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Review of international migration of nurses from the state of Kerala, India

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from the state of Kerala, India

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Project team members and other contributors

Health Systems Research India Initiative Trust

- Dr A S Pradeep Kumar, Director Research and Training
- Ranjith R Menon, Project Coordinator
- Dr S Rajalakshmi, Research Associate
- Captain S Saritha (Rtd.), Research Assistant

World Health Organization

- Dilip Singh Mairembam
- Hilde De Graeve
- James Buchan
- Rakshita Khanijou

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Abbreviations

ACLS	advanced cardiac life support
ANEP	Advanced Nursing Excellence Programme
ANM	Auxiliary Nurse Midwife
AREMT	Australian Registry of Emergency Medical Technicians
ASAP	Additional Skill Acquisition Programme
BLS	basic life support
BSc	Bachelor of Science
CECA	Comprehensive Economic Cooperation Agreement
CEPA	Comprehensive Economic Partnership Agreement
CGD	Centre for Global Development
CGFNS	Commission on Graduates of Foreign Nursing Schools
CoE	Centre of Excellence
CSP	community skill park
DFID	Department for International Development
DHA	Dubai Health Authority
DoH	Department of Health
EAG	Independent Expert Advisory Group
ECR	emigration check required
GCC	Gulf Cooperation Council
GLP	Global Learner's Programme
GNM	General Nursing and Midwifery
GoI	Government of India
GoK	Government of Kerala
HEE	Health Education England
ICD	informed consent document
ICMR	Indian Council of Medical Research
ICU	intensive care unit
IDI	in-depth interview
IELTS	International English Language Testing System
INC	Indian Nursing Council
ISDC	International Skills Development Cooperation
iSTEP	International Skill Training and Employability Programme
ITLS	International Trauma Life Support
JCI	Joint Commission International
KASE	Kerala Academy for Skills Excellence
KNMC	Kerala Nurses and Midwives Council
KSA	Kingdom of Saudi Arabia
KSWDC	Kerala State Women Development Corporation
KUHS	Kerala University of Health Sciences
MAHE	Manipal Academy of Higher Education
MoC	Memorandum of Cooperation

MoH	Ministry of Health
MoU	Memorandum of Understanding
MRA	Mutual Recognition Agreement
MSc	Master of Science
NALS	neonatal advanced life support
NEP	Nursing Excellence Programme
NHS	National Health Service
NHWA	National Health Workforce Accounts
NICE	Nursing Institute for Career Enhancement
NORKA	Non-Resident Keralite Affairs
NPCC	nurse practitioner critical care
NRTS	Nurses Registration and Tracking System
NSDC	National Skill Development Corporation
NUID	Nurse Unique Identification Number
OSCE	Objective Structured Clinical Examination
ODEPC	Overseas Development and Employment Promotion Consultant
OECD	Organization for Economic Cooperation and Development
OET	occupational english test
OJT	on-the-job training
OMC	Overseas Manpower Corporation
OSCE	Objective Structured Clinical Examination
PALS	Paediatric Advanced Life Support Provider Course
PI	principal investigator
PIS	participant information sheet
PGoE	Protector General of Emigrants
PoE	Protector of Emigrants
PPE	personal protective equipment
PTSD	post-traumatic stress disorder
SC	scheduled caste
ST	scheduled tribe
SOWN	State of the world's nursing
TITP	Technical Intern Training Programme
TNAI	Trained Nurses Association of India
TPC	Temporary Practicing Certificate
UHC	universal health coverage

Executive summary

The human resources for health (HRH) are an important building block for a well-functioning health care system. Nurses as part of the health workforce are required not just for the tertiary and critical-care units, but are an integral part of the secondary and primary health care functions too. They are trained to not only perform critical-care functions, handle vital information, administer care, ensure standards of care but at the same time, bridge the gap between the doctor, patient and his/ her family members.

The COVID-19 pandemic not only highlighted the strenuous conditions in which health care teams performed their duties, but also brought to the fore, the sheer dedication and grit they demonstrated when they delivered care in the most difficult situations. In responding to this unprecedented health crisis, the nurses revealed skills to deliver care in emergency situations while continuing to provide Essential Health Services (EHS), in all phases of the COVID-19 illness trajectory and vaccinations for all age groups along with reassuring, informing, and supporting communities.

Despite their roles and its importance, there was a shortfall in the required number of nurses which is now anticipated to only increase in the coming years. This shortfall will likely have major impact on the low-and middle-income groups which would be required to cater to the health care needs of a growing population and epidemiology of a changing disease burden.

While the nurses-to-doctor ratio remains skewed around the world, better ratios prevail in the Organization for Economic Cooperation and Development (OECD) and high-income group countries. India is the world's second largest supplier of trained workforce to these countries. The pandemic provided an opportunity to nurses from India to migrate and take up jobs in the international market, especially at a time when the shortfall of health-care providers was acute.

This study was undertaken to understand the challenges, hurdles, and experiences of nurses in the country and encountered during the out-migration processes. The state of Kerala has a large number of nurses who migrate to other countries for better job opportunities, lifestyle, and career growth. Given the current scenario, it is important to understand the policy reforms which the Government of India (GoI) and Government of Kerala (GoK) have taken along with other initiatives to ease out the difficulties faced by them while also facilitating their migration both within and outside the country. It also documents the experiences of nurses during the COVID-19 pandemic and their key concerns associated with their work-environment.

Study objectives

The key objective of the case study on “Review of International migration of nurses from the state of Kerala, India” was to provide country-level perspective on trends, policies and practices with respect to international recruitment and mobility of health personnel. Within the country, it was decided to take up Kerala as a special focus state given its historicity in terms of producing a large number of nurses for domestic and global health systems. The specific objectives of the study were:

- To review data and trends on international flows of nurses;
- To discuss existing challenges and enablers in the process of achieving effective and ethical international recruitment/s and integrating health workers, taking account of “the WHO Code”;
- To develop an understanding of policy reforms and initiatives taken up by the Department of Health in Kerala, in partnership with other government departments and agencies with a view to facilitate migration of nurses to destination countries;
- To share and review experiences with the use of bilateral agreements and other international recruitment modalities; and
- To document key challenges and bottlenecks in nurse migration due to the COVID-19 outbreak.

Research methods

A two-pronged strategy consisting of desk review of existing policies, documents and available information was undertaken.

Phase 1 included literature review and secondary data analysis on the stock and flow of migrants in the country. Over 230 relevant articles were found, of which 79 articles were identified as eligible for the study, based on the pre-defined criteria. In addition, information from websites of the state government and related agencies such as the department of health, Non-

Resident Keralite Affairs (NORKA), Overseas Development and Employment Promotion Consultant (ODEPC), Kerala Nurses and Midwives Council (KNMC), and nursing associations was also collected.

In Phase 2, primary data collection in the form of qualitative interviews and focus group discussions (FGD) was undertaken to understand the specific situation from important experts and stakeholders in Kerala. A list of relevant stakeholders was prepared with the experience of desk review. They then held discussions with select faculty members of nursing institutions and officials in the state government. A total of 44 participants including 17 nurses, seven academicians, five nurses' association representatives, and 15 policymakers including skill-building agencies were interviewed.

Key findings

A major finding was that post attaining independence in 1947, India has been suffering from a scarcity of nurses. The state-wise disaggregation revealed that the distribution of scarcity varied from state to state. Andhra Pradesh, Tamil Nadu, Rajasthan, and Kerala had a larger nurse population ratio than other states. Other key findings are enumerated below.

- The year-wise number of approved Nursing Educational Institutions (NEI) and seats for various courses in India from 2017–2018 to 2020–2021 showed consistent increase. However, this increase was insufficient to meet the growing demand for nurses, in both domestic and international sector. Most institutes are in the private sector and have to therefore be monitored for imparting quality education.
- The NIE in Kerala is registered by the Kerala Nurses and Midwives Council (KNMC). This is an autonomous statutory body under the Government of Kerala (GoK). In the academic year 2019-2020, 124 nursing colleges (seven of which were government institutions) offered Bachelor's in Science (BSc.) in Nursing degrees and 135 nursing schools (20 of which were government institutions) offered General Nursing and Midwifery (GNM) diploma courses. These courses were registered with the KNMC. The trend was similar to the national level, with a greater number of institutions being run by private providers. However, it was important to corroborate the information on the number of seats and colleges between various platforms.
- In the year 2017, GoI started the Nurses Registration and Tracking System (NRTS) and instructed the state nursing councils to register nurses by allotting a National Unique Identity Number (NUID). However, even after the Gazette notification by the GoI dated 7 July 2019, only 5,89,114 NUID cards had been issued as on 28 October 2021.
- The nurses were employed in the private sectors post their education and were working in non-ideal working conditions, which were made worse due to COVID-19 with extended working hours and lack of consumables. The working conditions in the public sector were reported to be better, with more social and financial security but the number of nursing seats were limited. The within-country migration was also reversed, when the nurses working in other states returned to their native place due to work pressure and deteriorated working conditions during the pandemic. This was amplified by the trauma and physiological stress they faced during patient management and caring for the bereaved family members.
- International migration was seen as a step towards securing greater financial independence and leading of an improved social and professional life. This was based on the nurses' own understanding for a secured job, which assumed importance under the influence of their peers, family members and friends. The other reasons also included increased avenues of professional development and better quality of life for their families. Countries like USA and UK were the most preferred countries for migration. It was also noted that the usual practice was to move to the northern states within India before moving onwards to the Middle East and then to Europe or America as there were more migration avenues and accredited agencies to facilitate the processes. It also helped them develop better communication skills.
- The key barriers to migration which were faced by the nurses related to lack of fluency in communication in English language and clearing the Objective Structured Clinical Examination (OSCE) type of screening for the licencing examination. This was in addition to the prerequisite of a desired work experience after completing their education for qualifying for a country. The skill development trainings were also undertaken in the state by certain professional associations to meet the requirements in certain countries which included training in English language to government sponsored candidates and those who were able to pay for these trainings.
- Various such trainings are provided to the nurses after their course completion. They build on their communication, personality, and soft skills along with clinical capacities. However, not all the nursing candidates were aware about these mechanisms provided by the Government to support migration of nurses to another country. The other respondents who were aware about these services presumed delay and poor customer service from the Government counterparts, often opting for private agencies, given their personal preferences.
- In addition, by 2018, India was having ongoing Agreements or Memoranda of Understanding (MoU) or Memorandum of Cooperation (MoC) or Statement of Intent (SoI) in the health sector with as many as 53 countries. Each of these have potential for further strengthening, given the trained human resource capital in the country.

Recommendations

- Strive for improved working conditions to ensure retention of nurses in the state with social security measures which are the mainstay for a well-functioning and resilient health system within the country.
- All efforts to be in sync with improving the quality of nursing education and providing them with improved technical inputs, communication and soft skills.
- Provide inputs that help nurses adopt the communicative English language and OSCE method as part of the nursing course curriculum in order to help them be better equipped to meet requirements of the health-care sector.
- Advocate with Government bodies to disseminate information regarding their programmes directly through nursing institutions and indirectly through all social media channels to reach prospective nurses and their parents.
- Government agencies to adopt more customer-friendly, informative and easily accessible approaches with liberal feedback provisions.
- Governments to make regular efforts to maintain updated records of all health personal being trained in public or private institutions along with a database for international migration of nurses. This must include their country of destination and a strict mandate for the implementation of the NUID for registration and its renewal.
- Further strengthen the efforts that have been made by the State government to promote and support migration of nurses and promote Government-led initiatives, including better coordination and monitoring of several different agencies working for assisting recruitment and skill-building with similar courses.
- Encourage nurses to study one foreign language like German, Japanese or Dutch as an optional choice along with other mainstream nursing related education.

With the ease of bilateral agreements in light of the WHO clarification, India can now sign agreements for job-oriented migration. This will facilitate easy migration, after ensuring that their own shortage of health care staff is met by capitalizing on trained human resources.

Chapter 1

Introduction and background

The COVID-19 pandemic has disrupted the domestic and international migration of the health workforce and deepened the crisis in many health systems which were already struggling from staff shortage, especially nurses.

1.1. Background situation in Human Resources for Health

According to the State of the World's Nursing (SOWN) 2020 report, as of 2018, there were 27.9 million nursing personnel that included 19.3 million (69%) professional nurses, 6.0 million (22%) associate professional nurses and 2.6 million (9%) unclassified nurses and a shortage of 5.9 million nurses globally in 2018.^[1] Among the shortage, 5.3 million were in the middle-low-income countries.

The report projected a raise in the total stock of nurses to 35.9 million by 2030. This would help the shortage of nurses to drop to an estimated 5.7 million with 89% in low-and middle- income countries. To cater to the demand , an estimated 10.6 million additional nurses will be needed globally by 2030. Other important points to consider are:

- shortage due to population growth
- about 17% retirement in the next ten years^[2]
- job diversification due to heavy workload, insufficient resourcing, burnout and stress
- increased demand following the COVID-19 pandemic^[3]

The Royal College of Nursing (RCN) in its July 2021 report, informed that 36% of the nursing workforce in the UK was contemplating leaving the profession by the end of 2021, in addition to the already existing 40 000 vacancies.^[4] The International Council of Nurses (ICN) reported that 74% countries were keen to increase the number of nurses and 54% countries had commitments to improve the conditions for retention of nurses who were currently in employment.^[3] The destination countries were expected to shift towards self-sufficiency by improving their domestic training, due to short-term disruption of international supply of nurses during the COVID-19 pandemic^[5]. The total number of nursing graduates would need to be increased by 8% per year on an average and employed along with retaining the existing nurses in all countries, to address the shortage by 2030.^[1]

1.2 Nurse availability in different regions of world

Even though the nurse and midwife to physician ratio was 2:1 globally^[6], there were 3–4 nurses per doctor in most countries under the Organization for Economic Cooperation and Development (OECD)^[7]. The number of native-born nurses working in OECD countries in 2015–2016 was 87,821 and emigration rate was 3%. The number of home-trained nurses working in OECD countries from India in 2017–2018 was 34 114 and the emigration rate was 1%.^[8]

Around 81% nurses in the world were found to be concentrated in America, Europe and Western Pacific regions where the density of nurses per 1000 population was 8.34, 7.93 and 3.60 respectively.^[1] As per the report, the density of nurses per 1000 population in South-East Asia Region (1.65) was less than half of the world average (3.69). The large-scale migration of nurses from developing countries, especially Philippines and India, during the pre-COVID times, resulted in this situation.^[5]

According to the SOWN report, in the year 2018, India was the second-largest source country for the international supply of nurses, next to the Philippines.^[1] The Philippines barred the migration of their health workers internationally in April 2020 and instructed them to work against the COVID-19 pandemic within the country; but later the government eased the ban to those workers with existing contracts abroad.^[9] The outflow of nurses from the Philippines to other countries reduced and the annual number of nurses who had passed the national licensing exam too decreased.^[5] Hence, Indian nurses were estimated to have far better opportunities to acquire top positions in post-COVID times. Keeping these changing dynamics in mind, a study that could provide a better understanding of the situation on nurse migration in Kerala was undertaken. One more reason for taking up Kerala was the fact that it had a higher nurse population density and higher international migration rate than other states.

1.3 Objectives

The key objective of the case-study was to develop an understanding of policy reforms and initiatives taken up by the department of health, in partnership with other government departments and agencies to facilitate the migration of nurses from Kerala to destination countries. The case-study also documented the impact of COVID-19 on nurse mobility from Kerala.

1.3.1 Specific objective

The key objective of the case-study was to provide a country-level perspective on trends, policies and practices on international recruitment and mobility of health personnel with specific focus on the state of Kerala.

1.3.2 Other objectives

- To review data and trends on international flows of nurses;
- To discuss existing challenges and enablers in the process of achieving effective and ethical international recruitment/s and integrating health workers, taking account of “the WHO Code”;
- To develop an understanding of policy reforms and initiatives taken up by the Department of Health in Kerala, in partnership with other government departments and agencies with a view to facilitate migration of nurses to destination countries;
- To share and review experiences with the use of bilateral agreements and other international recruitment modalities; and
- To document key challenges and bottlenecks in nurse migration due to the COVID-19 outbreak.

Chapter 2

Research methodology

The present study considered the WHO report, namely From brain drain to brain gain: migration of nursing and midwifery workforce in the state of Kerala as the baseline.^[10] A two-pronged strategy consisting of desk review and qualitative interviews was used to collect information.

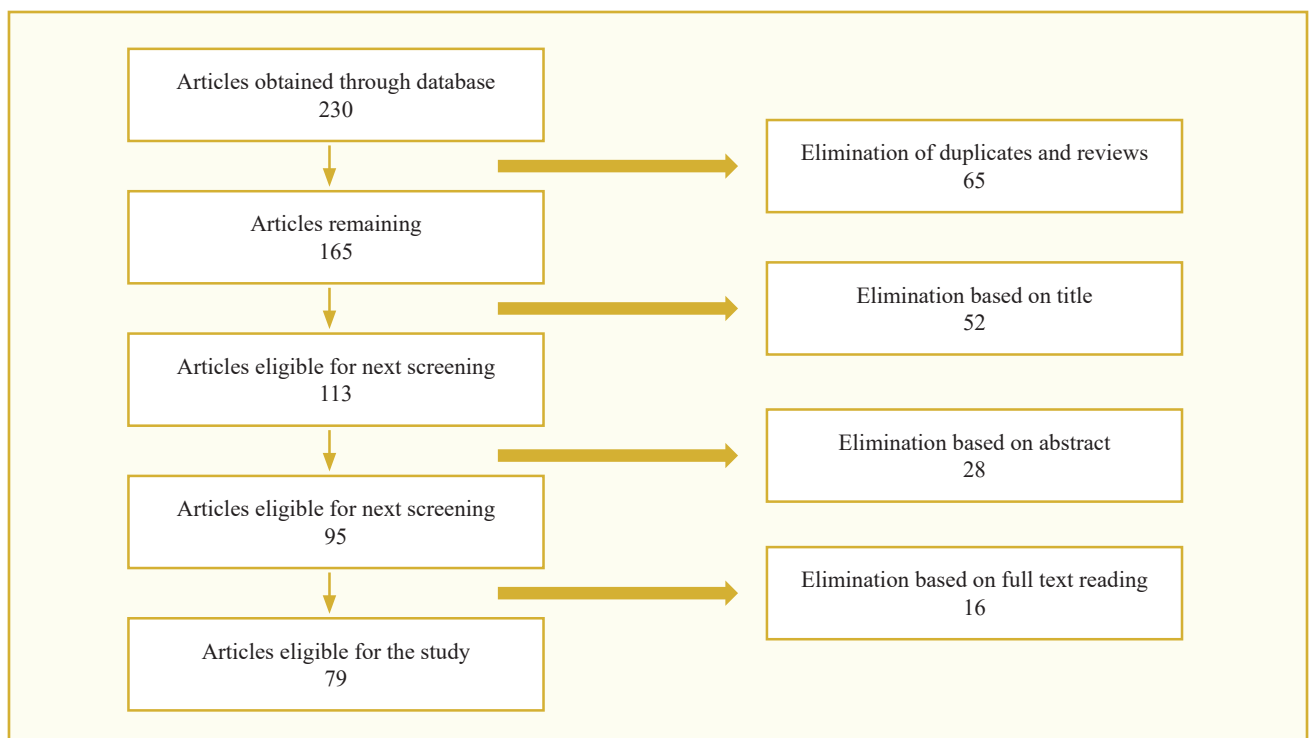
Phase 1 included a literature review and secondary data analysis on the stock and flow of migrants.

Phase 2 included identifying experts and relevant stakeholders and conducting in-depth interviews with them using study tools that had been developed prior to conducting the interviews.

2.1. Secondary data collection

A detailed desk review of articles dealing with nurses' migration and published between January 2016 and June 2021 in various databases like PubMed, Google Scholar, nursing journals, the Lancet, and the British Medical Journal publications was undertaken. The articles in the English language, which were complete and dealt with 'impact of COVID-19 on nurses in India', 'nurse migration from India and Kerala', 'nurse', 'burnout', 'recruitment in India and Kerala', published from 2016 to June 2021 were included.

Fig. 2.1. Selection procedure for relevant articles



A combination of search terms like ‘international migration’, ‘COVID-19’, ‘recruitment’, ‘mobility pattern’, ‘burn-out’, ‘skill-training’, ‘surge’, ‘replacement’, ‘bilateral agreements’ were used for searching the literature with Boolean algebras ‘AND’, ‘OR’ and ‘NOT’ for uniting the terms. Publications in other languages and unpublished manuscripts were excluded. The shortlisted articles were subjected to screening based on title, abstract and then selected for complete reading as shown in Fig. 2.1.

2.1.1 Selection procedure of relevant articles

Even though 230 relevant articles were found, only 79 articles could be identified as eligible for the study. In addition, information from websites of the state government and related agencies such as the State Department of Health, NORKA, ODEPC, KNMC and nursing associations were also collected.

2.2 In-depth interviews

As part of the qualitative study, a list of relevant stakeholders was prepared, and in-depth interviews (IDI) carried out with them. Individual nurses who had migrated and/or were planning to migrate from Kerala to a foreign country were also conducted.

2.2.1 Selection of participants for in-depth interviews

The list of relevant stakeholders was prepared with the experience of desk review and discussions with some faculty members of nursing institutions and select state government officials. Based on this list, the following stakeholder organizations and agencies were identified for IDIs:

1. Non-Resident Keralites Affairs Roots (NORKA)
2. Overseas Development and Employment Promotion Consultants (ODEPC)
3. Kerala Nurses and Midwives Council (KNMC)
4. Trained Nurses Association of India (TNAI)
5. United Nurses Association (UNA)
6. Kerala Academy for Skills Excellence (KASE)
7. Nursing Institute for Career Enhancement (NICE)
8. Additional Skill Acquisition Programme, Kerala (ASAP)
9. Nursing Institutes (colleges and schools)
10. Kerala State Women’s Development Corporation (KSWDC)

2.2.2 In-depth interview study tools

Five different interview tools were developed to conduct IDIs with stakeholders and nurses. There were different interview tools for nurse faculty, policymakers and related training agencies, KNMC, nurse’s associations and nurses. In addition, one participant information sheet (PIS) and informed consent form (ICF) was also developed. (Annexure I)

2.2.3 Selection procedure and sample size

The purposive sampling technique was used to identify key persons from each stakeholder group as per their availability and willingness. This was followed by a snowball sampling technique to find more participants from the same group. Similarly, nurses were identified by purposive sampling technique and more nurses were identified from the same country of migration through the snowball sampling technique. Thus 44 participants, including 17 nurses, seven academicians, five nurses’ association representatives, and 15 policymakers, including skill-building agencies were interviewed. (Annexure II)

2.2.4 In-depth interview procedure with stakeholders and nurses

Important policy-makers available in Thiruvananthapuram, Kerala were visited, and face-to-face interviews conducted. Out of 44 interviews, 11 (one official from each of ODEPC, KASE and NICE, two officials from NORKA, three policymakers and three officials from KSWDC) were conducted in person. Due to COVID-19 pandemic lockdown and consequent travel and entry restrictions, remaining interviews with stakeholders and nurses within Kerala, were conducted through an online platform. The nurses working in GCC, UK, Ireland, Canada and Australia participated online in the interview.

The principal investigator (PI) conducted the IDIs with the help of the interview tool developed and pretested by the team. The interviews were conducted with all 44 participants in the local language (Malayalam) between May and August 2021 after obtaining a verbal informed consent at a date and time convenient to the participants.

2.3 Focus group discussion with nurses and supervisors

A focus group discussion (FGD) was conducted among four nurses who worked in the COVID-19 intensive care units (ICU) in the state along with their three nurse supervisors. The participants were requested to share their valuable remarks

and to narrate anecdotal accounts and experiences to their colleagues. These could relate to the discomfort and misery of patients and their close relatives. Later these interviews and findings proved to be useful in accumulating information on the frustrations, stress, absenteeism and burnout among nurses during the COVID-19 pandemic situation.

2.4 Consent and confidentiality

The Informed Consent Documents (PIS and ICF) were sent to individuals who were found to be eligible and willing to participate in the study, through an e-mail before the interviews. They were then explained the purpose of the study just prior to starting the interviews. Verbal informed consent and permission for recording the interviews were obtained from all participants. They were assured that their identity would be kept confidential, and no information shared by them would be made public or placed in the public domain, without their consent or legal directive.

2.5 Data analysis

The IDIs were recorded with the consent of participants. They were transcribed and translated into English. The summary notes from the interviews were prepared and content analysis performed to obtain findings corresponding to the objectives. These findings gathered through the desk review and IDIs interviews were triangulated to understand the scenario, trends, challenges in the nursing field and their recommendations. All the relevant findings are included in this report and enumerated in the following chapter.

Chapter 3

Key findings

India is a large country with 1.38 billion population living in a diverse geography and with a wide range of socioeconomic and cultural backgrounds.^[1] The health indices and literacy rates also vary widely in different regions and states. However, Kerala is a small state in the southern part of India with 33 million population having more than 90% literacy rate and high health indices like infant mortality rate (IMR), life expectancy at birth, maternal mortality ratio (MMR) etc.^[12] The key health indices in India and Kerala are given in Table 3.1.

Table 3.1. Key health indices in India and Kerala

Indices	India	Kerala
Infant mortality rate (2019) ^a	30	6
Birth rate (2019) ^a	19.7	13.7
Maternal mortality ratio (2018) ^b	113	43
Expectation of life at birth (2020) ^c	69.9 years	74.9 years
Literacy rate ^d	74.04	93.91
Sex ratio (females per 1000 males) (2016–2018) ^a	899	957

Sources:

https://censusindia.gov.in/vital_statistics/SRS_Bulletins/SRS%20Bulletin%202019.pdf

https://censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR%20Bulletin%202016-18.pdf

<https://knoema.com/atlas/India/topics/Demographics/Age/Life-expectancy-at-birth>

https://censusindia.gov.in/2011-prov-results/data_files/india/Final_PPT_2011_chapter6.pdf

3.1 Nursing education in India

In India, there are two types of Nursing Educational Institutions (NEI), namely the nursing schools and nursing colleges. Both provide two types of basic nursing courses such as:

- General Nursing and Midwifery (GNM) diploma and BSc. degrees^{1, 2}
- Post-basic BSc. in Nursing³
- Post-basic diploma in Nursing⁴ and MSc. Nursing⁵

The academic year for the above courses is from June to March. The INC is an autonomous body under the Government of India (GoI) and is responsible for establishing a uniform standard of training for nurses, midwives and health visitors.^[13]

1 Nursing schools provide a three-year GNM diploma course while nursing colleges provide a four-year BSc degree course

2 During 2015 and 2016 GNM was a three- and half-year course, for a short period of two years

3 Post-basic BSc. Nursing is a two-year undergraduate course for GNM diploma holders to equalize with a BSc Nursing degree

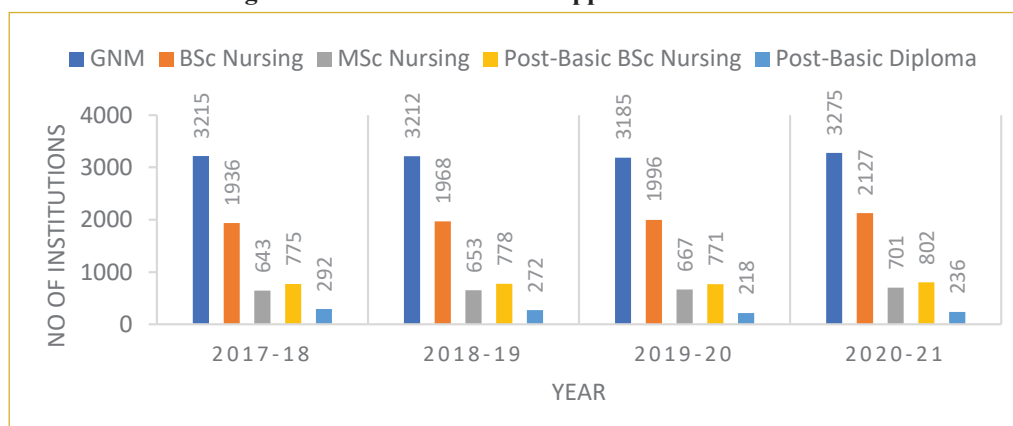
4 Post-basic Diploma in Nursing programme is a one-year long course for registered nurses (like those who pass the qualification of GNM diploma or alternate course or BSc Nursing or BSc (Honours) in Nursing or Post Basic BSc) to acquire in-depth knowledge and skills in specialized areas of nursing

5 MSc. Nursing is a post-graduate degree programme of two years duration in a specialized nursing subject

3.1.1 Nursing educational institutions and seats in India

The year-wise number of approved NEI and seats for various courses in India from 2017–2018 to 2020–2021 are given in Fig. 3.1. and Table 3.2. respectively.^[13]

Fig. 3.1. Year-wise number of approved NEI in India



Source: INC website, figures as of 31 March for the corresponding year

Table 3.2. Year-wise number of seats in NEI in India

	No of nursing seats in India			
Nursing qualification	2017–2018	2018–2019	2019–2020	2020–2021
General nursing and midwifery	1 29 926	1 30 676	1 30 182	1 34 949
BSc. nursing	96 475	98 864	100 865	1 07 814
MSc. nursing	12 617	12 940	13 322	13 971
Post-basic BSc. nursing	24 415	24 520	24 310	25 485
Post-basic diploma	4131	4176	3030	3170
Total	2 67 564	2 71 176	2 71 709	2 85 389

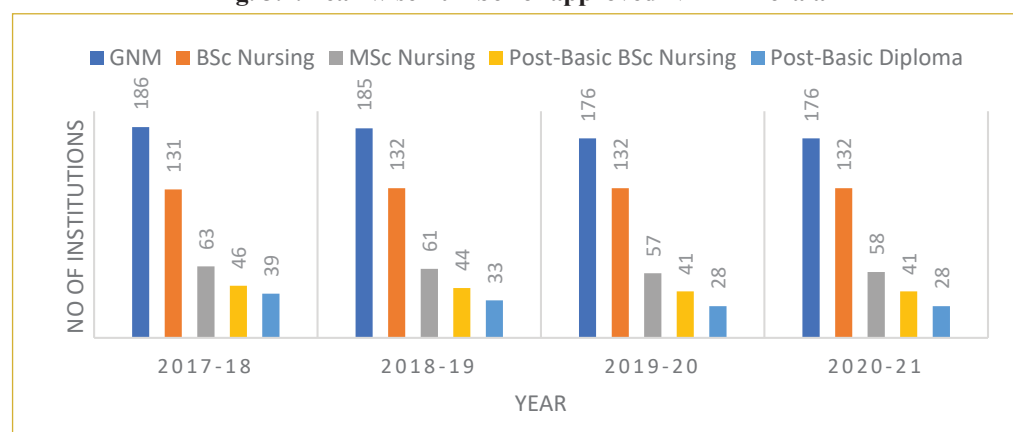
Source: INC website, figures as of 31 March for the corresponding years

3.1.2 Nursing educational institutions in Kerala

Kerala produces the largest share of nurses working in India and abroad.^[10] The Kerala Nurses and Midwives Council (KNMC) is an autonomous statutory body under the GoK and is responsible for registering NEI in the state.^[14] According to the KNMC register, there were 124 nursing colleges (seven are government institutions) offering BSc Nursing degrees and 135 nursing schools (20 are government institutions) offering GNM diploma courses in the academic year 2019–2020.

The total number of nursing educational institutions for GNM and degree courses was 259. But according to the details given in the NCI website, the figures were different. Here, the data shown in NCI website is given for easy comparison. The year-wise number of approved NEI and seats for various courses in Kerala from 2017–2018 to 2020–2021 are given in Fig. 3.2.^[13]

Fig. 3.2. Year-wise number of approved NEI in Kerala



Source: INC website, figures as of 31 March for corresponding years

3.1.3 Production capacity of nursing educational institutions in Kerala

The year-wise details of the number of nursing seats for the past four years are shown in Table 3.3.^[13] Though the number of nursing institutions was almost the same during the past few years, there were some variations in the number of seats during this period. This was due to adjustments for maintaining quality standards through compulsory annual verification.

Table 3.3. Year-wise number of seats in NEI in Kerala

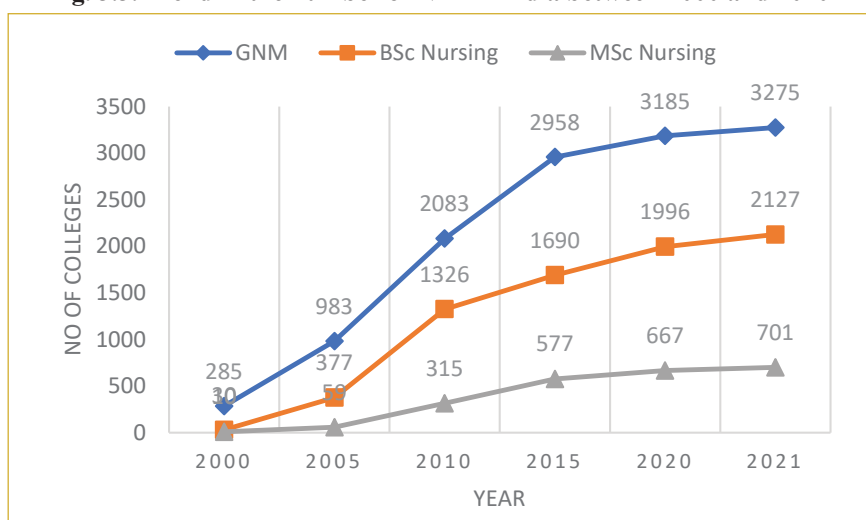
	No of nursing seats in Kerala			
Nursing qualification	2017–2018	2018–2019	2019–2020	2020–2021
General nursing and midwifery	5770	5740	5415	5420
BSc. Nursing	7200	7225	7275	7320
MSc Nursing	1250	1195	1097	1091
Post-basic BSc. Nursing	1575	1465	1290	1290
Post-basic diploma	507	417	347	347
Total	16 302	16 042	15 424	15 468

Source: INC website, figures as of 31 March for corresponding years

3.1.4 Trend in nursing educational institutions in India and Kerala

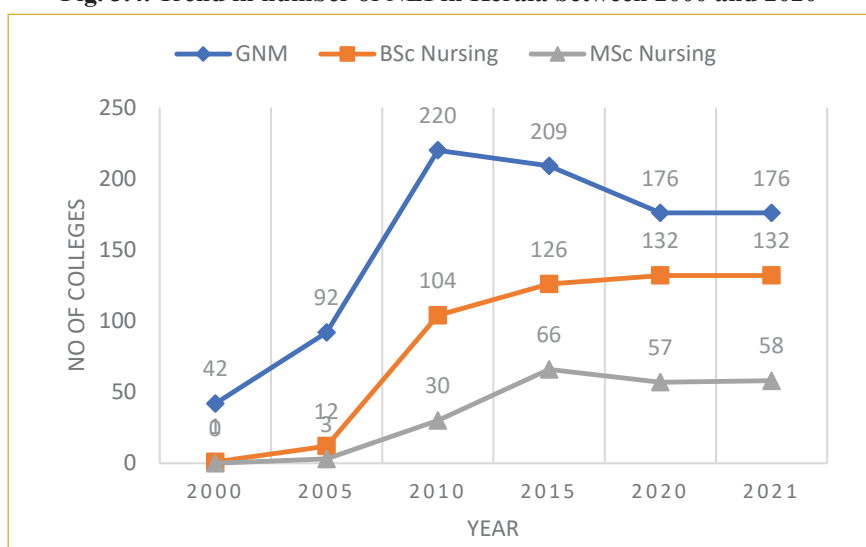
The trend in the number of NEI in India and Kerala between 2000 and 2020 is shown in Fig. 3.3 and Fig. 3.4.

Fig. 3.3. Trend in the number of NEI in India between 2000 and 2020



Data source: INC website, figures as of 31 March for corresponding years

Fig. 3.4. Trend in number of NEI in Kerala between 2000 and 2020



Data source: INC website, figures as of 31 March for corresponding years

3.2 Impact of COVID-19 pandemic on nursing education and remedial measures adopted

During the COVID-19 pandemic, there were restrictions on classroom teachings. The teachers and students could not come to the institutions due to lockdown restrictions.⁶ Hence, online platforms were used for imparting lessons. In addition, digital resources like YouTube videos, PowerPoint presentations, and printed notes were shared with students to strengthen self-learning. Thus, most of the theory curriculum could be completed satisfactorily. Even then, didactic sessions and practical skill developments, such as bedside consultations, clinical postings and nurse–patient interpersonal relationships suffered.

During periods when lockdown control measures were relaxed, students could be posted in hospital wards in small groups. They could attend to more labour cases since a larger number of deliveries took place in these apex hospitals as compared to earlier times. However, the number of other clinical cases were less in hospital wards. Hence, the students could not see or study all the different types or variety of diseases. Consequently, examination of all students except those in the final year were cancelled for this year and they were promoted to the next class. The GoK would be taking a decision regarding the conduct of examinations for the next year later, keeping in mind the COVID-19 situation.

In the year 2020, nursing colleges started trying the Objectives Structured Clinical Examination (OSCE) method⁷ for conducting practical examinations, following the instructions of the Kerala University of Health Sciences (KUHS).⁸ In OSCE, the nursing procedures were done in a structured manner with many stations for doing different procedures. Now, both government and private nursing institutions were transiting to the OSCE model. This OSCE experience will be helpful for those who wish to migrate abroad too.

Response from select faculty members is enumerated below.

“We have started online classes, and are following up with YouTube videos for practical sessions. We have conducted one-on-one viva and also revised the theory three times. In December 2020 and January 2021, so many deliveries happened within a short period. Due to this reason, the only clinical experience which the students got during the pandemic time was in the field of gynaecology.”

“During COVID-19, teaching was greatly impacted. I teach mental health nursing. Here, patient interviews and interactions play an important part. I think almost 90% of clinical experience was missed in the last year.”

3.3 Registered nurses in India and Kerala

India has been suffering from scarcity of nurses since its independence in 1947. The state-wise disaggregation revealed that the distribution of scarcity was not the same in all states. Andhra Pradesh, Tamil Nadu, Rajasthan and Kerala had a larger nurse population ratio than other states.^[15] The High-Level Expert Group (HLEG) report for the Planning Commission in 2012 had suggested a ratio of one doctor per 1000 population and 1:2 for doctor: nurse for India.^[16] The available details of registered nurses are given in Box 3.1 and Fig. 3.5.

Box 3.1 Registered nurses in India and Kerala

India

- Nurses available per 1000 population in 2011 was 1.7^[17]
- Physicians, nurses and midwives available per 10 000 population in 2015 and 2017 were 35.8 and 37.6 respectively^[18]
- Doctors and nurses per 10 000 population in 2019 were 9.28 and 23.89 respectively^[19]

Kerala

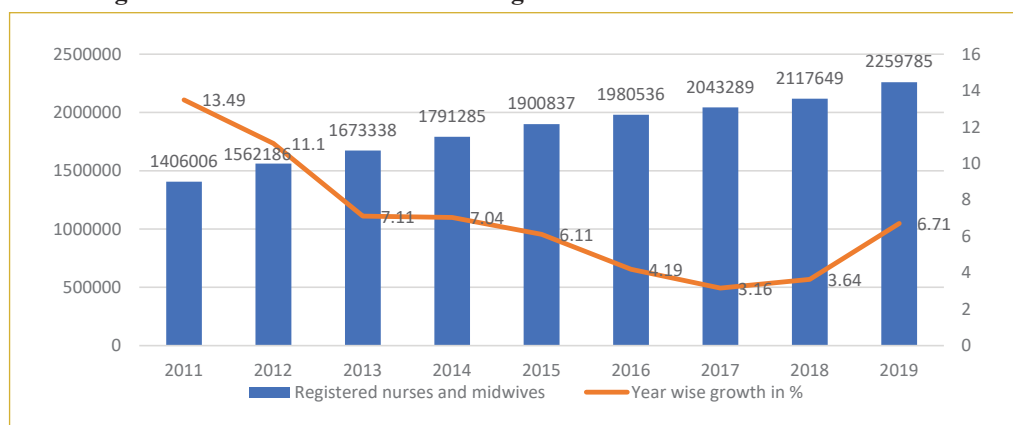
- Registered nurses and midwives available in 2010 and 2017 were 1 09 393 and 2 61 951 with an average annual growth rate of 16.15%^[6]
- Registered nurses and midwives in Kerala in 2017, 2018 and 2019 were 2 61 951, 2 75 544 and 2 88 971 respectively^[13]
- Nurses per 10 000 population in 2018 was 23.4^[15]

⁶ Author interview with nursing faculty

⁷ OSCE is a standardized educational method to evaluate students' clinical skills in simulated conditions in similar settings as the clinical ones that they will encounter. It assesses the three domains of psychomotor, cognitive and affective

⁸ Author interview with nursing faculty

Fig. 3.5. Year-wise total number of registered nurses and midwives in India



Source: INC website^[13]

3.3.1 Registration and tracking of nurses

The data of nurses who had migrated could not be found from any of the available sources. In the year 2017, GoI had started the Nurses Registration and Tracking System and instructed the state nursing councils to register the nurses by allotting a NUID.^[20] Fig.3.6 shows the details on its website. As on 28 October 2021, the number of nurses registered was 5 89 114 and their registration is yet to be completed.

“According to the Kerala Nursing Council, there were about 3 50 000 registrations as of last year. There is uncertainty about the exact number of those who migrated and to make an accurate estimate remains difficult and complex.”

Official, Nurses Association

Fig. 3.6. Screenshot of INC nursing registration and tracking system

3.4 Problems faced by nurses in Kerala during COVID-19

Issues experienced with respect to the COVID-19 pandemic, relating to nurses and the nursing profession in Kerala are detailed in the paragraphs below.

3.4.1 General issues related to nursing profession

In-depth interviews helped recount some of the issues that have been touched upon and documented in the past too.^[21] to ^[27] The following concerns were shared by the nurses:

Inadequate job-related perks and benefits: Getting employment for nurses in the private sector in Kerala was not too difficult. The problem was that often their salary was low, and the extent of benefits offered to them abysmal.⁹ Many of them got jobs in private hospitals as trainee nurses, with meagre or no salary and poor working conditions. Low wages,

⁹ Author interview with nursing faculty members, nurses and nursing association representatives

poor prospects for the profession, absence of an adequate working environment and inadequate infrastructure in their own home state were major reasons as to why nurses migrated overseas.

Long working hours: In both public and private sector, the actual working time exceeded the scheduled working time of nurses by 30 to 120 minutes per day and when totalled, was above 50 hours a week. They had to work continuously for more than six or eight hours for a day's shift without any break and had only a short break for food.

Health security in private sector not at par with public sector: Job security, safety, and service conditions were better in the public sector as compared to the private sector.¹⁰ Although nurses were working with potentially risky diseases, the provisions with respect to immunization, medical support schemes, and social security were meagre or limited in the private sector.

Inability to pay study loans: The Hindu, daily newspaper dated 30 September 2017, reported that most nurses in the state had taken loans for their education and were not in a position to repay them from their minimal salary.^[24]

3.4.2 Specific issues during the pandemic situation

Experience of Kerala nurses working in other states: The Mumbai Mirror daily newspaper dated 3 June 2020 reported that several Kerala nurses working there returned to their home state at the peak of the COVID-19 pandemic. This was largely because they were posted in places that were far from their homes and where their safety was not sufficiently protected.^[25] Also, the nurses who had worked in the government hospitals in Rajasthan said that they had been engaged in duty with a heavy amount of mental and work pressure. In the initial period of the pandemic, the rules and standard operating procedures (SoP) changed on a daily basis. There were issues with the supply of masks and personal protection equipment (PPE) and the authorities had tried hard to maintain uninterrupted supply.¹¹

Experience of nurses working in Kerala: All participants from Kerala said that the majority of nurses who worked with COVID-19 patients suffered from work pressure, stress, emotional problems, mental agony, psychological outbursts and mental derangements. They had witnessed the pathetic conditions of the patients and mental agony of their close relatives.¹² One representative of the nurses' association said that some of the junior nurses lost their job during the early phase of the pandemic since they did not follow the instructions of the management to work in intensive care units (ICU) for longer hours; or did not attend duty even when they were suffering from the disease.¹³

“Since the Nurses Association has a good backup and rapport with some of the hospitals, we were well placed to provide jobs to some of those who had lost jobs. Many nurses had sad stories to share like one nurse who was sent away from her job about a month ago only because she was COVID positive. We were fortunate that we could place her in another hospital without losing much time.”

Representative, Nurses Association

Experience of young nurses: The frustrations, emotional outbreaks and mental agony were more among young nurses than elders.¹⁴ The emotional outbursts of near and dear ones of the bereaved family also affected them more.

Experiences from inpatient wards and ICUs: Most of the nurses had to work long hours wearing the same PPE kit and facing difficulty in meeting their basic needs. The nurses and supervisors worked in inpatient wards and ICUs, during the pandemic and reported frustrations, emotional out-breaks and mental agony in addition to experiencing common issues.¹⁵ They also reported psychological and physical stress by witnessing the sudden death of young patients. The participants said that their friends and colleagues also suffered the same. The nurses who were assigned duty for longer hours with insufficient protective measures in the beginning were other factors that aggravated the sufferings.¹⁶ Some of them even abstained from duty. One study in August 2020 among 120 nurses working in a critical care unit in North India identified a moderate and high level of burnout in 37% and 54% nurses respectively.^[26]

Training of COVID-19 protocols and guidelines: At the beginning of the pandemic, nurses were imparted training about new protocols and guidelines to deal with the pandemic situation.¹⁷ The nurses in the public sector received training on an ongoing basis depending on the way the pandemic was evolving and the government guidelines that were being shared. However, those in the private sector took some time to follow suit since the percolation of knowledge and skills were slow

10 Author interview with nursing faculty from private sector

11 Author interview with nurse participant who worked in Rajasthan during COVID period

12 Author interview with nurse participants worked in both public and private sectors, their supervisors in Kerala

13 Author interview with nurses' association representative

14 Response in the focus group discussion organized as part of this study

15 Response in the focus group discussion organized as part of this study

16 Author interview with nurse participants worked in private sector and their supervisors

17 Author interview with nurse participants worked in both public and private sectors, their supervisors and nurse faculty

in reaching them. In the initial phase of the pandemic, there was not much clarity on how to use protective measures like wearing PPE kits, masks and managing patients in closed rooms like ICUs. This also aggravated stress and emotional outbursts, although with the passage of time, things became easier to manage. There was a lot of clarity and support from multiple quarters with respect to information on how to manage the pandemic.

3.5 Nurses' outlook regarding migration

The experience of Indian nurses from Kerala who worked abroad was documented through interactions and in-depth interviews. They touched upon several issues of concern such as their motivation to take up the nursing profession, intention of nursing students to migrate overseas

3.5.1 Motivation to take up the nursing profession

Three major reasons for choosing the nursing profession were cited among nursing students. They were:¹⁸

- assured employment within the country or abroad. Currently, the need to secure a job, irrespective of sex has assumed greater significance over time;
- opportunity to go abroad and experience the wider world; and
- influence of relatives and friends working in the nursing profession abroad and leading a better professional and social life.

3.5.2 Intention of nursing students to migrate overseas

More than half the students who joined the course had the intention to migrate overseas.¹⁹ By the time they reached the third year of their course, majority would report their desire to migrate. One of the major reasons for their intention to migrate was peer influence. More than three-fourth students were therefore ready to seek opportunities by the time they graduated. The reasons that influenced their decision to migrate were:

- economic factors like low wages and difficulty in repayment of bank loan taken for education;
- influence of relatives and /or siblings in the same profession working abroad;
- peer influence and group decision among students; and
- information obtained from government agencies like NORKA and ODEPC about facilities that were available through the government for safe and secure migration.

“Majority of the students have a plan to migrate because they do not get deserving remuneration and reputation. Also, job satisfaction and job security are much better in other countries. Most of the graduates are migrating in order to build a better family and social life for themselves.”

Senior faculty member

3.5.3 Factors influencing migration

The interviews with nurses working abroad revealed that the pull factor of the destination country and push factor in the home country aided them in shaping their future careers and in the selection of countries for migration. The enabling and supporting factors influenced are given below:²⁰

- lack of deserving remuneration in the home country;
- lack of deserving recognition in society in the home country;
- influence of peer friends who studied together and had relatives working abroad;
- sensitization sessions by recruitment agencies (both government and private);
- avenues of professional development in the USA, Australia, Canada and European countries. (in the West, nurses can work as specialist nurses after completing higher studies);
- possibility of better lifestyles in destination countries;
- opportunity to take the family along with availability of free education for children, free accommodation and permanent settlement in Western countries;
- opportunity for travelling and exploring newer places in developed countries; and
- availability of language translators in the Gulf countries, along with the possibility of further migration to Western countries.

¹⁸ Author interview with nurse faculty mainly and some nurses

¹⁹ Author interview with nurse faculty

²⁰ Author interview with nurses working abroad

Anecdotal accounts from media articles

- Nurses were highly regarded in all other countries and were often paid more than what was being offered in India.^[27] Those working in the USA, Canada, and UAE could earn up to 82.7%, 28%, and 20% more than their Indian counterparts respectively.^[28]
- Lower salaries in public and private sector, poor employment conditions, and lack of jobs in the government sector in the host country, were some push factors of migration.^[29]
- Nurses working in the private sector were more prone to migration than those in the government sector since the conditions were worse in private sector.
- Less security, safety, respect and dignity of the profession in the home country also influenced the decision for migration. Nurses in India were mostly women (79.85%) and an easy target of exploitation because of their gendered stereotypes and submissive nature.^[30]
- Low-level of professional autonomy for nurses in India added the desirability of migration to locations where professional development and skills promotion were possible.^[29]

3.5.4 Preferred destinations for migration

The preferred destination countries and difficulties in migrating to these locations were shared by nurses and the same have been enumerated below.²¹

- The USA and UK were the most preferred destinations;
- Countries in the Gulf or Middle East region such as Dubai, Kuwait, Muscat and Qatar were preferred earlier by many since migration to those countries was comparatively easier;
- Australia and Canada are the other countries which were preferred; and
- Even though the Kingdom of Saudi Arabia (KSA) had more vacancies for nurses, the strict regulations and cultural practices like strictures regarding movement and dress code, especially for women, made it a less preferred destination.^[31]

- Migration does not end with one country but rather continues, depending on the migrants' aspirations and resources. Even though the working and living conditions were not very attractive in the Middle East, as reported by the respondents, migration to those countries facilitated future and onward movement to Western countries.
- Migration to Australia and Canada were reported to be more expensive than migration to the Middle East as the fee for the training courses to meet the essential requirements before starting the job were added to the cost.
- Study of native languages is a pre-requisite to migrate to Germany and Japan and the study of these languages was reported to be more difficult than that of English.

3.5.5 Preferred channels of migration

In the past, the nurses migrated in a step-by-step manner. First, they moved to North Indian states, mainly metropolitan cities like New Delhi and Mumbai and then to countries in the Middle East and finally to Europe or America. Finding jobs in metropolitan cities within India had never been a problem since there were always a lot of vacancies in the private sector. Even though the terms and conditions were not so attractive, the experience gained was useful for the further migration through recruitment agencies located in metropolitan cities and having tie-ups with super-speciality hospitals in the US, UK and the Middle East.^[32]

Some nurses who participated in the interview also used a step-by-step migration method to reach their desired destination country.²² In-depth interviews revealed that some nurses had started their career in specialist hospitals from cities in North India, soon after completing their course. This was followed by getting recruited through agencies accredited with the Gulf. Some of them got recruited while others got offers after completing their mandatory two years of work experience.

The migration to Gulf countries was smooth and easy from North Indian states since the hospital environment, colleagues and agencies were favourable and active in promoting migration. Here, the agencies too were more active in connecting nurses to hospitals in the UK, Ireland and Canada.

Presently, hospitals in the UK have started recruiting nurses directly and those successful recruited processed the visa and made travel arrangements, either directly by themselves or with the help of travel agencies. One nurse working in the KSA

21 Author interview with nurses working abroad and those nurses planning to migrate

22 Author interview with nurses worked in North Indian states and then migrated to UK, Ireland, Canada etc

for 3 years secured a job in a hospital in the UK and conveyed that the migration was easy from Delhi to the Gulf and then to the UK.²³

“I got a job easily in a specialist hospital in Delhi, immediately after completing the course. Several of my friends also got similar jobs in Delhi. There, the hospital connected us with agencies that were approved and accredited. Our colleagues and agencies helped us get appointments in the Gulf countries and facilitated our travel arrangements, on completion of two years’ work. The migration process was easy and smooth. In KSA, the agency connected me with one hospital in UK when I cleared my language test. After that the hospital was dealing directly with me. I myself gave the visa for stamping and booked tickets. The migration to UK was also easy and smooth.”

Nurse working in KSA

Another nurse having the desire to reach Australia, directly went to Ireland and is now developing skills to secure her registration in New Zealand.²⁴ She thinks that registration in Australia would be easily secured if she gets her registration in New Zealand.

“I aspired for a nursing job in Australia for long. Immediately after completing my BSc Nursing, I went to Pune and worked for two years in the A & E department, upgrading my skills in emergency management. On return, I attended the OET examination and got a score to go to Ireland. I could not get the requisite score to be eligible for Australia so I went to Ireland and worked there for a year and completed few skill development courses to help me get registered in New Zealand, knowing that this would pave the way for getting my Australian registration.”

Nurse

Majority of nurses who worked outside their home state perceived it as an advantage since that enabled them to develop better communication skills in English and improve their chances of journeying overseas.²⁵

3.6 Assistance and support to aspiring nurses

Considering the requirements and demands of aspiring nurses, certain agencies were formed under GoK to provide skill development trainings and assistance for overseas recruitment, career guidance, visa processing and travel to destination countries.

3.6.1 Skills and knowledge required for aspiring nurses

The nurses working in UK, Ireland and Canada reported that the curriculum of teaching in Kerala was much more than what was required to work there. They could work comfortably in all specialities with the knowledge acquired from the institutions in their home state. However, the skills required in the destination countries were slightly different from what they had studied back home. The good thing was that these missing skills were easily acquired, since hospitals in the destination countries provided the necessary training for each procedure during the adaptation period. The problems were more in the knowledge of communicative English and OSCE type of screening to clear the licensing examination. The heartening piece of news was when faculty members informed that the computer knowledge and English language skills had been recently introduced in the nursing curriculum.²⁶

“In the first-year syllabus, English was taught as a subject, and most of the classes were taken in English medium. In my experience, intensive communicative English teaching is the need of the hour.”

Nurse working in the UK

The UK and Ireland have reduced the duration of required experience. Recently, some nurses with good English language skills got selected to these countries even though their duration of experience was less than six months.

Nurses working in Gulf countries found that additional skill development was useful before they reached there. One to two years of work experience in some speciality after their educational qualification helped them score a higher ranking in screening tests that helped them in their selection in these countries.

23 Author interview with the particular nurse working in KSA

24 Author interview with the particular nurse working in Ireland

25 Author interview with nurses and nurse faculty studied or and worked in states other than Kerala

26 Author interview with the particular nurse working in UK

3.6.2 Skill development agencies

The Kerala Academy for Skills Excellence (KASE), Additional Skill Acquisition Programme Kerala (ASAP Kerala), and Nursing Institute for Career Enhancement (NICE) have been working in association with government agencies like NORKA Roots and ODEPC to provide skill training and English language skills that are a prerequisite for nurses to work abroad. Now they are planning to start courses in other languages like German, Japanese and Dutch.

The ASEP–Nursing is a joint initiative of the Kerala State Women’s Development Corporation (KSWDC), Centre for Management Development (CMD) and ODEPC to provide essential advanced nursing skills and comprehensive finishing programme for nurses who are interested to migrate.

3.6.3 Skill development trainings

Details regarding training programmes offered by KASE, NICE, ASAP and ASEP–Nursing are given in Box 3.2. The professional associations and private agencies are also conducting some trainings.

Box. 3.2. Skill development agencies under GoK and its purpose/objectives		
Agency	Type of agency	Purpose/Objectives
KASE ²⁷	Nodal agency of GoK under labour ministry collaborates with NORKA and ODEPC	• To facilitate and coordinate various skill development initiatives in the state • To provide accreditation to various courses under NICE, OET centre, multi-language learning institute
NICE ²⁸	Skill development agency under KASE collaborates with NORKA and ODEPC	• To train nursing skills and language skills to graduate/ diploma nurses • To train nurses for government licensing examinations in Middle East countries
ASAP ²⁹	Government company registered in 2013 under higher education department	• To create unique demand-based, industry-led skill training ecosystem through 121 Skill Development Centres • To provide a crash course suitable for overseas employment for 10 000 qualified nurses
ASEP – Nursing ³⁰	Joint initiative of KSWDC, CMD and ODEPC	• To conduct a six-month programme on basic nursing skills, emergency and critical care nursing skills, infection control and patient safety, language communication, personality and soft skills
ODEPC ³¹	Government-approved agency	• To provide recruitment services in the domestic and international job markets • To process contractual agreement between the employer and candidate for the above • To train nursing skills and language skills to nurses • To assist visa processing and travel arrangements
NORKA ³²	State-run agency	• To facilitate overseas recruitment • To provide skills suitable for overseas employment • To rehabilitate returnees

3.6.3.1 Trainings under KASE

KASE is one of the nodal agencies of GoK that is authorized to facilitate and coordinate various skill development initiatives in the state. Feedback about the organization is shared below.

Three skill development centres that proved to be useful for medical professionals established under KASE are NICE, the Occupational English Test centre (OET centre), and the Multi-Language Learning Institute. OET centre undertakes OET course while the Multi-Language Learning Institute undertakes IELTS and OET courses. They plan to start the training in new languages like German, Japanese and French, once the COVID situation eases. KASE is working in association with NORKA and ODEPC for providing placements for trained people.^[33] For more details see Annexure III.

27 Details collected from KASE website (<https://www.kase.in/>) and author interview with representatives of KASE

28 Details collected from NICE website (<https://sutpattom.com/nice/>) and author interview with representatives of NICE

29 Details collected from ASAP website (<https://asapkerala.gov.in/>) and author interview with representatives of ASAP

30 Details collected from ASEP website (<https://kswdc.org/asep-nursing/>) and author interview with representatives of ASEP

31 Details collected from ODEPC website (<https://odepc.kerala.gov.in/>) and author interview with representatives of ODEPC

32 Details collected from NORKA website (<https://norkaroots.org/>) and author interview with representatives of NORKA

“We run on a convergence model. As part of this convergence, we have collaborated with organizations such as NORKA and ODEPC. We give skill development training to nurses through NICE and provide overseas employment through ODEPC. Also, KASE organized training for 800 nurses from Kerala and 170 nurses from the Maldives. About 250 nurses from Kerala got employment outside. Training for nurses from the Maldives was in association with their government and hence all of them got jobs.”

Official from KASE

3.6.3.2 Trainings under NICE

NICE Academy provides skill upgradation training of international best practices to selected nurses to prepare them for employment abroad.³³ They are Advanced Nursing Excellence programme (ANEP) of 120 days duration, Nursing Excellence Programme (NEP) of 40 days duration, Fresher Nurse’s excellence programme that offers a Basic of 45 days duration and OET of 3 months and 5 months duration.³⁴ During the training, nurses also learn soft skills, lessons on personality development, cultural adaptation, and work ethics. The other trainings are Government Licensing Examinations of the Middle East and Communication skills in English and Arabic.^[34]

Both NORKA and ODEPC utilize the service of NICE for providing skill upgradation training and language skills. They trained more than 900 nurses (80% sponsored by NORKA and 20% paid by students).³⁵ They have a tie-up with NORKA and ODEPC for the recruitment of successful trainees abroad. For more details see Annexure III.

“More than 900 nurses were trained by us. We offer services to government-sponsored students and also to students who pay out of their own pocket. We train students sponsored by NORKA and ODEPC. Here, we offer classes on personality development, language and nursing skills. We provide three levels of instructions that are suitable for Gulf countries, Western countries and also for India. . For each of them, specific classes and trainings have been set up”

Officer in NICE

3.6.3.3 Trainings under ASAP

ASAP Kerala announced a health care-related training programme to provide a crash finishing course suitable for overseas employment for 10 000 qualified nurses. The programme included three components, namely language training, clinical training and overseas placement. Even though arrangements were made for IELTS with British Council, clinical training through Joint Commission International (JCI) approved institutions and German language with the Indo-German Chamber of Commerce, the classes could not be started until recently.

Now, the modules for medical vocabulary and clinical nursing courses on respiratory medicine have been developed and finalization of modules on clinical research and pharmacovigilance courses are underway.^[35] For more details see Annexure III. Feedback regarding openings in few other countries is shared below.

“Those who want to work in Germany, Japan, France, etc., have to learn the local language. You will be allowed to work in Japan, only if you pass the skill training exam. You have to go and stay in Japan for 3 to 6 months to prepare and pass the examination. Therefore, nurses are less interested in migrating there. A Multi-Language Training Centre will be started soon by ASAP to solve this problem.”

Official, ASAP Kerala

3.6.3.4 Trainings under ASEP-Nursing

This programme has been developed to update and upskill qualified nurses. It is a six-month programme that includes 18 weeks of classroom/online/simulation laboratory training and six weeks of practical training in emergency and ICUs in an established tertiary care hospital. The course included five modules such as basic nursing skills, emergency and critical care nursing skills, infection control and patient safety, clinical training (observership at emergency and critical care units), English communication, foreign language communication, personality and soft-skill training. There is an exit examination at the end of the programme.^[36] For more details see Annexure III.

33 NICE is the first Centre of Excellence (CoE) established by KASE in partnership with one private hospital on 2 July 2015

34 It is tailor-made course including bedside clinical experience for graduate and diploma nurses with a minimum of 2 years.

35 Author interview with NICE official

“We focus on the aspects where nurses require clinical updating. For the recruitment to the UK, they are asking for 6 months of clinical experience within 2 years. So, we have added 6 months of clinical experience to the ASEP programme and for that, we have a tie-up with the government medical colleges. If the nurses complete the course successfully for 6 months, the observership is ensured to satisfy the criterion.”

Interviewee from KSWDC

“We conducted online classes in basic and advanced nursing procedures during the COVID-19 pandemic. The training was provided by a team of experts (doctors, nurses and nursing tutors from tertiary hospitals). Also, one week of offline practical laboratory simulator scenario-based training was provided. We conducted an examination based on OSCE. If nurses go abroad, exams like computer-based tests and OSCE examinations are required and to familiarize them, we conduct examinations in a similar manner. Mainly this programme is concentrated for those who are migrating to the UK.”

Interviewee from KSWDC

3.6.3.5 Trainings under nursing associations and private agencies

- Trained Nurses Association of India (TNAI) is a professional organization of nurses that exists at the national level. They provide continuous and ongoing nursing education and skill training programmes for nurses to upgrade their skills and efficiency.³⁶ It is an onsite training venue at Noida, North India and was set up in 1980. The association is also organizing workshops in collaboration with national and international organizations, as part of their e-learning programme.^[37]
- The United Nurses' Association (UNA) is a professional organization of nurses at the state level. It also provides training to the nurses for IELTS and OET.³⁷ This is an online coaching that was started three months back. The charges were only one-fifth of the fees incurred by private coaching centres. Around 150 people were trained so far in one batch.
- There are many private agencies which offer IELTS and OET coaching with a duration of one to two months or sometimes crash course of two weeks. The course fee ranges between INR 10 000 to INR 14 000. They provide classroom and online sessions on concept-based speaking and pattern-based writing techniques.^[38] The fee is higher than that of government agencies and nurses' associations.³⁸

NORKA signed agreements with

54 agencies from 16 countries

GCC countries (UAE, KSA, Bahrain, Kuwait, Oman), Brunei Darussalam, Israel, Australia, Austria, UK, Ghana, Finland, New Zealand, Australia and Kenya.

3.7 Assistance for recruitment

- NORKA and the Overseas Development and Employment Promotion Consultants (ODEPC) are the two government-approved agencies in the state which are engaged in the recruitment process for safe overseas migration to minimize illegalities and visa fraud. They mostly sign agreements with private agencies abroad, and occasionally with governments based on specific assignments as per requirement. Agreements were signed by NORKA with 54 agencies from 16 countries. This was followed by ODEPC facilitating overseas employment in eight countries for over four decades.^[38]

Box 3.3. e-Migrate system

Overseas Employment Division of Ministry of External Affairs, GoI established the e-migrate system to automate the emigration process. The Emigration Check Required (ECR) passport holders, nurses and travellers migrating for work to the notified 18 ECR countries needed emigration clearance certificate from authorities through the e-migrate system to ensure protection of Indian emigrants proceeding abroad, for overseas employment.

The 18 ECR countries are the UAE, KSA, Qatar, Oman, Kuwait, Bahrain, Malaysia, Libya, Jordan, Yemen, Sudan, South Sudan, Afghanistan, Indonesia, Syria, Lebanon, Thailand and Iraq.

- In addition to these two agencies, TNAI is also involved in the recruitment of nurses to the UK and certain GCC countries.^[40]
- Furthermore, some private agencies also work towards the direct recruitment of nurses to specified hospitals abroad.

36 Details collected from TNAI website (<https://www.tnaionline.org/>) and author interview with representatives of TNAI

37 Author interview with UNA representatives

38 Author interview with nurses

- Apart from such recruitments, some nurses migrated abroad along with family members and then secured jobs after settling down.³⁹ The in-depth interviews with nurses who had migrated revealed that they had migrated to Italy, Ireland and Australia either by themselves or with the help of family members/friends who had already migrated earlier or through private agencies. But most of such migrations were to GCC countries and they chose to migrate further to English speaking countries, after improving their nursing and language skills.

3.7.1 Recruitment modalities

NORKA and ODEPC are using the e-Migrate system to facilitate overseas recruitment.^[41] They scrutinize the terms and conditions of the employment demand submitted by the foreign employer through the e-Migrate system and approve it after necessary negotiations. Thereafter, they publish the relevant details in the job portal, and also inform registered candidates through SMS alerts. The system facilitates the emigration processes as well.

3.7.2 Assistance for career guidance

Organizations and agencies disseminated their information regarding trainings and recruitment facilities through various modalities.⁴⁰

- NORKA and ODEPC informed that they visited the nursing institutions and sensitized the final-year students, disseminated through media such as websites, social media groups, newspaper advertisements, and nursing colleges. This was to avoid cheating and malpractices by private agencies.
- TNAI disseminated the information through the TNAI website and bulletin, namely the Nursing Journal of India.
- Friends and UNA shared the information through WhatsApp and websites like LinkedIn, Naukri etc.
- Private agencies publicized the information in newspapers and canvased personally either directly or through friends.

ODEPC signed agreements with eight countries and with the:

- Ministry of Health of KSA and the Maldives
- Private hospitals in KSA and other GCC countries (State of Kuwait, Qatar, Singapore, Bahrain, UAE, Sultanate of Oman etc).
- European countries (UK and Ireland)

Box. 3.4. Response of nurses

- Many nurses were not aware of government mechanisms existing to facilitate nurse's migration abroad and the skill development training to empower them.
- Few others had heard about these agencies but did not approach them since they presumed undue delay, less cooperation, poor customer service and client overload from the government side.
- Some of the nurses had similar experiences when they tried once. But the private agencies were customer-friendly, more informative and easily accessible with liberal feedback provisions.
- Those who remembered the sensitization sessions of NORKA/ODEPC said that one-time sessions were not effective, and that more sessions were needed to prove that the exercise was beneficial.
- Many nurses arranged travel tickets by themselves since they were familiar with online bookings etc.

3.7.3 Assistance for international travel

ODEPC also runs a travel agency which arranges air tickets for migrating nurses and provides suitable guidance in visa formalities, labour laws and travel regulations. Private agencies also provide all assistance but at a higher cost.

3.8 Migration of nurses

3.8.1 Historical background in India

- India has been one of the largest suppliers of health workers since the 1950s.^[42]
- India was the largest supplier of physicians and the second-largest supplier of nurses after the Philippines.^[29]
- In 2016, about 33 147 nurses from India worked in OECD countries and 9% of the internationally trained nurses in the US were trained in India.^[10] Other major destination countries from India included Kuwait, KSA, United Arab Emirates (UAE), Bahrain, UK, Canada and Australia. The share of migration of nurses to KSA and the USA decreased by 10% and 6.2% respectively between the period of 2011 to 2016. But at the same time, the share of nurses migrating to Canada increased marginally from 3.3% in 2013 to 5.5% in 2016.
- Even though there was a decline in overall migration, there was a shift in the trend in migration from Gulf Cooperation Council (GCC) countries to Canada and Australia.^[10]

³⁹ Nurses and nurse associations revealed about their colleges and friends working abroad during author interviews with them

⁴⁰ author interview with nurses, nurse faculty, nurses' associations, policy makers and agencies

3.8.2 Historical background in Kerala

Nurses from Kerala started working in the Gulf and European countries way back in the 1950s and 1960s respectively.^[44] The sequence of important events is given below:

- **1930:** The British Indian influence opened its doors for Indians to the Middle East. Keralites were marked by their willingness to take up overseas jobs in the first phase of migration to Gulf countries.
- **1940s:** Women from Kerala moved to study and work in places like Mumbai and Patna where missionaries ran nursing schools and hospitals. A large number of nurses from Kerala continued to work in hospitals across the country. A gap between supply and demand in Kerala was not a major issue since there were sufficient prospects in the private sector across the country.
- **Early 1950s:** Kuwait set up its health infrastructure with nurses from Kerala where the first Indian women were employed.
- **1970s:** The oil boom enabled Keralites to take up employment in the Middle-East countries on a large scale.^{[44], [45]}

The early phase of mobility (1930–1970) generated social networks and channelled information regarding jobs in the Middle-East countries back to Kerala. Nurses who had migrated to Gulf countries enjoyed prosperity and this enabled aspirants without social networks with inspiration to also consider migration.^[45]

3.8.3 Global dispersion of nurses from Kerala between 2012 and 2016

In 2012, among the nurses who migrated from Kerala, 38% were working in the US, 30% in the UK, 15% in Australia and 12% in the Gulf. The trend changed in 2016 and among the emigrant nurses 57% were found to be working in Gulf countries. The number of nurses from Kerala who were working abroad between 2011 and 2016 is given in Fig. 3.7.^[10] The detailed dispersion of nurses who had migrated, along with nurse assistants from Kerala to other major destination countries, in 2016 is shown in Fig. 3.87.

Fig. 3.7. Number of Kerala nurses working abroad, 2011–2016

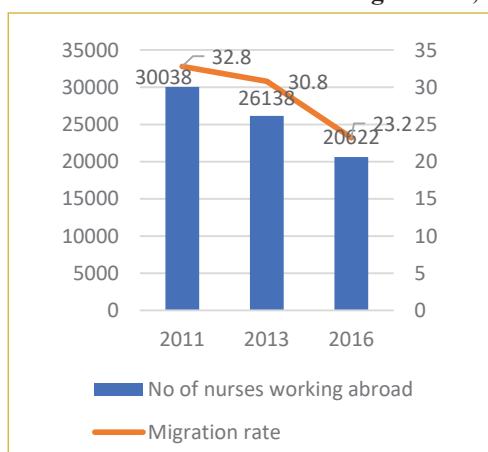
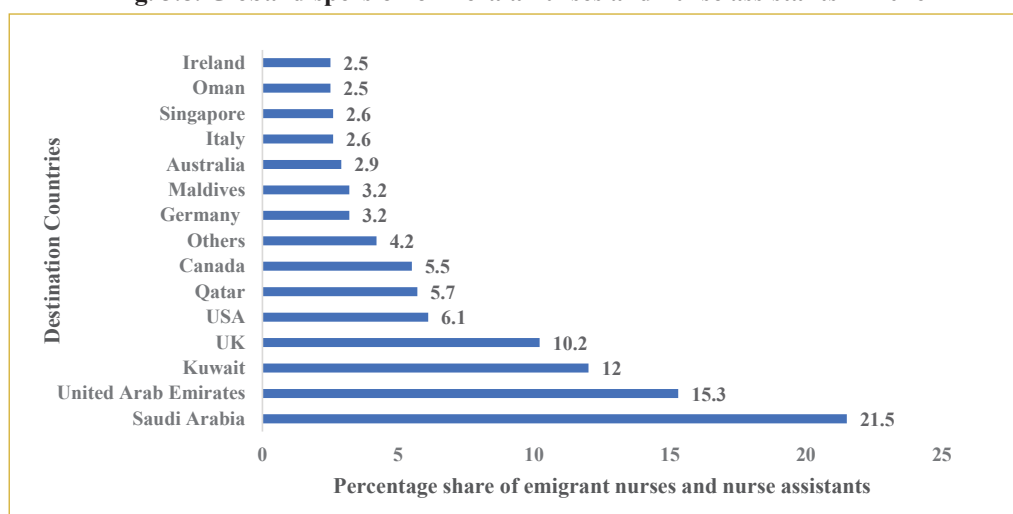


Fig. 3.8. Global dispersion of Kerala nurses and nurse assistants in 2016



Source: From Brain Drain to Brain Gain: Migration of Nursing and Midwifery Workforce in Kerala^[10]

3.8.4 Recent trends in migration from Kerala

The recent data of migration of nurses could not be found. The total number of nurses who migrated from Kerala to various countries through ODEPC during the last three years (April 2018 to March 2021) was 1216 as indicated in Table 3.4.⁴¹ The migration during 2020–2021 was twice of the numbers in 2018–2019, though there was a 25% dip in 2019–2020. During this period, migration to UK and UAE increased by 15.4 times and 3.3 times respectively but reduced towards the KSA to about one third. Even then, the number of out-migration was more than double that of those who returned home from abroad.⁴² Now, there is increased demand for Kerala nurses in European countries like UK, Ireland, Germany, Italy and Japan but less demand in KSA and the USA.⁴³

Table 3.4. Number of nurses recruited through ODEPC over the last 3 years

Countries	Period			Total
	2018–2019	2019–2020	2020–2021	
KSA	222	156	70	448
Maldives	-	22	-	22
Kuwait	-	-	1	1
Oman	2	2	3	7
UAE	89	15	298	402
Ireland	1	-	-	1
UK	17	56	262	335
Total	331	251	634	1216

Source: ODEPC website^[46]

The pre-COVID-19 trends of growing nurse flow from low- to high-income countries is likely to persist. This would perhaps decrease the availability of nurses in the home country which may aggravate the suffering of people in low- and middle-income nations, especially if country-level policy adjustments relating to the nursing workforce are not made immediately or have not gathered support from international organizations.[10] In which case, a substantive increase in the production of adequately trained nurses could be one solution.

3.8.5 Impact of migration of nurses in India

- Migration has undoubtedly improved the social status of the person/s who have migrated as also their families but has aggravated the shortcomings in the health system. This has resulted in weaker services in rural areas and extensive privatization with skewed service towards higher-income groups. This inevitably poses a threat to the Indian health-care system, so much so that this could even compromise efforts to achieve universal health coverage (UHC) in India.^[30]
- The negative impacts of international nurse emigration from low-income nations have been addressed by several Western countries with the adoption of ethical recruitment guidelines and strategies for the retention of health workers. This has resulted in complex professional assessments of nurses trained in countries like India, in the destination countries.
- The shortage of nurses in the home country has been mainly due to the inability and commitment of domestic countries to retain their health workers.^[30] This has occurred largely because of inadequacies in domestic policy on production, recruitment, healthy work environment, career progression and retention than as a direct consequence of international migration.

3.8.6 Impact of COVID-19 pandemic on international flow of Kerala nurses

Only a few nurses had returned from overseas since the onset of the COVID-19 pandemic and most of them came from the Middle East countries.⁴⁴ This was due to work-related stress, burnout and issues of personal unsafety. According to a TNAI representative, the number of out-migration was more than double that of those who returned home from abroad.

Many countries announced generous packages to attract nurses from source countries after the initial phase of the pandemic.⁴⁵ These attractions were already reported in grey literature.

- The Times of India daily newspaper dated 1 June 2020 reported that several European countries, including the UK, reduced the IELTS score from 7 to 6.5.^[47]

41 ODEPC website (<https://odepc.kerala.gov.in/>)

42 Author interview with ODEPC official

43 Author interview with representative of ODEPC, NORKA, ASAP, KASE

44 Author interview with nurse's associations representatives

45 Author interview with nurses working abroad

- The New Indian Express daily newspaper reported that the Dubai Health Authority (DHA), Sharjah Ministry and the UK enhanced the salary of nurses. These countries offered free visa and tickets, food and accommodation, insurance etc., in addition to a hike in salary.^[48]
- The Times of India daily newspaper dated 1 June 2020 reported that there was a demand for nurses from Kerala in hospitals in Saudi Arabia, and old age homes and private hospitals in Ireland even during the lockdown period.^[47]

One representative of the recruitment agency mentioned that the officials from UK–NHS, and Germany approached them during the COVID-19 lockdown period with a request to recruit more nurses for their government hospitals for immediate appointment.⁴⁶ Even though UK NHS, and Germany requested 1500 and 10 000 nurses for this year respectively, the state could not meet the demand. Low pass percentage in licensing examination in the UK and lack of nurses knowing the German language were major hindrances. Even then, more than 250 nurses were recruited to the UK during the year 2020. The interviewee added that about 300 nurses were recruited to various GCC countries through ODEPC every year and they could recruit more than 150 nurses to UAE during the COVID-19 period. However, in the current situation, there has been less demand from Saudi Arabia, Italy and the USA. Overall, the pre-COVID-19 trends of growing nurse flow from low- to high-income countries is likely to persist.

3.9 Policy approaches and instruments in use to manage international HRH mobility

3.9.1 International documents that influenced Indian agreements

Various international documents such as (i) WHO's World Health Report 2006, (ii) "the WHO Code" 2010, (iii) 2015 review of "the WHO Code", (iv) 2020 review of "the WHO Code", (v) World Health Assembly 2021 resolution and (vi) UK Code of Practice (CoP) influenced the bilateral agreements for the migration of nurses in India.

World Health Report 2006: The 2006 WHO's World Health Report explained that the rich countries receiving migrants from poor countries should adopt adequate recruitment policies and bilateral agreements to treat migrant health workers fairly well. The report recommended a minimum of 2.28 health workers per 1000 population for sufficient skilled birth attendance and prepared a list of 57 countries with "critical shortage". India featured in the list since it had only 1.87 skilled health workers per 1000 population in 2006.^[49]

"The WHO Code" 2010: In May 2010, the WHO endorsed the Global Code of Practice on the International Recruitment of Health Personnel ("the WHO Code") to manage the increased migration of health workers.^[50] Points to consider with respect to this Code:

- this code discouraged unilateral active recruitment from those 57 countries without having a government-to-government agreement;
- the code insisted that migrant health personnel should be hired, promoted and remunerated based on the levels of qualification, years of experience and degrees of professional responsibility; and
- the code was instructed to promote and remunerate health personnel based on equality of treatment with the domestically trained health workforce.

2015 review of "the WHO Code": In May 2015, an Independent Expert Advisory Group (EAG) was formed to review the relevance and effectiveness of "the WHO Code".^[51] The group reported that:

- population growth, ageing population, ageing health workforce, urbanization and liberalization rules of migration will enhance the global demand for health personnel;
- many countries still depend on foreign trained health personnel to meet increasing requirements, though they made some progress in production of health personnel with improved quality and competency;
- this will accelerate the international flow of health personnel and supply-demand constraints will be driven by demographic, economic, and epidemiological trends; and
- there will be delay in implementation and effective operation which requires widespread awareness of the instrument, improves political, technical and financial capacity and intersectoral cooperation.

2020 review of "the WHO Code": In May 2020, review of "the WHO Code" recommended identification of countries suffering from health workforce challenges in meeting the fulfilment of UHC and development of plans to support and safeguard their interests.^[52] The report highlighted the following:

- the Code is still relevant and effective in guiding countries in making bilateral agreements and strengthening availability of information;
- limited production and employment of nurses in low- and middle-income countries (LMIC) still persists;
- importance of health workforce related data, education, governance and partnership in countries with greatest need for support;

46 Author interview with representative of ODEPC, NORKA, ASAP

- higher significance of health workforce in the wake of the COVID-19 pandemic;
- significance of adopting the WHO Code in advancing towards UHC; and
- benefits of applying guidelines of the WHO Code for safe, regular, and orderly migration; and human capital development.

In spite of this, EAG found critical gaps in the Code's implementation. The current level of Code's implementation was insufficient realizing in its full potential to progress towards UHC and to achieving the Sustainable Development Goals (SDG). The report insisted the incorporation of Code recommendations into national law, policy, agreements and regional policies.

It re-emphasized the value of providing health workforce-related support and active recruitment-related safeguards for those countries which had the greatest challenges. The EAG found that the UHC service coverage index (UHC SCI) and health workforce density should be used by countries to identify the most pressing UHC-related health workforce challenges.^[53]

But the code was misinterpreted by many countries. For example, all recruitment of health workers from these 57 countries were banned by Germany in 2013 through an employment ordinance.^[54] Resultantly, they banned all recruitments from the 57 countries which included India. This was not intended by WHO and moreover this was not the spirit of the Code. In other words, recruitment was always allowed and encouraged, as long as it was steered under a mutually beneficial government-to-government agreement. Infact, it discouraged unregulated migration of health workforce. Now, India has 2.85 skilled health workers per 1000 population and 81% skilled birth attendance. Hence India is eligible for exclusion from the list of 57 countries with "critical shortage."^[55]

Box 3.5. Health Workforce Support and Safeguards List, 2020

- In 2020, the number of "critical shortage" countries used the same formula dictated by the 2006 report. With the most recent available data then, the number of countries were reduced from 57 to 43 (removing 17 countries from the existing list and adding three new countries).^[53] However, in the light of the 2020 EAG report, the 73rd WHA 73 in November 2020 instructed WHO to prepare the list of countries requiring support and safeguarding the same for implementing UHC properly.
- Consequently, WHO identified countries with a UHC Service Coverage Index that was less than 50 and density of doctors, nurses and midwives below the global median of 48.6 per 10 000 population. The "Health Workforce Support and Safeguards List, 2020" was published in February 2021. As per the new criteria and updated status of countries, India, Indonesia, Kenya, Zambia, Zimbabwe and all Western hemisphere countries except Haiti were excluded from the critical shortage.^[54]
- There were 47 countries in the new list and these were recommended to prioritize and support the health personnel development and health system. The WHO discouraged active international recruitment of health personnel and clarified that the government-to-government agreements were not prescribed for these listed countries. These countries ensured adequate domestic supply of health workforce through health labour market analysis and health sector stakeholders' engagement. This should be notified to the WHO Secretariat through NHWA and Code reporting process.^[53]

World Health Assembly 2021 resolution: The resolution of 74th WHA in May 2021 on the protection and safeguarding of the health and care workforce, emphasized the need for:

- multisectoral collaboration and investments, in order to ensure they were skilled, trained, equipped, supported, and enabled;
- decent pay, safe working environment, recognition and protection of their rights;
- access for COVID-19 vaccines, PPE; and
- implementation of the WHO Code of practice on international recruitment of health personnel.^[56]

UK Code of Practice (CoP): The NHS had been following the UK Code of Practice (CoP) since 2003 and promoting high standards of ethical practice in the international recruitment and employment of health and social care personnel. The code was republished in February 2021 by debarring recruitment from all 47 countries listed in the "Health Workforce Support and Safeguards List, 2020" published by WHO. Now NHS can recruit nurses from India.^[57]

3.9.2 Efforts of the India government in promoting migration of nurses

GoI has been promoting safe migration of nurses by signing bilateral agreements with foreign governments. After 2010, they tried to observe ethical practices in signing agreements. Currently in 2021, the agreement holds good with approximately 22 countries as per the treaty list of the Ministry of External Affairs, GoI.^[58]

a. The e-Migrate system

GoI established the e-Migrate system to automate the emigration process to assist legal and safe migration of nurses. The details are given in Box 4.3.

b. Provision for safe migration of nurses

On 25 March 2015, the MOIA decided to restrict emigration of nurses for overseas employment with effect from 30 April 2015.

c. Bilateral agreements with foreign countries

i. Bilateral agreements before the “WHO Code 2010”

- India had an agreement with 12 countries (Nepal, China, Tanzania, Syria, Fiji, Philippines, Maldives, Egypt, Poland, Mongolia, Colombia and Malaysia) in the health sector before the WHO code 2010. Agreements with all countries included the exchange of medical professionals including nurses. India's agreements with most countries were valid for 5 years which were automatically extended for another term of 5 years^{[58],[59],[60]}. For more details see Annexure IV.

ii. Bilateral agreements after “the WHO Code” (between 2010 and 2015)

- Consequent to the adoption of “the WHO Code”, the developed countries banned all recruitments from the 57 countries, including India. But India had an agreement with 10 countries (Republic of Croatia, Rwanda, Bulgaria, Latvia, Kuwait, Tajikistan, Burundi, Yemen and Japan) in the health sector after “the WHO Code” (between 2010 and 2015) of which the agreements with all countries included the exchange of medical professionals including nurses. India's agreements with most of the countries were valid for 5 years which were automatically extended for another term of 5 years^[58]. For more details see Annexure V.

iii. Bilateral agreements after 2015 review of the WHO Code

- India signed an agreement, namely the Memorandum of Cooperation (MoC)/ MOU/ MRA with 16 countries. These were Brunei Darussalam, Papua New Guinea, Australia, Palestine, Spain, Germany, Iran, Jordan, Timor-Leste, Bahrain, Uzbekistan, Indonesia, Maldives, Kyrgyzstan, Macedonia and Japan in the health sector after the review of “the WHO Code” in 2015 and of which the agreements with all countries included the exchange of medical professionals including nurses. India's agreements with most of the countries were valid for 5 years which were automatically extended for another term of 5 years with some of them for indefinite periods.^[58] Among the 16 agreements, 12 included training programmes. For more details see Annexure VI.
- In addition to the above, the literature reported agreements, including training programmes with four countries, namely Singapore, Japan, UK and Scotland, University of Houston college of nursing in USA and job-oriented agreements with four countries, namely Oman, Swaziland, Japan and Maldives. The details are given below.^{[61],[62],[63]}

Bilateral agreements after 2015 for educational exchange programmes

- The Economic Times daily newspaper dated 1 July 2015 reported that the Singapore Nursing Board and INC had agreed to recognize the nursing degrees awarded by four Indian nursing institutes namely the All India Institute of Medical Sciences (AIIMS), New Delhi; Manipal College of Nursing; Christian Medical College, Vellore and College of Nursing, Thiruvananthapuram. However, this limited agreement was not formally signed.^[64]
- In November 2016, Japan designed the Technical Intern Training Programme (TITP) with the view to transfer skills between developing countries to contribute towards their growth. Under this programme, the GoI had agreed to send skilled workers, including nurses from India to work in Japan. Those who had the experience for one to five years were eligible to apply for training through On-the-Job Training (OJT) mode. The skilled workers including nurses, were offered to work, learn and earn in Japan and then come back to India for work. In November 2016, this Memorandum of Cooperation (MoC) was concluded on skill development and later in 2017, a bilateral joint statement was issued, confirming the terms of the TITP, Japan. As part of this programme, Japan worked with the National Skill Development Corporation (NSDC), GoI to mobilize, counsel and conduct various stages of the TITP selection programme of nurses. The programme envisioned to gain international work exposure, lucrative salary and incentives on a regular scale and opportunities to learn the Japanese language.^[65]
- The Times of India daily newspaper dated 6 December 2018 reported that, the Manipal Academy of Higher Education (MAHE), India; International Skills Development Cooperation (ISDC), UK and the University of West Scotland, UK signed an MoU to help Indian nursing graduates to better equip nurses to clear certifying examinations in UK and Scotland.^[66]

- On 17 April 2018, The University of Houston College of Nursing (UNCON), USA and the INC signed an MoU for developing opportunities of nursing in India through academic and leadership exchange programmes.^[13] Fifty nursing programmes from around India participated in a two-day conference to select candidates suitable to create the Nurse Practitioner Critical Care Programme (NPCC). The selection process was based on recommendations from the INC and willingness for the nursing programmes.^[67] The NPCC offered support to hospitals in India to increase the number of higher educated nurses who were competent to take care of critically ill patients and to work closely with physicians to provide treatment and care for patients in intensive care units.^[68]
- On 1 June 2018, in continuation of the agreement in 2015, India signed the Mutual Recognition Agreement (MRA) with Singapore to expand the coverage in seven nursing institutions, the first MRA by India for free trade agreements. This MRA came into force from the date of signing and shall remain in force until terminated by either party with six months prior written notice.^[69]

Bilateral agreements after 2015 for job-oriented recruitment programmes

- In 2018, the Ministry of Health and Family Welfare (MoHFW), GoI signed Agreements/ MoU or Memorandum of Cooperation (MoC) with five more countries, namely Oman, Iran, Jordan, Timor-Leste and Swaziland for cooperation in the health sector. The International cooperation encouraged joint initiatives in capacity building, training, exchange of information, exchange of experts, health manpower development, and technical support in establishing laboratories/hospitals and research in mutually identified areas, based on equality, reciprocity and mutual benefit.^[70]
- The Hindustan Times daily newspaper dated 14 December 2019 reported that in 2019, India and Maldives signed an agreement of cooperation to streamline the recruitment of nurses.^[71]
- In January 2021, India and Japan signed an MoC for the transfer of specified skilled workers in 14 categories, including nursing. Those who met skill requirements and passed the Japanese language tests would be eligible for employment on contractual basis.^[72]
- The Hindu daily newspaper dated 20 June 2021 reported that in 2021 June, the Indian High Commission in the Maldives aided NORKA-Roots signed an MoA for workforce recruitment as part of strengthening connections between the two nations. The NORKA-Roots began recruiting nurses for private hospitals as well as 400 health care professionals for hospitals and health care centres under MoH.^[73]

iv. According to the website of the Press Information Bureau, in 2018, India had several ongoing Agreements/MoUs/ MoC/SoI in the health sector with 53 countries, as per the website of Press Information Bureau. For more details see Annexure VII.^[70]

3.9.3 Efforts of Kerala government to promote nurse migration

More than 25 000 Keralites (over 10 000 from NEI within Kerala and above 15 000 from NEI outside Kerala) had been graduating from nursing school every year. However, there were only 10 000 nursing jobs available in the state and the career prospects too within the state were insufficient and unattractive. Hence, these qualified nurses migrated outside the state and country, in search of jobs. Thus, the GoK took a decision to promote the safe migration of nurses in different ways, some of which are outlined below.

a. Assistance and support to aspiring nurses

The state government established specific agencies to provide skill development trainings and assistance for overseas recruitment, career guidance, visa processing and travel to destination countries. These are given in section 4.6 (Box 4.2)

b. Bilateral agreements with foreign governments

- Agreement with MoH, KSA: The Khaleej Times daily newspaper dated 25 November 2015 reported that in October 2015, ODEPC had signed an agreement with the MoH, KSA for the recruitment of doctors, nurses and other paramedical professionals. ODEPC developed relationships with many private hospitals in the KSA and other GCC countries like UAE, Bahrain, Qatar during this period.^[74]
- Agreement with MoH, Kuwait: The Khaleej Times daily newspaper dated 26 October 2015 reported that on 25 October 2015, the MoH, Kuwait and the Indian Embassy signed an agreement to restrict recruitment of nurses from India through three government agencies (NORKA-Roots, ODEPC in Kerala and one government agency in Tamil Nadu (Overseas Manpower Corporation)).^[75] The Kuwait Times daily newspaper dated 27 October 2015 reported that there was a consensus that a nominal amount only should be charged from the candidates as recruitment fees and it should not exceed Kuwaiti Dinar 100.^[76]

c. Bilateral agreements with private agencies abroad

NORKA and ODEPC signed agreements with 54 agencies from 16 countries and agencies from eight countries. The details are given in section 3.7.

d. Bilateral agreements with NHS, UK

When NHS, UK approached GoK for a bilateral agreement for the supply of nurses, GoI did not grant permission to sign the agreement initially, since India was included in the list of countries with critical shortage of health care workers in the “the WHO Code” in 2010. Some of the senior officials provided their views as enumerated below.

“To know more about opportunities available for migration to countries including the UK, we had discussions with a WHO official and an international expert in the field. Our aim was to send nurses to UK and other countries, for which we officially needed bilateral agreements. The WHO Indian team was against the idea because India was on the critical shortage list..... In North India, the number of nurses is less and if the talented nurses migrate from there, then there will be a shortage.....The distance from Kerala to North India is equal to the Middle East. But the salary and other benefits within India cannot be compared with that of the Middle East.”

“The World Health Organization considers India as a country with significant shortage of health care workers. As a result, nurses are not permitted to leave the nation for work abroad In 2018, the State Government and Department of Labour addressed the United Kingdom directly with permission of GoI and told them that Kerala has surplus nurses and that there are fewer chances for nurses here. However, the state government and United Kingdom reached an agreement on bilateral basis”.

“WHO listed India as a country with a critical shortage of health care workers. So, India could not make an agreement with other countries. But we informed GoI and WHO that there is no shortage of skilled health care workers, including nurses in Kerala. Hence WHO exempted India from the ban, even before the onset of the COVID pandemic.”

By the end of 2018, GoK had managed to get permission from GoI to sign the agreement with NHS of UK, since the state had surplus nurses, unlike other states.

Box 3.6. Agreement with UK, National Health Service

- In November 2018, ODEPC, on behalf of GoK, signed the agreement for the Global Learner’s Programme (GLP) for nurses with Health Education England (HEE) of NHS, UK with a validity period of three years.
- HEE requested 1500 nurses per year and offered job safety and better service conditions than before such as reimbursement of charges for skill development courses, visa fees, flight ticket charges and free stay for three months in UK to selected candidates.
- The nurses with one year of experience and who had passed IELTS or OET were eligible to get employment in the government hospitals under the NHS Trust for a period up to three years.
- However, this demand could not be met due to a high failure rate in screening tests.

The copy of the agreement is given in Annexure VIII

3.9.4 Efforts of associations to promote nurse migration

TNAI directly signed a similar agreement in 2018 and has since been recruiting nurses. Even though GoK prefers nurses in government service, TNAI had no such preference for any specific group. Long-term bilateral agreements with other governments by GoK or TNAI could not be found. Both ODEPC and TNAI had the same target for the same period.

3.10 Nurses returning from abroad

Most of the nurses were not allowed to settle in Gulf countries after their retirement.⁴⁷ A few of them came back before they attained their retirement age due to various reasons. However, most of the nurses who had migrated to Western countries, settled there. The actual data to support this could not be found on any of the available sources.

3.10.1 Reasons for returning

The most common reasons cited by nurses for returning included, fulfilling pre-determined goals, including accumulating considerable amount of wealth within a specified time period, family compulsions and responsibilities in the home country,

⁴⁷ Author interview with representative of nurses’ association

termination of contract, disease and /or retirement and failure to find suitable employment opportunity. Few other reasons included political instability, ethnic conflict and economic depression in the host country.

3.10.2 Rehabilitation of the returned

No notable rehabilitation initiative for nurses could be found under GoK. The association (UNA) representative reported that they helped those who were facing such problems through a welfare fund.⁴⁸ UNA claimed that they built houses, provided financial support for treatment and established pension schemes, amongst others. About 100 flights were chartered by them for bringing back health workers during the COVID-19 crisis period when international travel restrictions had been imposed by countries.

3.10.3 Integration of internationally trained nurses

While the knowledge and experience gained from working overseas should have been useful and of value for working more efficiently back home, the nurses did not prefer to work in their home state. This was largely because the remuneration, perks and other working conditions were not as suitable as the foreign country that they had chosen to work/live in.

⁴⁸ Author interview with representative of Nurses' Association

Chapter 4

Discussion

4.1 Easy bilateral agreements with WHO clarification

Since the year 2000, there have been several agreements between India and other countries. These agreements were active with about 22 countries in 2010, when WHO declared “the WHO Code” prescribing ethical practices in migration. India could not sign any agreement for job-oriented migration for about one decade between 2010 and 2020 since India was included in the list of “critical shortage” countries and the consequent ban had been imposed by developed countries. Hence many Indian nurses lost the opportunity to migrate for work and professional development during that period.

Nurses from Kerala had the tendency to first migrate to North Indian states and then abroad for more than half a century. Those nurses working in big hospitals in metropolitan cities inspired more and more nurses from Kerala to come and work there. Now they are working in many cities in India and abroad. The Kerala nurses working in Gulf countries, UK and USA have gained good reputation. They have also been regarded for their satisfactory work ethic from many other parts of the world. When the doors for migration were closed with the declaration of “the WHO Code”, many nurses were forced to work within the state under hardship or remain jobless since the production of nurses largely exceeded the job opportunities within the state. Though GoK pressurized GoI, to get permission to sign bilateral agreements with UK, GoI did not yield until WHA clarified the real spirit of the code, confirming that it did not apply to government-to-government recruitment since it occurred on mutually agreed terms to benefit both countries.

Kerala could sign the agreement with NHS, UK in 2018 and India could sign agreements with Japan and Maldives in 2021 with the clarification from WHO. This was followed by other countries who approached Kerala for recruitment of nurses to fill the gap in their countries with relaxed recruitment conditions and better remuneration. Now-a-days, higher demand for nurses, marginal reduction in screening standards, direct contract signing with hospitals in the destination country and offering of generous packages have attracted nurses to migrate to UK and Ireland. However, the slightly more laborious and expensive process followed in Canada has made this option less attractive. At present, Kerala is looking towards signing direct agreements with other countries like Germany, Japan, Australia etc. This development is likely to open doors to take Kerala nurses to newer heights.

4.2 Brain gain or brain drain with migration

“The WHO Code” of Practice on the recruitment of health personnel views migration of nurses towards developed countries as “brain gain” instead of “brain drain”. This is especially true if the trained nurses return after certain years of experience in the developed country and then subsequently bring that experience to work for their native country.^[77] Kerala government accepted the offer from NHS, UK for the Global Learners Programme (GLP) and decided to recruit nurses working in the government sector who agreed to return and serve the country on completing three years’ service cum education in the UK. The nurses migrated on agreeing to these terms and conditions but since they have not completed their term of three years it is not yet clear whether they will return to the country or not. However, the in-depth interviews in this study resonated with the thought that the nurses who had migrated to the Western world may not return to their native country. This was also because the nurses who had migrated earlier to developed countries, had every intention of settling there with their family.^[44] The job in the Middle East countries was temporary, hence they had to come back after retirement, whereas nurses who had migrated to English speaking countries had settled there permanently.^[10] Hence, the probability of their returning home after the three years of training was remote.

Better job security, safety and remuneration packages attracted the nurses to work in the public sector as opposed to the private sector within the state. Fewer job opportunities in the public sector and the financial obligations compelled the nurses working in the private sector to migrate abroad. Enhancing the job opportunities in the public sector would certainly help them with an improved standard of living in their home country. This would perhaps also reduce the migration to some extent and retain the nurses within the state.

4.3 Lessons from migration practices

Several interesting factors about migration practices revealed by successful nurses during the interviews serves as a useful guide for the nurses aspiring for migration.

- Nurses who started working in North India found migration abroad easy after improving their technical and language skills for patient management.
- Those nurses who worked in one or two specialities for two or more years and gained in-depth experience in that speciality, got better job offers more easily than those who had a similar period of experience in multiple specialities.
- Nurses who had experience in the ICU, neuro-intensive care unit, operation theatre, dialysis unit etc. were offered better jobs in a short span of time as compared to those who worked in general wards.
- Nurses with better communication skills, especially in the English language were able to easily clear the screening tests for the Western countries as compared to the others. But the nurses with better practical skills were able to perform well in screening tests for Gulf countries.
- In the case of nurses who had not succeeded to migrate to countries directly because they were yet not fluent in the English language, had to adopt an easier step-by-step process of migration. In alignment with other studies, the present study found that some nurses considered migration to Gulf countries as a stepping stone to migrate further towards Western countries.^[78] The common route of step-by-step migration was to the Gulf, directly or from metropolitan cities in north India, and then towards Australia, Canada or another European country.
- In conjunction, this study also found that the nurses preferred professional advancement, better financial and social status and dignity.^[78] European countries and Canada were more suitable places for migration for nurses who wanted to settle down with their family and had aspirations for professional development.
- Now-a-days, strict restrictions have made their migration to Middle East countries less preferred as a destination. In the current scenario, nurses considered migration to UK and Ireland as better and easier choices.

Further career guidance for the prospective nurses on the above facts may be helpful for them to choose the pathways which are best suitable.

4.4 Underutilized available government measures

Efforts have been made by the state government to promote and support the migration of nurses. Some of the support measures include high-quality training courses that promise results at lesser cost than that in private; an e-migration system for safe and secure recruitment modalities; career guidance services; assistance for safe and informed travel etc. Most of the prospective nurses approached the private agencies for the same services due to a lack of awareness about government measures, assumptions on account of undue delays, less cooperation and poor customer service from the government side, client overload etc.

To attract prospective nurses, it is imperative that innovative and catchy measures are introduced. These include wider publicity for the programmes, especially through social media, changing to people-friendly approaches which are customer-friendly, more informative and easily accessible with liberal feedback provisions.

Government measures available to promote and support migration	Reasons for under utilization	Suggestions for change to attract beneficiaries
• High-quality training courses with promising results at lesser cost than that in private • e-migrate system for safe and secure recruitment modalities • Career guidance services • Assistance for safe and informed travel	• Lack of awareness about government measures • Assumptions of undue delay • Less cooperation and poor customer service from the government side • Client overload	• Innovative and catchy measures such as wider publicity for the programmes, especially through social media • Changing to people-friendly approaches that include being customer-friendly, more informative and easily accessible with liberal feedback provisions

4.5 Inadequate production of nurses with adequate skills

The COVID-19 pandemic opened up newer avenues and better opportunities for nurses in the West. In addition, population growth, large number of nurses seeking retirement and change of profession from nursing to other occupations is likely to further increase vacancies for nurses. Even though developed countries expressed commitment to increase production of nurses and improve conditions for retention of nurses currently employed within those countries, these measures are still quite insufficient to meet the increasing requirements in the coming years. The UK's domestic supply of nurses per head of the population is well below the OECD average and is insufficient to meet demand. The UK government decided to keep a low key with respect to production of nurses and was looking to source from countries like India and Philippines to grab more nurses.

Undoubtedly, there is an increased demand for nurses from Kerala from the developed world. UK, Germany, Ireland, Belgium etc. are also round the corner with generous packages to attract nurses from Kerala. Even though production of nurses was more than double that of those required within the state, further increase in production may be helpful in future to meet the increased demand in European countries like UK, Ireland, Germany, Italy etc. and others like UAE, Canada, Australia, Japan etc.^[5]

According to the MoHFW 2020–2021 report, there is huge shortage of nurses in India. The report states that the requirement of nurses is increasing within the country and abroad and hence there is need to increase the number of nursing colleges and nursing seats. The report suggested increasing seats in hospitals where ample facilities are available.^[79] Seat capacity is indicative of the total number of students admitted in the nursing colleges. In this modern era of technological advancement, the role of nurses needs to be expanded to accommodate specialized areas. There may be nursing administrators, nursing educators, nurse advisors, nurse politicians and nurse advocates in addition to specialist nurses with experience in operation theatres, ICUs, dialysis units, transplantation centres, maternity wards, labour rooms, psychiatry services and community health programmes. With post-traumatic stress disorder (PTSD) becoming common after natural calamities like floods and the COVID-19 pandemic, the value of psychiatry services and community health programmes has become even more demanding, and the role of nurses within that is valuable to ensure regular provision of cost-effective services.

4.6 Quality improvement in nursing education

The quality of nursing skills acquired during the graduation was adequate to cope with the requirements in developed countries. But the skills imparted in the OSCE method of screening tests and communication in English language were reported to be insufficient at the time of graduation. The additional training from other sources during or after completion of the nursing course helped the aspirants to get through the screening tests.

In order to leverage the opportunities available in the developed countries, nurses should be equipped with advanced practical nursing and language skills. The nurses who completed their education outside the state fared better in English and were able to qualify the language screening tests easily as compared to the others. The key lessons echoed by the nurses to adopt language skills more easily was to incorporate these skills from the beginning of the nursing course and to put them into practice through daily communication among students and staff. Learning additional languages like German, Japanese, Dutch etc. along with the nursing course would help them explore more opportunities in countries which required the mandate.

The introduction of OSCE method to conduct examinations during the pandemic period gave additional knowledge and skills to these students. It also prepared them to get through the screening tests in case they planned to migrate. The regular practice of including the OSCE method in future assessments, was an added advantage.

4.7 Challenges

- The State government established several agencies to assist aspiring nurses in skill building, migration process, safe recruitment etc. But dissemination of information using conventional methods for youngsters and their parents was a big challenge.
- Large-scale utilization of private agencies for skill building and migration led to exploitation, cheating and fraud. The legal and in-practice mechanisms to prevent these were insufficient and inadequate.
- Pass percentage of candidates in IELTS and OET examinations, even among those who had attended the training programmes was low. The trainings for these are yet to be adapted to meet the need of the hour.
- The knowledge and communication skills in other languages like German, Japanese, Dutch are big hindrances for nurses to be able to migrate to developed countries where a large number of vacancies arise. The number of training centres and faculty to handle the courses are also inadequate.
- The nurses choose to migrate through different government or private agencies and also in their individual capacity at times. They seldom migrate to join their family members in other countries and then subsequently secure a job visa or further migrate to another country. Therefore, the assimilation of data of nurses migrating abroad is difficult.

Chapter 5

Conclusions and recommendations

Nursing has always been considered as a noble profession but is often neglected when it comes to a safe work environment with career progression and emoluments. This dichotomy has been the driving force for a vast majority of professionals wishing to seek better opportunities within the country or overseas. The nurses have had to face a series of events like high educational expenses, low remuneration, heavy workload, poor work environment, inadequate practical guidance for migration, and mental stress. These conditions are even prevalent in a state like Kerala where the health-care system is well-designed and comparable to many of the developed nations.

In addition to these factors gender discrimination, disrespect and humiliation have added burden to these professionals. In order to improve their professional skills, social status and dignity, many of them migrated to foreign countries. Even though, countries like USA, Australia and Canada provided a favourable environment to nurses, migration to these countries has been a tedious and expensive process. Migration to the Middle East countries remained and has been largely driven by an increased demand in these countries with feasible migration procedures. However, learning a foreign language and qualifying the OSCE examinations were hurdles which had to be crossed to find a suitable employment opportunity in Western countries.

Although, several governmental agencies like NORKA Roots and ODEPC exist for overseas recruitment, private agencies were preferred by candidates as completion of formalities could be expedited by following a customer-friendly approach. Nonetheless, fraudulent activities in this sector also rendered the candidate more vulnerable.

India has resumed the international migration of nursing professionals with other countries on mutual agreement as the ban was lifted, based on the revised list of WHO in 2021. Undoubtedly, foreign countries offer economic security, better social status, opportunity for higher education and job satisfaction to professionals.

The COVID-19 pandemic has been a double-edged sword, ushering in both opportunities as well as hindrances in their migration. This study found positive changes from the state government during the last few years in the facilitation of hassle-free international recruitment and mobility of nurses. But these changes were slow due to the pandemic related restrictions that were found everywhere and in all aspects. Even though there is an international demand for nurses, the opportunities could not be taken advantage of due to various factors like inadequate nursing and language adequacy skills to clear the licensing examination, international travel restrictions, uncertainty and apprehensions related to personal safety.

To tap the potential of foreign employment opportunities, urgent measures are needed to strengthen nursing and language skills and to promote government mechanisms that facilitate this process. It is also suggested that this may be strengthened early in their curriculum. The timely revisions of curriculum, elevation of basic salary and provision of a platform for mental support to nursing professionals are highly advocated within the state.

It is recommended that the government monitor all recruiting activities in the country to aid in a transparent process as well as periodically follow-up with nurses in foreign countries, assuring their safety. The field of nursing in Kerala, needs a proper reorientation in all aspects.

5.1 Recommendations

1. Adopt OSCE method of developed countries for screening to clear licensing examination of nurses for recruitment and use of the same extensively in the curriculum/teaching of nursing courses in Kerala.
2. Teach communicative English language right from the beginning of the course and promote the same so that it can be practiced in daily life. Also, explore the possibility of classroom and online sessions on concept-based speaking and pattern-based writing techniques etc.
3. Promote the study of one foreign language like German, Japanese and Dutch as an optional language during the nursing course via the medium of extracurricular classes.
4. Coordinate with different agencies that are working towards assisting recruitment and skill- building with similar courses to provide maximum benefit to trainees. A single agency may be entrusted with a specific task such as recruitment, nursing skill-building, language skill-building, travel assistance, career guidance etc. The idea being that if a client approaches any such agency, s/he should get whatever is required, as per requirements.
5. Disseminate information regarding programmes directly through nursing institutions and indirectly via all social media channels to reach almost all prospective nurses and their parents. This may be repeated often.
6. Have government agencies to adopt more customer-friendly, informative and easily accessible systems that have a more liberal feedback mechanism. Also, to strengthen call back systems to improve services and address the grievances.
7. Strictly monitor illegal ways of recruitment and visa fraudulence that may be adopted by private agencies and take necessary action. Also ensure that all recruitments are permitted only through the e-migrate system.
8. Maintain an updated data of international migration of nurses along with the country of destination and returning from abroad, along with reasons. Further, arrange facilities for repatriation of those who are returning with packages/ offer of reemployment, more so in case of those who are needy.

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Annexures

Annexure I. In-depth interview tool

Part A

Participant information sheet and informed consent form

Instructions for the interviewer

The following is to be read verbatim to the respondent prior to the interview. If the subject agrees to participate, then you must mark 2 “Yes” boxes and sign on the line marked “Witness to consent procedures” at the end of this form. Also mark the date on the appropriate line.

Purpose

You are invited to take part in a study commissioned by the World Health Organization (WHO) aimed at documenting policy reforms and analysing the pattern of migration of nurses from Kerala. The case study will review the initiatives taken up by the State Government in recruitment, skill-building and engaging in partnerships and signing MoUs with destination countries for facilitating international migration of nurses. In addition to this, the case study also documents the impact of COVID-19 on the mobility pattern of nurses, unscheduled return of nurses to the state and how disruptions in international travel affect movement of nurses. This may also collect some details regarding workforce behaviour and workload during the COVID pandemic.

Procedures

The interview will take approximately one hour of your time. We would like to record this interview with your permission to make sure we remember accurately all the information you provide. The interview will be on a Zoom online platform or through telephone. If you do not consent for the recording, we shall take notes instead. You do not have to answer any question that you feel uncomfortable with, and you have the right to withdraw your participation at any time without offering any explanation.

Benefits

The study will not provide any direct benefits for you, and it will also not affect your professional work. But the information collected from you and other participants will help in further research and policymaking which may benefit society as a whole.

Risk/discomfort

We do not think that being part of this project will create any risk for you. If at any point you feel uncomfortable or do not want to answer a specific question, and or decide you no longer want to participate, just let us know and we will skip the question or end the interview. You do not have to answer any questions you would prefer not to answer. The recording and transcript of the interview will only be accessible to members of the project team, and they will not be allowed to share it with anyone else. Only the aggregated data from the interviews (which will have no identifiers) will be shared.

Contact information

If you have any questions or doubt, please contact our investigators.

Co-investigator: Dr Rajalakshmi, mobile number – 9633313357

Principal investigator: Dr A S Pradeep Kumar, mobile number – 9447353912

Voluntary participation

Your participation in this study will be completely voluntary which means that you can decide whether to participate in the study or not. You are free and have the right to withdraw from the study at any time.

Permission to proceed

Are you willing to give consent to proceed with the interview? Yes ☐ No ☐

Are you willing to give consent to record interview with you? Yes ☐ No ☐

Agreed to give consent to proceed with the interview with me

Agreed to give consent to record the interview with me

Name of participant

Date

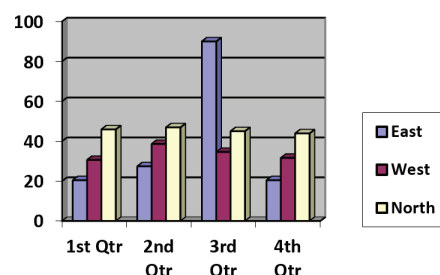
Witness to consent procedure

Name and signature with date

Part B

a. Interview tool for nurses

1. Can you please give the following personal information?
 - 1.1. Name
 - 1.2. Age
 - 1.3. Sex
 - 1.4. Marital status
 - 1.5. Religion
 - 1.6. Qualifications
 - 1.7. Additional trainings attended - details
 - 1.8. Year of basic nursing qualification
 - 1.9. Total duration of work in Kerala/ India/ Abroad (name of country please)
 - 1.10. Reason for choosing nursing profession, if any
2. Please share details about the working conditions and environment during your work in Kerala/ India/ abroad
 - 2.1. **Type of hospital and nature of duty** including government/ private facility; type of hospital (small/medium/ specialist); total no of beds in hospital; type of duty (ICU/CCU/operation theatre/dialysis unit).
 - 2.2. **Working conditions** with respect to job safety, salary, workload, workplace safety, work schedule, leave/ holidays ... before pandemic, changes after pandemic started etc.
 - 2.3. **Working environment** regarding availability of facilities, interaction with colleague nurses/ doctors/hospital management; misbehaviours from other staff, sexual offences, harassment redressal etc to you and general towards to doctors, nurses, others etc.
 - 2.4. **Your opinion regarding** satisfaction from present job, gap between expectations and present status, skill development etc.
3. Please answer the questions given below, regarding international migration
 - 3.1. **Intention to migrate.** When did the intention start, towards which country, expectations, motivating factors etc.
 - 3.2. **Factors influenced for migration.** Employment opportunities, remuneration, future career development/ goals, availability of options for higher studies, other factors etc.
 - 3.3. **How did you acquire the skills required in the destination country?** Possess required skills before going or gained after reaching there, acquired from curriculum or additional training, any plan to acquire more, if yes give details
 - 3.4. **Please explain the process related your migration.** Agency involved, selection process, visa, travel arrangements etc.
 - 3.5. **Barriers and facilitating factors** experienced for migration.
 - 3.6. **If no intension to migrate.** Why not, factors influenced for remaining in the state, motivated factors/ job opportunities/ working conditions within the state etc.
4. Please describe your knowledge about government policies and programmes existing for the promotion of nurse migration
 - 4.1. **Knowledge regarding migration of nurses.** Government orders and circulars, government schemes and special facilities, departments and agencies facilitating/involved in migration process, give details.
 - 4.2. **Source of information about vacancies abroad and migration process.** Friends, associations, departments and agencies.



5. How did COVID pandemic impact your present job and migration chances?
 - 5.1. **Workload.** Duration of work, changes in turn duty, holidays and leave.
 - 5.2. **Work safety.** Availability of personal protection measures, vaccination.
 - 5.3. **Experiences like** surge, psychologic issues, absenteeism, burnout, recruitment, redeployment, any discrimination from society etc.
 - 5.4. **Impact on your migration process:** In which way did it affect you? Provide details.
 - 5.6. **Experiences of your friends in Kerala and abroad:** Share variable experiences of nurses working in COVID cases in different countries? Give details of how it affected your friends working abroad.
6. Do you have any suggestions or recommendations to improve nursing education or migration process etc?
 - Any other information/ concerns/ suggestions/ recommendations to facilitate future migration of nurses?

Thank You

b. Interview tool for nurse faculty

1. Personal information
 - 1.1. Name
 - 1.2. Age
 - 1.3. Sex
 - 1.4. Marital status
 - 1.5. Religion
 - 1.6. Qualifications
 - 1.7. Organization and designation
 - 1.8. Total duration of service
 - 1.9. Reason for choosing nursing profession
2. Nursing curriculum, training and capacity building
 - 2.1. **Contents of curriculum and skill development training:** Whether the sessions match requirements abroad (skills and language), any recent changes made to suit with skills needed for working abroad. Give details.
 - 2.2. **Additional skills acquisition training:** Any provisions (postgraduate course, other agencies, work in specialized centres) for this.
 - 2.3. **Key challenges in providing training/capacity building skills etc.**
3. Knowledge on career opportunities and nursing migration
 - 3.1. **Upcoming career opportunities within the state:** Any knowledge about this in public and private sector, placement events in the institution etc.
 - 3.2. **International migration of nurses:** Any knowledge about opportunities, scope, compatibility of skills, recruitment process, departments and agencies involved, database of migrant nurses, your opinion about migration etc.
 - 3.3. **Experience of your students working abroad:** Any feedback.
4. Awareness on policy perspective
 - 4.1. Policy/guidelines regarding migration of nurses, WHO Code of Conduct, recruitment channels and any information regarding this and/or any changes needed.
 - 4.2. Attitude of nursing schools and associations on migration.
5. Impact of COVID pandemic
 - 5.1. **Any knowledge on the impact of COVID:** Health system, nursing institutions, nursing migration.
6. Suggestions/Recommendation
 - Any other information/ concerns/ suggestions/ recommendations?

c. Interview tool for policy makers and related training agencies (NORKA, ODEPEC, KASE, NICE, ASAP, ASEP-Kerala)

Can you provide available information regarding the following?

1. What are the services provided by NORKA/ ODEPC to nursing graduates for migration/recruitment to

foreign countries?

2. **Policies and recruitment modalities on nurse migration:** Attitude (facilitation or prevention) of government, policies and strategies put in place (support and prevention) for recruitment such as bilateral agreements between governments, agreements with recruitment agencies or health providers of destination countries, countries (number and name) with bilateral agreements/ adoption of “the WHO Code” on job safety, salary etc and direct MoU signing, any recent changes in these, any changes as a result of COVID pandemic etc. Please give details.
3. **Any information related migration process:** Data base of migration and return (year-wise country-wise inflow and outflow for last 6 years), recent changes in job opportunity abroad (country-wise/speciality-wise), monitoring of welfare of migrated nurses, impact of COVID on mobility pattern and implications of COVID on the future of the nursing workforce (increase or decrease in the attraction for job). Provide details.
4. **Welfare measures for nurses returning from outside:** Any supporting programme, relief measures, employment opportunities etc.
5. **Skill acquisition trainings:** Is there any such training programme for prospective nurses (details if any, along with curriculum/ optional sessions), how it is organized, types of training, any attachment with facilitation centres etc.
6. **Information dissemination to nurses regarding:** Career opportunities, mandatory requirements in destination countries (qualification and skills), skill acquisition training opportunities to prospective nurses etc. Provide details.
7. **Challenges and bottlenecks:** In recruitments, requirement of skills in destination countries, signing of MoU, travel restrictions etc.
8. Do you have any suggestions or recommendations to improve nursing education or migration process etc?

Any other information/ concerns/ suggestions/ recommendations.

Thank You

Additional tools for KASE, NICE, ASAP and ASEP-Kerala

9. **Organizational set up:** About organization, type of association with government, NORKA and ODEPC, trainings providing, training centres etc.
10. **Skill acquisition trainings for nurses:** Is there any such training for nurses planning to migrate (details if any, along with curriculum/ optional sessions), fees details, is it suited to skills required in destination countries, make any changes as required as the destination country modifies its needs (e.g., COVID management), how training programmes are organized, any facilitation centres etc, criteria for admission, demand, help for placement/ migration, OET etc.
11. **Migration related:** Any information on recent changes in job opportunity abroad (country-wise/speciality-wise), required skills etc. Provide details.
12. **Welfare of nurses returning from outside:** Any supporting programme, skill development programme for new initiatives etc.
13. **Information dissemination to nurses:** Skill acquisition training opportunities to prospective nurses. Provide details.
14. **Challenges and bottlenecks:** Providing skill acquisition training etc.
15. Do you have any suggestions or recommendations to improve nursing education or migration process etc?
 - Any other information/concerns/suggestions/recommendations

Thank You

d. Interview tool for nurses' associations

Can you please give available information regarding the following?

1. **Any information on career prospects within the state and abroad:** Opportunities, job safety, salary, working conditions, social status, etc
2. **Whether there has been any change in working conditions after the strike:** Public sector, private sector (any improvement after strikes and agitations).
3. **Nurses' complaints:** Whether nurses suffered from surge, absenteeism, burnout, recruitment, redeployment work during COVID-19 period.
4. **Any information on country-wise or speciality-wise opportunities abroad and impact of COVID on opportunities.**
5. **Any knowledge about:** Bilateral agreements between governments, government policies and strategies on migration, recruitment modalities/ signing of MoU/adoption of “the WHO Code” etc and any change in recent times in any of these. Please give details.

6. **Any liaising with policy makers for developing favourable policies:** Recruitment modalities/signing the MoU/ adoption of “the WHO Code” on job safety/salary, support programmes for nurses returning from outside. Please give details about the role of association.
7. **Migration data:** Is there any database of migration and return (country-wise, year-wise data), monitoring of welfare of migrated nurses, impact of COVID on mobility pattern (international inflow/ outflow) of workforce and implications of COVID on the future of nursing workforce (increase or decrease in the attraction for job), etc.
8. **Welfare programme for nurses returning from outside:** Any supporting programme, relief measures, employment opportunity etc. Please give details.
9. **Mode of dissemination of information to nurses:** Career opportunities abroad, mandatory requirements in destination countries (qualification and skills), skill acquisition training opportunities to prospective nurses etc.
10. **Skill acquisition trainings:** Organization of any skill acquisition training to prospective nurses, suggestions to nursing schools for curriculum changes etc. If yes give details.
11. **Challenges and bottlenecks:** In migration process, skills training, travel restrictions etc.
12. **Do you have any suggestions or recommendations to improve nursing education or migration process etc?**
13. Any other information/concerns/suggestions/recommendations.

Thank You

Interview tool for Kerala Nursing and Midwifery Council 1.

1. Please provide the number of nursing colleges in Kerala providing ANM, GNM, BSc (Nursing), MSc (Nursing), PB BSc (Nursing), PB Diploma? (Please provide year-wise information for 2016–2017, 2017–2018, 2018–2019 and 2019–2020).
2. Provide the number of seats in nursing colleges in Kerala for ANM, GNM, BSc (Nursing), MSc (Nursing), PB BSc (Nursing), PB Diploma? (Provide year-wise information for 2016–2017, 2017–2018, 2018–2019 and 2019–2020)). Data for 2020–2021 and 2021–2022 are not available in website.
3. Please provide the number of registrations with the Kerala Nurses and Midwives Council for ANM, GNM, BSc (Nursing), MSc (Nursing), PB BSc (Nursing), PB Diploma, for the period 2005–2016. Please provide year-wise information for 2016–2017, 2017–2018, 2018–2019 and 2019–2020 also.
4. Is there a registration system or tracking system maintained by the nursing council for nurses recruited to foreign countries? If yes, how many nurses are currently registered?
5. Whether nursing council has agreements with foreign countries for the recruitment of nurses? If yes, please share the details of the countries?
6. In the previous five years (2016–2017, 2017–2018, 2018–2019 and 2019–2020, 2021)), how many nurses were recruited to foreign countries through KNMC. Please give country-wise break up of recruitment of nurses to foreign countries.
7. Whether the Nursing Council provides any skill-building trainings to nurses recruited to foreign countries? If yes provide the details.
8. Whether the Nursing Council has any information on the impact of COVID on nursing institutions and education? If yes provide the details.
9. Any other information/concerns/suggestions/recommendations.

Thank You

Annexure II. List of participants of the in-depth interview

SL.No	Participant ID	Job profile
1	P1	Nurses (Kerala)
2	P2	Nurses (Kerala)
3	P3	Nurses (UK)
4	P4	Nurses (Kerala)
5	P5	Nurses (Saudi Arabia)
6	P6	Nurses (Ireland)
7	P7	Nurses (UK)
8	P8	Nurses (Qatar)
9	P9	Nurses (UK)

SL.No	Participant ID	Job profile
10	P10	Nurses (UK)
11	P11	Nurses (UK)
12	P12	Nurses (Canada)
13	P13	Nurses (Australia)
14	P14	Nurses (Australia)
15	P15	Nurses (Kerala)
16	P16	Nurses (Kerala)
17	P17	Nurses (Kerala)
18	P18	Academician
19	P19	Academician
20	P20	Academician
21	P21	Academician
22	P22	Academician
23	P23	Academician
24	P24	Academician
25	P25	Official, TNAI
26	P26	Official, TNAI
27	P27	Official, UNA
28	P28	Official, UNA
29	P29	Official, UNA
30	P30	Official, ODEPC
31	P31	Official, KASE
32	P32	Official, NICE
33	P33	Policymaker
34	P34	Policymaker
35	P35	Policymaker
36	P36	Official in NORKA
37	P37	Ex official, KNMC
38	P38	Official, NORKA
39	P39	Official, DNE
40	P40	Official, ODEPC
41	P41	Nursing Supervisor (Kerala)
42	P42	Official, KSWDC
43	P43	Official, KSWDC
44	P44	Official, KSWDC

Annexure III. Skill development agencies

Kerala Academy for Skills Excellence

KASE was established in 2016 as the State Skill Development Mission to function as the nodal body for the convergence of all skill development initiatives of the state. KASE promotes, establishes, sets up, monitors, governs and regulates institutions and academies in Kerala for the development of excellent skills, for core employability with competency standards in all sectors. It also promotes technology to meet the demands of various industries globally. KASE also provides accreditation to the courses conducted by various skill training institutions. They are subject to adherence to accreditation conditions, through a high-level committee of experts constituted for the purpose. KASE has launched an international outreach initiative named International Skill Training and Employability Programme (iSTEP), for setting up Centres of Excellence (CoE) in various sectors through faster, simpler, and more efficient processing. They work in 39 sectors for upskilling, multiskilling, and reskilling of job seekers in both organized and unorganized sectors to get employment in India and abroad. Health care is one of the 39 sectors wherein they have six centres of excellence and one accredited centre.⁴⁹

⁴⁹ <https://www.kase.in/>

Nursing Institute for Career Enhancement

NICE has established an Advanced Skill Lab equipped with high, medium, and low fidelity mannequins to teach nursing care to critically ill patients. This is established in connection with a multidisciplinary ICU in association with a tertiary care hospital. This is the state-of-art advanced skill lab with international standards to provide a life-like learning experience to students in critical care aspects required in a hospital. Standard guidelines related to critical care and infection control practices are displayed in the lab for easy learning. This provides a learning experience to work confidently in any health care setting anywhere in the world.

There are five certificate courses of four-month duration, under the Advanced Nursing Skill Excellence programme. This institute provides relevant skill training using an advanced skill lab by collecting a nominal fee. The following courses are on offer:

1. Infection Prevention and Control
2. Quality and Patient Safety
3. Basic and Advanced Cardiac Life Support (BLS and ACLS)
4. Emergency and Critical Care Nursing
5. Nursing Documentation

Elective subjects such as Paediatric Advanced Life Support Provider Course (PALS), Neonatal Advanced Life support (NALS), Australian Registry of Emergency Medical Technicians (AREMT), International Trauma Life Support (ITLS) and International English Language Testing System (IELTS) are also available.⁵⁰

ASAP

ASAP Kerala is a government company registered in 2013 under the higher education department of GoK to address the issue of unemployment among educated people.^[80] The objective was to create unique demand-based, industry-led skill training through Skill Development Centres attached to educational institutions and Community Skill Parks (CSP). There are preventive and curative types of training programmes. The preventive mechanism involves training students studying in regular schools and colleges in Kerala. This is to provide skills along with regular courses so that they can secure a job by the time of completing the course. The curative mechanism is to provide industrial training to people outside the institutional framework and to link them with placement agencies to increase employability.

So far, ASAP Kerala has trained 2 51 242 students in more than 100 courses from different sectors through 1477 educational institutions (schools, arts and science colleges, engineering colleges, polytechnics) and CSPs across the state. All courses conducted so far were in the industrial sector (information technology, heavy machinery, fashion design, agriculture, makeup and beautician course, electronics).⁵¹

Advanced Skill Enhancement Programme-Nursing

The ASEP -Nursing is a joint initiative of Kerala State Women's Development Corporation (KSWDC), Centre for Management Development (CMD) and ODEPC. It provides the essential advanced nursing skills and comprehensive finishing programme for nurses who are interested to migrate. Also, training is provided for soft skills and IT skills. During the COVID-19 pandemic, they have conducted online classes. The selection for admission is through an online screening test. The course duration is of 48 hours per week.⁵²

Annexure IV. Details of bilateral agreements between India and other countries, before “the WHO Code 2010”

Country	Type of agreement	Signed on	Abstract
1.Nepal	Bilateral Agreement	10.3.1994	For the development of the B.P. Koirala Institute of health sciences at Dharan (Nepal) Training slots provided by the government of India for the Nepalese Nursing (for degree course):15 candidates
2.China	Bilateral Agreement	03.9.1994	Forms of the agreement include the exchange of information of health and medicine, exchange of delegations of health and medical experts, conduction of mutual scientific programmes, sponsoring experts to attend the international meetings and conduction of meetings Validity: 5 years, automatically extend for 5 years Termination: 6 months written notice prior to expiration

⁵⁰ <https://niceacademy.net/>

⁵¹ <http://asapkerala.gov.in/>

⁵² <https://kswdc.org/asep-nursing/>

Country	Type of agreement	Signed on	Abstract
3.Tanzania	Bilateral Agreement	16.12.2002	Areas of cooperation include nursing, hospital management. The forms of cooperation include exchange of information in the field of health and medicine, exchange of health and medical experts, training in the mutually agreed areas, deputation of experts to attend international meetings, conducting symposia, academic meetings and working meetings Validity: 5 years, automatically for subsequent period of 5 years Termination: 6 months in advance before its expiry
4.Syria	Bilateral Agreement	09.9.2003	Areas of cooperation include exchange of information in health fields, exchange of specialists for the purpose of study and consultations, encouraging cooperation between institutions and organizations Validity: 5 years, automatically renewed for additional periods of 5 years Termination: 6 months from the date of notification of termination
5.Fiji	Bilateral Agreement	10.10.2005	Forms of cooperation include exchange of information in the field of health and medicine, exchange of health and medical experts, training, deputation of experts to attend international meetings Validity: 5 years, extended for a period of 5 years Termination: Written notice of 6 months in advance
6.Phillipines	Bilateral MoU	05.10.2007	Forms of cooperation include exchange of information in the field of health and medicine, exchange of health or medical experts, exchange visits of medical mission teams, training in the mutually agreed areas, deputation of experts to attend international meetings, conducting symposia, academic meetings and work meetings Validity: 5 years, automatically extended for similar periods Termination: 6 months prior to the intended termination
7.Maldives	Bilateral MoU	19.9.2008	Validity: 5 years, renewal for another 5 years. Termination- 3 months before the expiry of the MoU The training in India starting from 2008 will cover post-graduate students, MBBS, Nursing. Training in Maldives include nursing, managerial, technical and allied staff Validity: 5 years and agreed for maximum period of 5 years
8.Egypt	Bilateral MoU	18.11.2008	The areas of cooperation include hospital management and medical personnel including doctors, nurses, midwifery and paramedical staff, initiating and maintaining protocols to continue medical education The forms of cooperation include exchange of information in the field of health and medicine, exchange visits of health and medical experts, training and capacity building in the mutually agreed areas Validity: 3 years, renewed for similar periods Termination: 6 months prior notice
9.Poland	Bilateral Agreement	24.4.2009	Cooperation in areas like nursing and hospital management. Forms of cooperation include exchange for information in health, medicine, exchange of delegations of health and medical specialists for up to 30 days per year, delegation of specialists to attend international meetings Validity: 5 years, automatically renewed for an additional period of 5 years Termination: 6 months prior to expiration of the current 5- year period
	Bilateral Agreement	16.6.1979	Forms of cooperation include short- or long-term exchange of scientists and other officers of health departments, organizing symposia and conferences, exchange of experiences in health education, medicine and medical statistics Validity: 5 years, automatically renewed for another 5 years Termination: 6 months prior to expiry of aforesaid periods
10.Mongolia	Bilateral Agreement	14.9.2009	Exchange of information on technological processes, exchange of experts on short-term basis, training of up to 10 doctors and specialists for a period of 3 months Validity: 3 years, automatically extended for subsequent periods Termination: 6 months prior to the agreement
11.Colombia	Bilateral Agreement	19.1.2010	Main purpose is to promote and strengthen relations Also, to encourage the exchange to identify and resolve problems and to formulate policies of health Areas of cooperation include provision of health services and medical care services and formation of human resources in health Validity: 4 years, automatically extended for similar periods Termination: Written notice two months in advance

Country	Type of agreement	Signed on	Abstract
12. Malaysia	Multilateral Agreement	2007	Signed an agreement with seven countries like India, Indonesia, Myanmar, Pakistan, Albania, the Philippines and Bangladesh to counteract the shortage of nurses Foreign nurses with minimum requirements set by the Board (such as nurse registration in their own country, minimum of three years of clinical working experience), were permitted to work there after obtaining a Temporary Practicing Certificate (TPC) from Nursing Board Malaysia

Annexure V. Details of bilateral agreements between India and other countries, after “the WHO Code” (between 2010 and 2015)

Country	Type of agreement	Signed on	Abstract
1.Republic of Croatia	Bilateral- Agreement	9.6.2010	Areas of cooperation are nursing, hospital management and standards and curriculum of medical education Forms of cooperation include exchange of information about health and medicine, exchange of delegations of health and medical experts, training, deputation of experts to attend international meetings Validity: 5 years, automatically extended for 5 years Termination: 6 months before expiration of valid period
2.Rwanda	Bilateral-MoU	12.11.2010	Forms of cooperation include exchange of information in the field of health and medicine, exchange of experts in the field of health, training and deputation of experts to attend international meetings Validity: 5 years, automatically extended for similar periods Termination: 6 months prior to the termination of the period
3.Bulgaria	Bilateral	28.11.2011	Areas where participation includes medical services, medical science and training of medical personnel, medical education and research Forms of cooperation include exchange of medical, scientific information, experience on priority, participation of scientists in scientific medical activities organized in each country, short-term exchange of medical personnel Validity: 5 years, automatically extended for similar periods Termination: 6 months prior to the expiration
4.Latvia	Bilateral Agreement	28.02.2012	Areas where there is cooperation exchange of information and documentation on health subjects, information on new technologies and innovations in health, cooperation in education of health personnel in studies, postgraduation education, professional consultations, establishing direct cooperation between medical educational institutions, centres and other related institutions Promotes organization of educational seminars and trainings and exchange of specialists of related fields, of information on conferences, symposia and other international events in health care Validity: 5 years Termination:6 months written notice prior to expiration of the period
5.Kuwait	Bilateral MoU	23.04.2012	Provide appropriate training to doctors from Kuwait and allied health specialties like nursing in India. Training to Kuwait health personnel provided in India and Kuwait by Indian health professionals for which training expenses are borne by government of Kuwait Validity: 5 years, automatically renewed for same period Termination: 6 months from termination of initial period or any extended period
6.Tajikistan	Bilateral Agreement	3.9.2012	Areas of cooperation include training of medical or para medical professionals. Forms of cooperation include exchange of information and experts in health and medicine and training in mutually agreed areas Validity: 5 years, automatically subsequent periods of 5 years Termination:6 months in advance
7.Burundi	Bilateral MoU	18.9.2012	Forms of cooperation include exchange of information in health, medicine and exchange of experts in health, diagnostic laboratory support, training in mutually agreed areas, deputation of experts to international meetings, technical support in establishing laboratories of hospitals and research in mutually identified areas Validity: 5 years, automatically extend for similar periods Termination: 6 months written notice prior to expiration

Country	Type of agreement	Signed on	Abstract
8.Yemen	Bilateral Agreement	9.6.2013	The parties cooperate in areas like nursing and hospital management. The forms of cooperation include exchange of information in the field of health and medicine, exchange of health and medical experts, training and deputation of experts. Validity: 5 years, automatically renewed for 5 years Termination: 6 months in advance before its expiry
9.Japan	Bilateral MoU CEPA	1.9.2014 2011	Areas of cooperation include human resource development and training programmes for medical practitioners, nurses and public health professionals. Any other areas are mutually decided Validity: 5 years, automatically extended for another 5 years Termination: 6 months prior to the date of termination India and Japan signed a Comprehensive Economic Partnership Agreement (CEPA) to provide employment to Indian nurses and caregivers in Japan through a mutual agreement. ^[61] , (Welle D Japan, 2011) This involved high costs to selected candidates since they required to go to Japan and undergo tests in their language ^[62] , (Chandra R) However, this did not progress further
10.Mayaysia	Bilateral free trade agreement similar to CECA	30.6.2011	India and Malaysia signed a bilateral free trade agreement similar to CECA and facilitated temporary movement of medical, dental and nursing professionals. Malaysia made significant commitments such as contractual service suppliers and independent professionals, including medical and nursing services. ^[63] (The Economic times)

Annexure VI. Details of bilateral agreements between India and other countries, after 2015 review of “the WHO Code”

1.Brunei Darussalam	Bilateral MoU	02.02.2016	Main areas of cooperation include exchange of medical doctors, other professionals and experts; development of human resources; exchange of information on health Validity: 3 years Termination: 3 months before expiry of the MoU
2.Papua New Guinea	Bilateral MoU	29.04.2016	Forms of cooperation include exchange of medical or health delegation and experts, promotion of medical services, staff training in the areas of medicine and health care, improved access to health care services, providing training to Papua New Guinea national doctors and nurses in India and encouraging participation in international organizations Validity: 5 years, automatically extended to another 5 years Termination: 6 months before desired date of termination
3.Australia	Bilateral MoU	10.04.2017	Forms of cooperation between participants includes exchange of public information of health and medicine, exchange of health or medical experts, exchange of experts for training and development between institutions Validity: 5 years, automatically extended for another 5 years Termination: 6 months before desired date of termination
4.Palestine	Bilateral MoU	16.05.2017	Areas of cooperation include capacity building of health staff Validity: 5 years, extended for another 5 years Termination: 6 months before date of termination
5.Spain	Bilateral MoU	29.05.2017	Capacity building training programmes for experts including doctors, coordinators and other health personnel Validity: 5 years Termination: 6 months after the notification date
6.Germany	Bilateral Joint declaration of intent	01.06.2017	Areas where they seek to exchange experiences are postgraduate education, training of medical personnel, health economics Exchange of experts and medical personnel for post-graduation education and training, exchange of expertise, information and experiences, involvement in meetings, conferences and seminars for researchers, professionals and administrators Validity: JD to come into effect on the date of signature Termination: 6 months prior written notice

7.Iran	BilateralMoU	17.02.2018	Main areas of cooperation include exchange in training medical doctors and other health professionals, setting up of health care facilities and assistance in the development of human resources, any other areas mutually agreed Validity: 5 years, automatically extended for another 5 years. Termination: 6 months prior written notice before the desired date
8.Jordan	BilateralMoU	01.03.2018	Areas of cooperation in health system governance and any other area mutually decided Forms of cooperation include exchange of information, expertise, experts in the field of health and medicine, exchange visits of medical teams, any other forms mutually agreed Validity: 5 years, automatically extended for another 5 years. Termination: Written notice of at least 6 months before date of termination
9.Timor-Leste	BilateralMoU	07.04.2018	Areas of cooperation include exchange and training of medical doctors, officials, other health professionals and experts, assistance in development of human resources and setting up of health care facilities Validity: 5 years and to be renewed for further period of 5 years Termination: 3 months before expiry of MoU
10.Bahrain	BilateralMoU	15.07.2018	Main areas of cooperation will be in health services and medical care Forms of cooperation include exchange of information including publications and research outcomes, exchange of visits by governmental officials, academic staff, scholars, teachers, experts and students; participating in workshops and training courses; encouraging health and research activities at both private and academic level Validity: 5 years, renewed automatically for a period of 5 years Termination: 3 months written notice before desired date of termination
11.Uzbekistan	Bilateral Agreement	01.10.2018	Forms of cooperation include exchange and training of doctors, specialists and experts of health sector, trainings in field of health and sending of experts and delegations to attend meetings Validity: From date of signing and remaining in force until termination by either of the parties Termination: 3 months from date of termination
12.Indonesia	BilateralMoU	09.10.2018	Areas of cooperation human resource development, health services and any areas mutually agreed. The forms include exchange of information of health and medicine, exchange of health and medical experts, training in mutually agreed areas Validity: 3 years and can be renewed by mutual consent Termination: 6 months prior to the indented date of termination
13.Maldives	BilateralMoU	08.06.2019	Areas of cooperation include exchange and training of medical doctors, officials, other health professionals and experts Validity: 5 years, automatically expended for another 5 years Termination: 6 months before desired date of termination.
	BilateralMoU	02.01.2014	Areas of cooperation include exchange and training of medical doctors, officials, other health professionals and experts, assistance in development of human resources
14.Kyrgyzstan	BilateralMoU	14.06.2019	Areas of cooperation include strengthening of health care systems, improving capacity of human resources in the field of health, arranging visits for experience exchange among physicians, nurses, providing opportunities for health specialists to receive training and professional development at “India-Kyrgyz Centre for Information Technologies” and internships in India Validity: 5 years, automatically extended for another 5 years Termination: 6 months prior written notice before the desired date of termination
15.Macedonia	BilateralMoU	21.01.2021	Areas of cooperation include capacity building and short-term training of human resources in health, exchange and training of medical doctors, experts and other health professionals; and providing assistance in development of human resources and health care facilities Validity: 5 years and may be renewed for another 5 years Termination: Written notice of 3 months in advance
16.Japan	Memorandum of Cooperation (MoC)	Jan 2021	MoC for the transfer of specified skilled workers in 14 categories including nursing. Those who meet skill requirements and pass Japanese language tests will be eligible for employment on contractual basis ^[72] (Ministry of External Affairs)

Annexure VII. Details of ongoing Agreements or Memorandum of Understanding (MoU) or Memorandum of Cooperation (MoC) or Statement of Intent (SoI) between India and other countries in 2018

S.No	Name of country	Date of signing
1	Afghanistan	28.08.2005 (Agreement)
2	Australia	10.04.2017 (MoU)
3	Austria	17.02.2005 (Agreement)
4	Bangladesh	12.02.2013 (MoU)
5	Brazil	05.05.1998 (Agreement)
6	Brunei	02.02.2016 (MoU)
7	Bulgaria	28.11.2011 (Agreement)
8	Burundi	18.09.2012 (MoU)
9	Cuba	06.12.2017 (MoU)
10	Cyprus	08.10.2002 (Agreement)
11	China	03.09.1994 (Agreement)
12	Colombia	19.01.2010 (Agreement)
13	Croatia	09.06.2010 (Agreement)
14	Egypt	18.11.2008 (MoU)
15	Fiji Islands	10.10.2005 (Agreement)
16	Germany	01.06.2017 (JDI)
17	Iran	17.02.2018 (MoU)
18	Japan	01.09.2014 (MoC)
19	Jordan	01.03.2018 (MoU)
20	Hungary	18.01.2008 (Plan of Cooperation)
21	India-Brazil-South Africa (IBSA)	17.10.2007 (MoU)
22	Indonesia	11.10.2013 (MoU)
23	Israel	09.09.2003 (Agreement)
24	Italy	29.11.2017 (MoU)
25	Kazakhstan	16.04.2011 (Agreement)
26	Kuwait	23.04.2012 (MoU)
27	Latvia	28.02.2012 (Agreement)
28	Malawi	03.11.2010 (MoU)
29	Maldives	02.01.2014 (MoU)
30	Mauritius	12.03.2013 (MoU)
31	Mongolia	14.09.2009 (Agreement)
32	Morocco	14.12.2017 (MoU)
33	Mozambique	22.02.2004 (Agreement)
34	Myanmar	06.09.2017 (MoU)
35	Netherlands	30.01.2014 (MoU)
36	Oman	11.02.2018 (MoU)
37	Palestine	16.05.2017 (MoU)
38	Papua New Guinea	29.04.2016 (MoU)
39	Philippines	05.10.2007 (MoU)
40	Poland	24.04.2009 (Agreement)
41	Qatar	05.06.2016 (MoU)
42	Rwanda	12.11.2010 (MoU)
43	Saudi Arabia	20.11.2006 (Executive programme)
44	Seychelles	10.09.2003 (MoU)
45	South Africa	04.01.2006 (Agreement)

S.No	Name of country	Date of signing
46	Swaziland	09.04.2018 (MoU)
47	Sweden	24.02.2009 (MoU)
48	Tajikistan	03.09.2012 (Agreement)
49	Tanzania (Zanzibar)	16.12.2002 (Agreement)
50	Timor-Leste	07.04.2018 (MoU)
51	United Kingdom	19.05.2013 (MoU)
52	Vietnam	03.09.2016 (MoU)
53	Yemen	09.06.2013 (Agreement)



GOVERNMENT OF KERALA

Abstract

Health & Family Welfare Department – Health Services – Global Learners Programme - Work based learning programme for Nurses convened by Health Education England in collaboration with National Health Services, United Kingdom – Sanctioned – Orders issued.

HEALTH & FAMILY WELFARE (C) DEPARTMENT

G.O.(Ms)No.196/2018/H&FWD

Dated, Thiruvananthapuram, 08.10.2018.

ORDER

In the multi-country case study conducted by WHO-India and the Department of Health, Government of Kerala on migration of nurses, it was revealed that Kerala stands out as a major supplier of nurses to other States in India as well as to other countries. This reflects the State's high capacity for producing nurses with good quality. It was also observed that the tremendous production of nurses resulted in severe unemployment problem in the nursing sector of Kerala.

2. There is acute shortage of Nurses in the developed countries especially in United Kingdom due to recent issues related to withdrawal of financial support given to nursing education sector. Great demand for nurses now exists in United Kingdom (UK). It will be of great use to utilize the opportunity existing in UK, known as GLOBAL LEARNERS PROGRAMME which is a work based learning programme convened by Health Education England (HEE), a Public Sector institution in collaboration with National Health Services, United Kingdom.

3. This Global Health Exchange programme will provide better job opportunity to the nurses with attractive salary and will reduce the existing unemployment problem in the State to a certain extent. Since this programme equips Nurses to work at International Level, it will benefit the health service sector of Kerala also.

4. Considering the request from Health Education England, Government conducted a video conference with them and the representative of Health Education England has informed that their annual requirement of Nurses is more than 4500 and requested to provide a minimum of 1500 nurses per year.

5. The Health Education England has offered that they will provide £600 (INR-53,300/-) for preparing nurses for IELTS /OET and CBT examinations, free flight charge and accommodation for three months and work based learning opportunities in seven selected NHS Hospitals in selected specialities like Medicine, Surgery, Neonatology, Paediatrics, Obstetrics and Gynaecology, Trauma and Critical care etc. On placement, the nurses will be provided with band 3 Salary. They are required to get NMC registration after clearing OSCE examination. On getting registration, they will be placed in band 5 salary. The contract period is for three years.

6. Government have examined the matter in detail and found that health care sector of the State will also get benefited by providing suitable placement for Nurses, on return of those internationally trained nurses. Hence Government have decided to participate in the GLOBAL LEARNERS PROGRAMME, a work based learning programme convened by Health Education England, a Public Sector institution in collaboration with National Health Services, UK and hereby accord sanction to implement the above programme in the State on the following conditions:-

- i. The Overseas Development and Employment Promotion Consultants (ODEPC) is authorised as the implementing agency of the Programme in the State.
- ii. The Managing Director, ODEPC has to sign an MOU on behalf of Government of Kerala with Health Education England, UK.
- iii. Nurses under Government sector can apply for the programme, executing a bond that they would come back and rejoin government service after the contract period. They will be allowed to take Leave Without Allowance for the period.
- iv. The total number of nurses to be considered for foreign deputation will be decided by Government. For this, the Director of Medical Education and Director of Health Services have to obtain and forward the willingness and details of the interested Nurses serving under them.
- v. If adequate response from Government sector are not received, qualified private nurses(registered nurse) are allowed to make use of the offer. For other registered nurses, the relevant details have to be uploaded in the website of ODEPC for enabling them to forward the details directly to ODEPC.
- vi. The contract period for the Programme will be three years.
- vii. Training of Nurses has to be done utilizing the funds from Health Education England.
- viii. Visa processing : ODEPC is entrusted to provide support for visa processing.
- ix. Placement : Necessary clauses have to be incorporated in the draft MOU.

(By Order of the Governor)

RAJEEV SADANANDAN,
Additional Chief Secretary to Government

To

The Director of Medical Education, Thiruvananthapuram.
The Director of Health Services, Thiruvannanthapuram.
The Director, ODEPC Ltd., Floor V, Carmel Towers, Opposite to Cotton Hill School.
Vazhuthacadu, Thiruvananthapuram.
The Registrar, Kerala Nurses and Midwives Council, Thiurvananthapuram.
The Registrar, Kerala University of Health Sciences, Thrissur.
The Labour and Skills Department.
Stock File/Office Copy.

Forwarded / By Order

Milan

Section Officer

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