves y profesionales de la salud pública extranjeros y sudafricanos elegidos al azar, este informe hace hincapié en la contratación, el empleo y retención de los profesionales de salud pública extranjeros empleados en los servicios públicos de Sudáfrica.

El análisis estadístico identifica las pautas de empleo por profesión, nacionalidad, ubicación geográfica e instalaciones. Más de dos tercios de los profesionales que trabajan actualmente en el sector de la salud pública provienen de países SADC y del resto de África. El análisis cualitativo apunta a una falta de dirección política en las últimas dos décadas, lo que ha limitado el impacto de los avances logrados en la formalización de los procedimientos. El gobierno y los colegios profesionales apoyan un enfoque proteccionista basado en el supuesto de la posibilidad de una capacitación nacional autosuficiente. Los grupos de promoción rurales de la salud pública, insisten en la urgencia de cubrir las escaseces.

Si bien la verificación de los procesos de credenciales se consideró sólida, se encontró que las condiciones de contratación del sistema carecían de condiciones adecuadas para los procesos administrativos, que inducían a tiempos de respuesta inaceptables a veces, invalidando así el propósito del sistema. La falta de profesionalidad administrativa, desalentó y conllevó la pérdida de cualificaciones y la explotación de los solicitantes en economías paralelas. Aunque en menor polémica que la contratación, las condiciones de empleo se caracterizaron por tener tanto dimensiones negativas como positivas. En el lado negativo, se observó una creciente división del trabajo y formas de discriminación contra el personal extranjero. Por el lado positivo, se notó un sentido de orgullo en la contribución de uno a la sociedad sudafricana, el aprendizaje de nuevas técnicas y un sentimiento de logro personal. Esto fue lo que caracterizó las percepciones del personal extranjero, mientras que sus homólogos sudafricanos en general acogieron su presencia y sus diferentes calificaciones. El callejón sin salida de la política actual requiere de una reforma política integral, sobre todo en la competencia mundial actual de los escasos conocimientos. El informe finaliza con una serie de 21 recomendaciones específicas.

FRANÇAIS - Rapport N ° 7 MiWORC. *Les conditions de travail des professionnels de la santé étrangers dans la fonction publique sud-africaine*

Ce rapport, basé sur l'analyse statistique des données du système informatique PERSAL et sur plus de 70 entretiens qualitatifs avec des intervenants clés et un échantillon aléatoire de professionnels de la santé étrangers et sud-africains, fait état du recrutement, de l'emploi et de la rétention des professionnels de la santé étrangers dans la fonction publique sud-africaine.

L'analyse statistique permet d'identifier les tendances de l'emploi selon la profession, la nationalité, la situation géographique et le lieu de travail. Plus des deux tiers des professionnels actuellement employés dans le secteur de la santé publique sont issus de la SADC et du reste de l'Afrique. L'analyse qualitative



souligne un manque d'orientation politique au cours des deux dernières décennies limitant ainsi l'impact des progrès accomplis dans la formalisation des procédures. Le gouvernement et les conseils professionnels adoptent une approche protectionniste basée sur le principe de l'autonomie nationale en termes de formation. Cependant, les groupes de défense de la santé rurale insistent pour que des mesures urgentes soient prises pour faire face à la pénurie de personnel.

Bien que les processus de vérification et d'équivalence des qualifications professionnelles semblent solides, les conditions de recrutement dans le système font défaut en termes de procédures administratives longues, induisant des délais inacceptables, allant à l'encontre du système en place. Le manque de professionnalisme du système administratif entraîne l'exploitation, le découragement et la déqualification des candidats dans les économies parallèles. Bien que moins controversées que le recrutement, les conditions d'emploi ont des aspects à la fois positifs et négatifs : une plus grande division du travail et des formes de discrimination à l'encontre du personnel étranger ont été relevées, mais sur le plan positif, un sentiment de fierté de contribution à la société sud-africaine, l'apprentissage de nouvelles compétences et un sentiment de réussite personnelle caractérisent certaines des perceptions du personnel étranger. En général leurs homologues sud-africains acceptent leur présence même si leurs attitudes sont parfois tendancieuses à leur égard. Il faut une réforme politique globale pour faire face à l'impasse actuelle dans ce domaine, en particulier dans le cadre de la concurrence mondiale pour les compétences professionnelles rares. Le rapport contient 21 recommandations ciblées.

PORTUGUES – MiWorc Relatório N°7. *Uma mão-de-obra disponível. Profissionais de saúde estrangeiros nos serviços públicos sul-africanos.*

Com base em análise estatística de dados de PERSAL e em mais de 70 entrevistas qualitativas a informadores chave e profissionais de saúde Sul-africanos e estrangeiros escolhidos ao acaso, este relatório documenta o recrutamento, emprego e retenção de profissionais de saúde estrangeiros nos serviços públicos da África do Sul.

A análise estatística identifica modelos de emprego segundo a profissão, nacionalidade, localização geográfica e instituições empregadoras. Mais de dois terços dos profissionais presentemente empregados no sector da saúde pública são provenientes da SADC e do resto de África. A análise qualitativa indica a falta de direcção política nas últimas duas décadas, limitando o impacto do progresso conseguido na formalização de processos. Organismos governamentais e profissionais apoiam uma abordagem proteccionista com base no pressuposto da possibilidade de formação nacional que seja suficiente. Grupos de advocacia para a saúde rural insistem quanto à urgência do preenchimento de vagas.

Embora os processos para verificação de credenciais tenham sido considerados sólidos, as condições de recrutamento para o sistema foram consideradas inadequadas em termos de processos administrativos causando prazos de entrega inaceitáveis por vezes contrariando o objectivo do sistema. A falta de profissionalismo a nível administrativo causou o desencorajamento, desqualificação e exploração de requerentes em economias paralelas. Embora sejam menos contenciosas do que as condições de recrutamento, as condições de emprego foram caracterizadas por dimensões negativas e positivas. Quanto aos aspectos negativos, foram notadas uma maior divisão do trabalho e formas de discriminação contra empregados estrangeiros. Quanto aos aspectos positivos, as percepções dos empregados estrangeiros foram caracterizadas por um sentido de orgulho quanto à contribuição individual para a sociedade Sul-

africana, à aprendizagem de novas qualificações e à auto realização, enquanto os seus homólogos Sul-africanos aceitavam a sua presença de uma maneira geral, embora, por vezes, de modo qualificado. O actual impasse quanto a política exige uma reforma abrangente da política, particularmente na presença da actual concorrência a nível global no que respeita à escassez de competências. O relatório termina com uma série de 21 recomendações específicas direccionadas.

SESOTHO – Tlaleho ya MiWORC N°7. *Mabotho a basebetsi a ka nyahlatswang. Baporofeshenale ba matjhaba ba bophelo bo botle ditshebeletsong tsa Aforikaborwa tsa setjhaba.*

Ho latela tshekatsheko ya dipalopalo ya dintlha tsa PERSAL le ditherisano tsa boleng tse fetang 70 le mehlodi ya batho ya sehlooho ekasitana le baporofeshenale ba Maaforikaborwa le ba matjhaba ba bophelo bo botle ba qotsitsweng kae le kae, tlaleho ena e rekota ho batlwa, ho hirwa le ho bolokwa ha baporofeshenale ba bophelo bo botle ba matjhaba ditshebeletsong tsa setjhaba tsa Aforikaborwa.

Tshekatsheko ya dipalopalo e bontsha meralo ya kgiro ho ya ka porofeshene, botjhaba, sebaka sa tulo le setheo. Ho feta bobedi borarong ba baporofeshenale bao jwale ba hirilweng setheong sa bophelo bo botle ba setjhaba ba tswa SADC le dibakeng tse setseng tsa Aforika. Tshekatsheko ya boleng e bontsha tlhokeho ya leano le tataisang nakong ya dilemo tse mashome a mabedi tse fetileng, mme hona ho ile ha sitisa sekgahla sa tswelopele e bileng teng ya ho etsa hore ditshebetso e be tsa semmuso. Mmuso le makgotla a seporofeshenale a tshehetsa mokgwa o sireletsang o theilweng ho mohopolo wa hore ho ka ba le thupello ya naha e fepelang ka mokgwa o kgotsofatsang setjhaba. Dihlopha tsa mahaeng tse buellang merero ya bophelo bo botle di hatella bohlokwa ba ho potlakisetsa ho hlophisetsa ho kwala dikgeo tsa kgaello.

Le hoja tshebetso ya ho tiisa boitsebiso le mangolo a ho atlehile, maemo a ho batla le ho kenya bankakarolo tshebetsong a fumanwe a fokola hlakoreng la ditshebetso tsa taolo, mme hona ho ile ha diehisa dintho ho fihla maamong a sa amoheleng, hoo merero ya mokgwa wa tshebetso e ileng ya nyopa. Tlhokeho ya seporofeshenale bolaoding e ile ya tlisa ho fellwa ke matla, ho fokola ha bokgoni le tshebediso e bohlaswa ya bakopi dinaheng tsa meruo e sa ngodiswang. Le hoja ho sa belatse ho tshwana le hlakoreng la ho batla basebetsi, maemo a kgiro a ile a fumanwa a na le matshwao a mekgwa e mebe le e metle.

Hlakoreng le lebe, ho bile le ho arolelana mesebetsi ho atang ekasitana le mefuta ya leeme kgahlanong le basebeletsu ba matjhaba. Hlakoreng le letle, ho bonwe ho na le moya wa ho ba motlotlo wa ho kgona ho ba le seabo se lebiswang ho setjhaba sa Maaforikaborwa, ho ithuta bokgoni bo botjha le matshwao a ho iphihlisa maamong a hodimo a tshwayang pono ya basebetsi ba matjhaba, ha bamphato ba bona ba Maaforikaborwa ka kakaretso ba ne ba amohela le ho ananela boteng ba bona, le hoja ka dinako tse ding e ne e le ka tsela e sa phethahalang. Maemo a jwale a tlhokeho ya leano a laela hore ho be le ho ntlafatsa maemo a pholisi haholoholo maamong a jwale a lefatshe ka bophara a phehisano ka bokgoni bo haellang. Tlaleho e phethela ka letoto la ditshisinyo tse 21 tse tobilweng.

Kiswahili – Ripoti No. 7 ya MiWORC *Nguvukazi ya ziada. Wataalamu wa afya wa kigeni katika utumishi wa umma nchini Afrika Kusini.*

Kutokana na uchambuzi wa kitakwimu wa data za PERSAL na zaidi ya mahojiiano 70 ya ubora ya wahojiwa muhimu na wataalamu wa afya wa kigeni waliochaguliwa ovyoovyo nchini Afrika Kusini, ripoti hii hutoa



habari kuhusu uajirishaji, ajira na uhifadhi wa wataalamu wa afya wa kigeni katika utumishi wa umma nchini Afrika Kusini.

Uchambuzi wa takwimu hubainisha mwelekeo wa kazi kulingana na utaalamu, uraia, eneo la kijiografia na kituo. Zaidi ya theluthi mbili ya wataalamu ambao sasa wanafanya kazi katika sekta ya afya ya umma wametoka SADC na nchi nyingine za Afrika. Uchambuzi wa ubora huonyesha ukosefu wa mwelekeo wa kisera katika kipindi cha miongo miwili iliyopita ambao unaozuia uwezo wa maendeleo iliyopatikana kwa kurasimisha taratibu. Serikali na bodi za wataalamu wanaunga mkono mbinu za ulinzi ambazo zinategemea dhana ya uwezekano wa mafunzo ya kitaifa inayojitegemea. Makundi ya utetezi wa huduma ya afya vijijini husisitiza umuhimu wa kukabiliana na upungufu wa wahudumu.

Ingawa uhakiki wa michakato ya hati za utambulisho ulikubaliwa kuwa imara, masharti ya kuzingatia kwa kuajiriwa katika mfumo haikupatikani kulingana na michakato ya utawala, na hiyo husababisha mara kwa mara wakati wa utekelezaji usiokubalika ambao unatimia dhidi ya mfumo. Ukosefu wa utaalamu wa utawala umesababisha kuvunjika moyo, kupunguza kiwango cha ujuzi ambao unahitajika na kuonewa kwa waombaji wa kazi katika uchumi sambamba. Ingawa haina utata kuliko ajira, masharti ya kazi ina hali zote mbili hasi na chanya. Kuhusu upande hasi, kuna kuongezeka kwa mgawanyo wa kazi na aina za ubaguzi dhidi ya wafanyakazi wa kigeni. Kwa upande chanya, mtazamo wa wafanyakazi wa kigeni umebainishwa na hisia ya kiburi kwa ajili ya mchango wao kwenye jamii ya Afrika Kusini, mafunzo ya ujuzi mpya na mafanikio binafsi wakati wenziwe wa Afrika Kusini walipokuwa wakikubali kuwepo kwao angalu saa zingine kwa namna za ufahamu wa kazi. Msugurano wa sera za siku hizi unahitaji mabadiliko ya kina ya sera hasa zaidi katika mashindano ya siku hizi ulimwenguni kwa ajili ya ujuzi adimu. Ripoti inamalizika na mfululizo wa mapendekezo 21 yaliyolengwa.

ISIXHOSA – MiWORC Ingxelo N°7. Abasebenzi bebonke abanokulahlwa. Iingcali zempilo zasemzini ezikwinkonzo karhulumente eMzantsi Afrika.

Ngokusekelwe kuhlalelo lweenkcukacha-manani kwiinkcukacha ze-PERSAL nakwiinkqubo zodidi zodliwanondlebe ezingama-70 zabanikeli ngolwazi abangundoqo abathathwe ngeesampulu ezingakhethiyo beengcali zempilo zaseMzantsi Afrika nezamanye amazwe, le ngxelo ingqina ngamaxwebhu ukugaya amalungu amatsha, ingqesho nokugcina iingcali zempilo zamanye amazwe kubasebenzi bakarhulumente baseMzantsi Afrika.

Uhlalelo lweenkcukacha-manani luchonga imifuziselo yengqesho ngokobungcali, ubuzwe, indawo yejografi neziko lolungiselelo. Ngaphezulu kwesibini kwisithathu seengcali esiqeshiweyo ngoku kwicandelo lezempilo lesizwe zivela kwi-SADC neAfrika iphela. Iinkcukacha-manani zodidi zibonisa ukusilela kwendlela elandelwayo yomgaqo-nkqubo kwithuba leminyaka egqithileyo engamashumi amabini ebeka umda kwifuthe lenkqubela efikelelwe ekuzinziseni iinkqubo. Iibhodi zikarhulumente nezeengcali zixhasa indlela yokwenza yokhuselo ngokusekelwe kukuzigqibela kwangaphambili kwemo enokubakhona yoqeqesho lwesizwe olunokuzanelisa iimfuno. Amaqela enkuthazo yempilo yasemaphandleni azingisa ngokungxamiseka kokwanelisa iimeko zokunqongophala ezikhoyo.

Xeshikweni iinkqubo zokugqinela amaphepha eziqinisekiso kuthathwa kuliqilima, iindlela zokugayelwa ukungena kwinkqubo kufunyaniswe kusilela ngokweenkqubo zolawulo okuphemelela kumaxesha angamkelekiyo okugqitywa kwenkqubo ngamanye amaxesha kuphikisana nenjongo yenkqubo. Ukusilela

kobungcali kwezolawulo kuphembela ekulahleni ithemba, ukuphelisa izakhono nokuxhaphaza abenzi bezicelo kwiinkalo zoqoqosho ezinxuseneyo. Xeshikweni imbambano enganeno kunokugaya, imiqathango yengqesho iphawuleka ngemiba engalunganga nelungileyo. Kwicala elingalunganga, ulwahlulo olukhulayo lwabasebenzi neendlela zocalucalulo ngokuchasene nabasebenzi bamanye amazwe kuthe kwaqaphelwa. Kwicala elilungileyo, uluvo lokuzingca ngegalelo lomntu kuluntu lwaseMzantsi Afrika, ukufunda izakhono ezitsha nokuzakha okubonakaliswa ngabasebenzi bamazwe angaphandle xeshikweni oogxa babo baseMzantsi Afrika ngokubanzi besamkela ubukho babo nangona ngamanye amaxesha ngeendlela ezinokuchazwa ngenye indlela. Ingxaki yangoku yomgaqo-nkqubo imemelela uhlaziyo lomgaqo-nkqubo oqukayo ngokukodwa kolu khuphiswano lwangoku lwezakhono ezinqabileyo kwihlabathi. Ingxelo iphela ngothotho lwezinkomo ekujoliswe kuzo ezingama-21.

ISIZULU – umbiko iMiWORC yesi-7. *Abasebenzi okuhlukanekayo nabo kalula. Abasebenzi bezempilo abaqeqeshekile bomsebenzi womphakathi eNingizimu Afrika abavela kwamanye amazwe.*

Kusukela ekuhlaziyweni kwezibalo emthonjeni wabaqashwa, nasophenyweni lokuxoxisana nomuntu ngamanye lwabangaphezu kwama-70 lwabanikezi bolwazi abaqavile, nocwaningo lokucaphuna lapha nalaphaya lwabasebenzi abaqeqeshekile bezempilo baseNingizimu Afrika nabavela emazweni angaphandle, lo mbiko uqopha ukufunwa kwabasebenzi, ukuqashwa nokugcinwa kwabasebenzi abaqeqeshekile bezempilo abavela emazweni angaphandle abasemsebenzini womphakathi eNingizimu Afrika.

Ukuhlaziywa kwezibalo kuhlonza izindlela ezithile zokwenzeka kwezinto kwezokuqashwa ngokwemikhakha yemisebenzi eqeqeshelwayo, ubuzwe, ngokwebalazwe nesikhungo. Ngaphezu kwezingxenywe ezimbili kwezintathu zabaqeqeshekile njengamanje beqashiwe emkhakheni womphakathi wezempilo bavela emazweni e-SADC nase-Afrika yonkana. Ucwano olusekelwe yimibhalo luveza ukusweleka komhlahlandlela wenqubomgomo esikhathini esingaphezu kweminyaka engamashumi amabili, okukhubaza amagalelo enqubekelaphambili etholakele ekushicileleni izinqubo. UHulumeni namabhodi aqeqeshekile basekela uhlobo oluvikelayo olugxile emcabangweni wokuthi kungenzeka kubekhona uqeqesho oluzimele nolwanele ezingeni likazwelonke. Izinhlangano ezikhulumela ezempilo zasemaphandleni, ziqinisa ngelokuthi kuyaphuthuma ukuba kubhekwane nokungeneli.

Ngenkathi kwakuthathwa ngokuthi kwenele ukuhlolisisa imigudu yokufakazisa ukuqeqesha kwabasebenzi, imibandela yokufunwa kwabasebenzi abazosebenza ohlelweni lukaHulumeni itholakale ishoda maqondana nemigudu yezokuphathwa komsebenzi, okudala ukubambezeleka okungemukeleki okuphambana nenhloso yokusebenza kukaHulumeni. Ukusweleka kokuqeqesha kwezokuphathwa komsebenzi kudala ukukhinyabezeka, ukuqashwa kwabangenamakhono nokuxhashazwa kwabafaka izicelo zomsebenzi abavela kwamanye amazwe. Nakuba ukuphikisana kungefane nokusodabeni lokufuna abasebenzi, imibandela yezokuqashwa yabonakala iphawuleka ngezinhlangathi ezimbili, olubi noluhle. Ohlangothini olubi, kuphawuleka ukukhula kokwahlukana kokusebenza nezinhlobo zokucwasa abasebenzi abavela kwamanye amazwe. Ohlangothini oluhle, kubonakala ekubukeni kwabasebenzi abavela emazweni angaphandle umuzwa wokuzethemba ekuphoseni esivivaneni ezakhamuzini zaseNingizimu Afrika, ukufunda amakhono amasha nokuzithuthukisa, ngenkathi ozakwabo bakuleli besingatha ubukhona babo kwenye inkathi okwenzeka ngendlela elindelekile. Inqubomgomo ekhona njengamanje idinga ukuguquka okuphelele kwezenqubomgomo, ikakhulu kulesi sikhathi sokuncintisana okusezingeni lomhlaba kwezokusweleka kwamakhono. Umbiko uphetha ngochungechunge lwezinkomo ezisophiwe ezingama-21.





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Comparative Regional Integration Studies

