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INTERNATIONAL NURSE MIGRATIONS – GLOBAL TRENDS

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Abstract: This paper presents global trends of migration of nurses, as specific qualified personnel in high demand. In the last couple of decades, and especially in the last couple of years, many countries have faced the problem of insufficient healthcare workers, particularly nurses. Reasons for this occurrence might be found in the deficiencies of their education systems, as well as the population aging of northern and western countries. As a response to this deficiency, those countries have begun intensive recruitment of foreign qualified female healthcare workers, which has led to the point that nurse migration today presents a very intense, and by many accounts specific migration flow. Female migrating work force is often in pursuit of low-wage and low-qualified work. Nurse migration is actually an example of motion of qualified female migrants in pursuit for better employment opportunities. While such a way of filling up the vacant positions works for the "importing" countries as a temporary solution, departure of trained female personnel presents a significant loss for the originating countries. In this paper we pay special attention to the countries who are the main "importers", but also to those who are "exporters" of nursing personnel, and to specific national strategies these countries have applied.

Keywords: nurse migration, female migrants, qualified work force

Introduction

Migrations go back to the dawn of humanity, but their directions, types and volume have changed in accordance with specific socio-historic conditions. Today, migrations are more massive than ever, which is one of the characteristics of the modern society. According to the data by IOM (International Organization for Migration) in 2010 some 214 million people took part in international migrations, which makes about 3.1% of total world population. Although this is a significant number of migrants, we should keep in mind that the percentage of migrating world population has changed very little in the last 40-50 years, which shows that migrations are limited to a more-less

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constant part of the population. So, increase of international migrants should definitely be observed in the context of increase of the world population.

Participation of women in international migrations

A noticeable occurrence pertaining to international migrations is the increasing participation of women. Out of the 214 million international migrants registered worldwide in 2010, 104 million were women; that makes almost half, more specifically 49% (IOM, 2010) of the total migrating population. In 1960 this percentage was 46.6. Although the difference in percentage is small, increase of migration of female work force, more specifically increase of women that move to other countries in pursuit of work, has attracted attention of scientists and general public. Although women have always been migrating, throughout most of human history they didn't migrate independently, but rather as part of their families, or accompanying their spouses. Recent intensification of work force mobility, which was a response to globalization of markets, has led to increased independent migration of women in pursuit of better employment opportunities. In regard to that there are even discussions of feminization of migrations, which should be understood conditionally. Question is whether it is indeed feminization or just increased transparency of women in migration flows (Morokvašić, 2010). In certain migration flows, usually men migrate as the forefront, while women would join in later, and that would lead to balancing out the gender ratio. Today we often have the opposite. Due to higher education and greater degree of emancipation, a considerable percentage of women decide to migrate on their own, or as a forefront for the rest of the family.

Today female immigrants are a majority for many countries, particularly for North America, Europe, and Middle East. Increase of female migrants has become especially prominent during the nineties of the twentieth century. Women are a majority of emigrants from most countries, particularly from Asia and Latin America. According to the data from 2002 (Harrod, 2007), there were twice as many women than men emigrating from Sri Lanka. Women accounted for more than 80% of Indonesian emigrants from 2000 to 2003 and about 60% of the Philippines emigrants in 2005 (Asian Development Bank, 2006). There are similar tendencies in the countries of Latin America.

It is taken for granted that dominant migrations are directed from south to north. However, migration relations south to south should not be neglected. About two million female migrants from Asian countries work in the neighboring countries. The same goes for African female migrants, with the exception of a few

countries like Cape Verde, where the majority of migrants go overseas. There are a lot of women who migrate within the global south, but across greater distances. The countries of the Persian Gulf are among the main destinations for Asian women. About a million women from Indonesia, Philippines and Sri Lanka work in Saudi Arabia (Asian Development Bank, 2006).

Female emigrants on the labor market

Women in pursuit of work migrate as both qualified and unqualified work force. Yet, better part of scientists' scrutiny is focused on migrants looking for low-qualified positions, like cleaning work, household maintenance, and taking care of children or the elderly. Many other business sectors where women are also present are thus ignored. As Kofman and Raghuram (2009) noticed, migrations of women imply low educated female work force looking for low-wage positions. However, women of higher education level make a significant part of the overall qualified migrants worldwide. We should keep in mind that a certain part of these qualified female migrants on the work markets of the destination countries end up working on positions of lower education level, which means they are being deskilled. This is happening with immigrants of both sexes, but to a certain percentage it is prevalent with women. This is a consequence, on one hand, of non-recognition of qualifications acquired in the country of origin, and, on the other hand, with lower expectation by the female migrants, and their acceptance of the positions with lower qualification requirements and lower salaries.

Economies of certain countries rely significantly on female immigration work force. Then again, for many countries, incomes of female emigrants are among the biggest financial incomes. One third of the six million dollars that annually come to the Philippines originate from female emigrants (Ochi, 2005). Women often send home smaller amounts of money than men do, which is often consequence of the fact that in many countries "women's" jobs are often less paid than "men's" jobs. On the other hand, UN data (UN-INSTRAW, 2006) show that women send home proportionally bigger part of their salaries than men do, regardless of whether they work abroad or within the borders of their own country. Women from Bangladesh working in the Middle East send home on average close to three quarters of their salaries (White, Gammage, Sharmin, & Afsar, 2007).

The highest concentration of women employed in destination countries can be found on positions on lower levels of professional hierarchy. In all the destination countries, women are mostly employed in services, cleaning jobs,

taking care of children or the elderly, in restaurants, hotels, bars, household maintenance. Women with college degrees mostly find work in three basic sectors: healthcare, education and social services.

Household employment abruptly increased in 1900, especially in South Europe, but also in the northern countries. In the countries of Global North the process of population aging has intensified, and a lot of the elderly have the need for paid caretakers. Women from the Global South are faced with poor economic situation in their countries of origin, and they migrate to richer countries so that they could do the caretaking. Most of female migrants from Latin America are employed in some sort of "household" positions in the destination countries (Wells, 2005). In Spain 70% of all female immigrants (Dobner & Tappert, 2010) are employed in this sector. Also, in the countries of the Middle East, Saudi Arabia and Lebanon (Ally, 1986; Momsen, 2005), most of immigrants are employed in household maintenance. That confirms and cultivates the dominant notion about women migrants as unqualified work force.

In this paper we will focus on migrations of the qualified female work force that migrates to other countries in pursuit of work. As a good and specific indicator of these migrations are migrations of nurses. There are men who also take part in these migrations, but their share in this profession on global levels is still very minute.

Nurse Migration

Deficiency of healthcare personnel

In the previous decades, in many countries there has been a problem of the healthcare system due to the insufficiency of nurses. This problem is particularly characteristic for the developed countries (like USA and UK), but it is emerging within the developing countries as well. World Health Organization estimates that the world needs the overall increase in healthcare workers for about two millions so that the global goals set by the World Health Organization could be met.

There are several causes for the great deficiency in the healthcare sector of some countries. Apart from the omissions in the educational systems, aging of the population in most of the countries of Western Europe as well as Northern America has led to higher pressures on healthcare systems, and on some families. Still, we should mention that doctors are not in high demand as nurses in many countries. For that reason, the recognition of doctoral degrees acquired

in other countries has been made formidable, while recognition of qualifications of nurses has been significantly simplified.

The phenomenon of international migration of nurses is of global concern, especially in countries of emigration. While developed countries are solving the problem of lack of personnel with importing, developing countries are having losses in several areas. There are primarily economic losses (Dovlo, 1999), since the departure of skilled workers on whose education the state has invested leads to loss of investment, and also to the weakening of health systems of these countries. This migration, therefore, result in strengthening and deepening of inequalities between developed countries that can afford imports and developing countries that find it difficult to retain their health workers. Discussions on global level about ethics of these international trends have become very popular in recent years. Appeals of developing countries resulted in the adoption of regulations in certain countries which define from which countries and how nurses can be employed. This code was adopted by the British Government, however it caused a sharp criticism and a key issue raised related to whether it is truly ethical (Mensah, Mackintosh, & Henry, 2005), or restricting immigration of African nurses actually had implicitly given priority to those from other ("white") countries. Although the ethical principles stand out as something that should not be ignored during recruitment of foreign nurses (McElmurry, Solheim & Kishi, 2006), currently on a global level no greater advances have been achieved.

Nurse importing countries

In order to fill the vacant positions of nurses, countries with deficiency of nursing personnel have put into motion programmes of recruiting foreign healthcare personnel. "Import" of nurses became a fast and efficient way to solve this problem. Since the sixties and seventies of the twentieth century there were intense international migrations of the medical staff and especially nurses. These migrations are very much present today as well. The biggest global "importers" of nurses are the United States of America and the United Kingdom. Also, many other North European countries, Australia and New Zealand more or less have a deficiency of nurses. Fast growing economies of South-East Asia feel the lack of certain qualified personnel – medical staff as well. Specific in this aspect are countries of the Middle East, which have undergone a rapid economic growth in the sixties and seventies of the twentieth century and they still have a great deficit of qualified female work force, due to strong traditional habitude.

Even in the sixties, healthcare in the United Kingdom was greatly dependant on nurses who came from Ireland or the Caribbean. During the nineties, the United Kingdom, most actively in England, started accepting nurses from all over the World, so in 1997 the UK imported more than 90 000 (Aiken, Buchan, Sochalski Nichols & Powell, 2004) international nurses. In the nineties, every year, some 3 000 to 4 000 nurses immigrated to the UK, while in the last couple of years that number increased to 15 000 annually (Migration watch UK, 2004). The main nurse supplier countries for the United Kingdom are the Philippines, India and South Africa. It is estimated that one in ten nurses in the United Kingdom (Buchan & Seccombe, 2006) acquired her nursing degree in some other country. If we focus only on London, we see even greater percentage: surprisingly 28% of nurses working on the territory of this city were educated outside of the United Kingdom (Buchan & Seccombe, 2006). It may be interesting to mention that in the last couple of years there was a direction change in the migration flow of nurses between the UK and Ireland. Due to abrupt development of economy and opening of a great number of work places, Ireland has changed from a traditionally emigrational country to being attractive for employees from the United Kingdom. Also, nurses from the United Kingdom are migrating to other developed countries of the World, mostly to Anglophone ones.

From the late eighties, the USA has intensely commissioned immigration of women with nurse degrees. Percentage of foreign nurses working in the USA, compared to those born in the USA, from 1998 to 2002 more than doubled; specifically it rose from 6 to 14% (Aiken et al., 2001). Until recently, more than half of the nurses originated from the Philippines, in the mid eighties it was 75%(Brush & Sochalski, 2004), while today they make "only" about 20%, due to greater influx from other countries (Brush & Sochalski, 2004). In order to be able to be employed in the United States of America, all foreign nurses have to pass an exam with the National Council of State Boards of Nursing. Also, a recently developed by-law and included in the draft of the US Immigration Strategy, enables easier entry for all qualified foreign nurses. Measures similar to this one are undertaken by other countries, like the United Kingdom, Switzerland and Australia as well, thus giving nurses a privileged position for acquiring visas, with the aim of faster and simpler influx of the deficient personnel. Nurses from Mexico are also interested in working in the USA, but in addition to the language, part of the barrier is the educational system difference; in Mexico, nurse education is acquired in high school, while in the USA it is acquired in college. As a result of synchronized education systems, a significant number of female migrants from Canada are moving to border areas of the USA

to work. On the other hand Canada is also one of the great global importers of nursing personnel.

Table 1. Percentage of foreign nurses in the total of nursing staff of selected countries

	USA	UK	Italy	Malaysia	Thailand	Singapore
Total of nursing staff	2 689 000	648 003	341 015	42 613	93 000	14 831
Percentage of foreign nurses in the total	14	10	2	2*	0	16
Total number of foreign nurses	364 000	64 000	6 730	813	1	2 397
Countries of origin	The Philippines, India, Canada, Nigeria	The Philippines, India, South Africa	Romania, Poland, Albania, Tunisia	Albania, Bangladesh, India, Indonesia, Myanmar, Pakistan, the Philippines	Germany	Malaysia, China, the Philippines, India, Myanmar

Source of data: Malaysia, Thailand, Singapore: Ayaka Matsuno. Nurse Migration: The Asian Perspective. ILO/EU Asian Programme on the Governance of Labour Migration Technical Note. 2009.

*In Malaysia foreign nurses are allowed to work only in private hospitals, so their part in the private sector is rather big, but overall they make only 2%.

Italy – Mismatches in the formals sector, expansion of the informal sector: immigration of health professionals to Italy. Jonathan Chaloff. Organisation de Coopération et de Développement Économiques. 2008. OECD HEALTH WORKING PAPERS, no.34

USA – “Imported Care: Recruiting Foreign Nurses To U.S. Health Care Facilities“ Barbara L. Brush, Julie Sochalski and Anne M. Berger, 2004. Health Affairs, 23, no. 3 (2004): 78-87 doi: 10.1377/hlthaff.23.3.78

UK – James Buchan, Ian Seccombe. Words apart? The U.K. and International Nurses , The Royal College of Nursing, 2006

Like some other West European countries, Italy faced a great lack of nurses in the eighties and the nineties, and thus developed a series of measures to ensure simplification of recognition of foreign qualification and some limitations for work of foreign women workers were abolished. Local governments enabled families to freely employ nurses so that they could care for their elderly. Most of approximately 7 000 foreign nurses who were working in Italy at the end of 2005 (2% of the work force) (Chaloff, 2008) were employed in the private sector, because private employers could offer a contract necessary for acquiring the Visa much easier. It is almost impossible for foreign nurses to get a job in

public – state owned hospitals while they are still in their native country. Certain regions of Italy have begun forming bilateral relations with some foreign regions in order to provide immigration of health workers. Such relations were established with countries like Romania, Hungary, Serbia, Bangladesh, Peru and India.

According to the data from the World Health Organization, the greatest lack of nurses is in Asia, where large population countries are dominant. In many of these countries, the ratio of nurses to inhabitants is very low. Still, because of insufficient health system budgets, these countries do not import nurses. Furthermore, some of them, like China, stimulate emigration of qualified nurses, although their lack is evident in the country as well. Some Asian countries already face – or soon will – the problem of nurse deficiency. In 2001 Malaysia started the program "Malaysia - My Second Home". This program motivates foreign citizens older than 50 years to move to Malaysia after they retire. One of the basic things Malaysia emphasizes as its advantage related to this program is modern health care and highly qualified medical staff. Yet, nurses from Malaysia have intensively emigrated to the USA, Saudi Arabia, Australia, countries of the Middle East and Western Europe over the last couple of years; consequently, Malaysia turned from "exporting country" of nurses to "importing country". As part of the strategy for keeping the local staff, some private hospitals allow their nurses to go work abroad for several years provided they come back to their old job, in the same hospital afterwards. In order to resist the lack of nurses, Malaysia signed contracts with seven countries: Albania, Bangladesh, India, Indonesia, Myanmar, Pakistan and the Philippines. From September 2007, a total of 813 nurses have been working in the private hospitals in Malaysia (Matsuno, 2009), which makes about 40% of all the nurses working in private hospitals.

Countries with the lack of this personnel offer various conveniences for nostrification of degrees for foreign nurses, as well as special advantages for acquiring visas, compared to other immigrants. Japan, which is otherwise very strict regarding immigration – especially for low qualified work force, has contracts with certain countries for mobility of nurses. However, even though according to these contracts, nurses from Malaysia and the Philippines are able to emigrate to Japan, many of them choose to go to the USA or the UK. The language barrier and relatively high degree of probability for failing the Japanese national nursing exam are very significant impediments for arrival of immigrants. Also, Japanese work visa is for the maximum of three years. Although migrants are able to renew the visa unlimited number of times, getting the residence is very difficult, and so far there is no system for migrants to bring

the rest of their families to Japan. Singapore has, on the other hand, adopted two groups of preventive measures in order to mitigate the deficiency of nursing staff. On one hand, foreign doctors and nurses are motivated to do their internship in Singapore and on the other the number of foreign medical schools the degrees of which are being recognized was increased. Also, unlike in Japan, employees can bring their families, even the family members can get long-term residence visas. And along with stimulating immigration of foreign nurses, Singapore puts efforts into keeping the native professionals, in order to increase the quantity and quality of medical educational institutions. These efforts were effective. In 2005 percentage of foreign nurses in the total number of nurses dropped below 20 – it was 16% (Singapore Nursing Board, 2005).

We should also mention that there are countries lacking nursing personnel, but have no open policies for foreign healthcare workers. The government of Thailand is aware of its lack of the personnel, but doesn't try to solve it by promoting immigration, but by strengthening own capacities of education and healthcare institutions. Although there are no limitations, Matsuno states that in the last couple of years only one nurse received working permit for employment in Thailand. That is attributed to the fact that the nurse license exam is in Thai.

Countries of origin of migrating nurses

On the global market of nurses, some countries particularly stand out as “exporters” of nursing staff. While countries with the deficiency of nurses put efforts in attracting as many of qualified female immigrants as possible, countries that “export” nursing personnel are also taking steps to ensure their qualified staff would fit more adequately on the international market. Asian countries play a significant role in providing other countries with nurses, with the Philippines standing out in that regard. A case study from 2003 (Lorenzo, 2005) showed that an astonishing 25% of all nurses taking part in international migrations originate from the Philippines, and almost 80% of the Philippine nurses migrate to the USA.

According to UNESCAP researches (UNESCAP, 1999) about 70% of 7 000 nurses who graduate every year on the Philippines migrate, and leave a lot of vacant positions in public and private hospitals all over the country, especially in rural areas. In the last 10 years, close to 90 000 nurses left to work abroad (Adversario, 2003), and in the last couple of years average of about 8 000 to 9 000 nurses every year leave this country. Some of them get employed in the countries of west Asia, but a significant number of them leave to work in the developed countries of Europe and North America. Nurses from the Philippines

today have the reputation of qualified and respected female workers with high work ethics, and are in high demand worldwide. Departure of these qualified female workers is a loss for their country, which is losing trained work force, and the resources invested in their education. But still, the Philippines government supports emigration of their workers including nurses, abroad, because that is one of the basic sources of foreign currency for the country.

Although women are dominant in this profession, increase in male nurses is noticeable. Particularly apparent is the phenomenon that doctors attend medical schools in order to acquire nursing degrees, with the goal of getting a job abroad and bettering their financial situation. Since 2000, some 3 500 doctors migrated abroad as nurses and about 6 000 doctors are currently attending medical schools (Matsuno, 2009). The immigration policy of the USA, which is very favorable towards nurses from the Philippines, further contributes to the reeducation of the Philippines doctors. So, while interest for the profession of nurses in the Philippines rapidly increases due to employment opportunities abroad, interests for medical studies decreases.

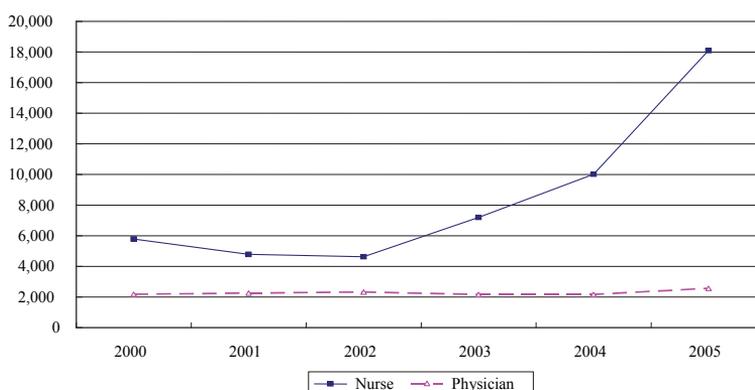


Figure 1. Number of newly registered nurses and doctors on Philippines (Matsuno, 2009)

Although the Philippines continue to dominate the field of nurse “export”, some other countries are also providing a large number of female migrants. In the last couple of years, India has emerged as a new global *power* regarding emigration of nurses. India has well trained nurses who speak English, which is an important condition for transoceanic migration. Although there are no official data, it is known that many hospitals in India suffer great losses due to massive resignations and departure of nurses. It is estimated that some 20% of current nurse graduates leave for abroad (Thomas, 2006). In Ireland and the United

Kingdom, the number of Indian female immigrants with nurse's degree is dominant even to the Philippine ones, who were absolutely dominant until 2005 (Edward, 2005). And while migrating for the United Kingdom or Ireland takes on average four to six months, the migration of nurses to the USA takes significantly longer. That is the reason why – in spite of potentially higher salaries in the USA – many nurses decide to go to the United Kingdom or some other Anglophone country.

African countries, especially Sub-Saharan, also appear as the exporters of nurses, although they also lack this kind of work force. On average, in Sub-Saharan Africa (SSA), at 1 000 persons comes only one nurse (Dovlo, 2007), although there are significant differences: in Botswana it is only 0.3 nurses, 1.7 in Zambia and in South Africa 4 (Dovlo, 2007). Due to the incomplete and heterogeneous data, it is difficult to determine precisely the scope and extent of migrations. Major destinations are United Kingdom, United States of America and Canada, but there are also some regional migrations, mostly to South Africa. Between 1998 and 2003, more than 3 000 nurses from Ghana verified their diplomas to emigrate and about 2/3 of them went to the UK (Mensah, 2005). Research of WHO and GTC in 2004. shows that in addition to dominant economic factors, as the motives for emigration it is important to have possibility of further education and career advancement, better working conditions and supportive work atmosphere. Since the departure of skilled staff is a major setback with heavy losses, the SSA countries are trying different ways to retain their health workers. These include financial incentives, fees for duty and a more favorable mortgage loans (Connell, 2007). However, these programs have not been giving significant results, and it is expected that migration will continue, likely to intensify.

Nurses migrate from Europe, particularly from East and Southeast European countries, as well in pursuit of better work conditions. Nurses from former Yugoslavia have been leaving to work in Arabic countries (Stanić, 1998), which faced deficiency of qualified workers, especially women, due to abrupt economic development, from mid seventies all up to the nineties. These women migrated independently and on their own, as a result of the required qualification, and furthermore as a result of their high degree of emancipation. Albania is one of the main countries that supplies nurses for Italy. Nurse migration from Albania is mostly done via agencies. The agencies find employment in Italy for the nurses, provide necessary documents, and organize language education. This is one of seldom areas where Albanian work force can get qualified employment in Italy. Although nursing is one of the traditional professions for the Albanian women, in the last couple of years about half of the

clients were men, who according to Chaloff (2008) attend nursing schools so that they could emigrate. There is no doubt that the increase of medical high schools in Albania is the result of emigration opportunities nursing degree provides.

Some countries are difficult to fit in either the group of "exporters" or "importers" of nurses. Namely, some countries have intense emigration, sometimes supported by the government, in spite of the deficiency of the nursing personnel. For example, China has a very small ratio of nurses to citizens (1:1000) (Fang, 2007), but still supports their emigration. In reality, the healthcare system of China doesn't have sufficient budget to hire the needed capacity of nurses, so a lot of them face unemployment. Current Chinese policy is to promote international programs that enable emigration of these personnel, primarily to Singapore, Saudi Arabia and the USA. Emigration is considered by many Chinese female migrants, as an opportunity to strengthen their own work capacity, with an outlook for career progress. Chinese Nursing Association also gives strong support for emigration, expecting that thus acquired skills and knowledge will contribute to improvement of healthcare education in China, and make it competitive on global levels. Thus, for the first time, in 2004, China was in the top ten countries (Xu, 2003) that "export" nurses.

Conclusion

In the last couple of years more women have independently migrated in pursuit of better employment opportunities. There are some distinct sectors where women find positions in the destination countries, whether they are migrants with or without qualifications. Healthcare is one of the highly feminized sectors, and nurse migration flows are the result of the deficiency of nursing personnel in some countries and regions, as well as specific conditions in the countries where the female workers are migrating from. The lack of healthcare workers, more specifically nurses, is a serious global issue. Countries with large deficiency of these personnel have begun specific immigration policies so that they could attract the highest possible quality of workers. Still, on the global levels these are just temporary solutions, because due to the more intense aging of population and higher standards in healthcare institutions, even bigger deficiency is expected in the countries of the global west and north and in the Asian countries with large population. The countries of migrants' origin need special consideration. They are losing qualified workers, but due to intense emigration they also face the problem of deficiency of nurses in their own healthcare systems. However, due to the attractive foreign currency income sent by the

emigrants to their country of origin, the “exporting” countries tend to favor the emigration.

Migration flows of nurses will undoubtedly become even more massive and involve a wider area. Certain countries are holding their positions of traditional “importers” or “exporters”, but there are other countries which are becoming significant actors on the global migration scene of nursing personnel. Potential solutions, apart from migrations should be found in adapting education programs to the new social and economic conditions.

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