

have for the professional concerned.

Although there were differences in socio-economic extraction (nationality, willingness and ability to pay, shorter stay in Maputo and more females), there were no major clinical differences between patients, were it not for somewhat more rheumatic heart diseases among public patients.

The marginal benefit of a consultation as a private patient stood in no proportion to the marginal cost. The direct cost of the consultation to the patient in the public sector was symbolic; it was considerable as a private patient. Treatments were similar – maybe even more rational for private patients. Para-clinical investigations were more complete for public sector patients, probably reflecting less cost-consciousness, or the fact that public patients tend to be first consultations more often than private ones. A consultation as public patient seems to be used as a means to initiate patients to the private sector, at the earliest stages of their process of treatment, when the need for investigations seems most frequent.

There is no evidence for discrimination against public patients in terms of investigation or treatment. The most striking observation is the extent of the competition for the time of a civil servant doctor. Out of 66 hours seeing outpatients in one month, less than 12 were spent seeing public patients; a considerable amount of time – over 37 hours – was for seeing private patients who were not nationals. Private practice in Maputo may allow a doctor to earn enough income to be able to care for public patients without much discrimination – but there is not all that much time left to do just that.

At the other end of the brain-drain: African nurses living in Lisbon

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Introduction

“Brain-drain” of trained health professionals through emigration is a problem faced by Ministries of Health in many African countries. There is surprisingly little scientific evidence about its extent, determinants and consequences.

The opportunity for this exploratory study⁷⁷ arose during the development of an action research project in an immigrant squatter community in Greater Lisbon. Initial contacts with the community revealed that its inadequate housing conditions and lack of basic infrastructure belied a surprising wealth of human resources, including the presence of a number of trained health professionals. In most cases, these health professionals had abandoned relatively prestigious posts in public sector hospitals in Portuguese-speaking African countries to take up residence in this urban slum in Lisbon.

Having previously considered the issue of “brain-drain” from the perspective of African Ministries of Health, we were intrigued by the possibility of examining this phenomenon from the perspective of the emigrants them-

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selves. We wondered why these professionals had chosen to emigrate, what their professional experiences in Portugal had been, whether they intended to stay in Portugal, and under what conditions they would consider returning to their country of origin.

Methods

In early 1999, a focus group discussion was held with eight health professionals who had emigrated from Portuguese-speaking African countries (PSACs) to a squatter community comprised largely of African immigrants. The focus group participants were sampled using a "snowball" technique. The primary contact, a nurse living in the community, contacted several individuals known to her. These individuals in turn suggested others known to them. The criteria for inclusion were that the individual be a health professional, a PSAC national, and a resident of the study community. A community resident who had received training on focus groups led the two-hour discussion, which was observed and tape-recorded by authors ML and MJF.

During the month following the focus group discussion, individual interviews were held with the participants in order to collect information on more sensitive issues, such as salaries and family problems, and to follow up on issues raised during the focus group discussion. The interviews were conducted and tape-recorded by author MJF.

The tape recordings of the focus group and individual interviews were transcribed using word processing software, and were coded and analysed using Nud.Ist software. The interviews were analysed using domain analysis.

Of the eight participants, four were nationals of São Tomé and Príncipe, two of Angola, and two of Guinea-Bissau. Seven were female, and one male.⁷⁸ The participants ranged in age from 31 to 56 years, with a median age of 39 years. Seven of the participants were nurses, and one was a pharmacy technician. All had worked in public sector hospitals in their country of origin, with a median length of service of 14 years (range 4-20).

The participants' year of arrival in Portugal ranged from 1989-1998, and the median duration of residence in Portugal was 6 years.

Circumstances in Country of Origin

In order to understand the participants' personal circumstances prior to

⁷⁸ To enhance confidentiality, information about and quotations by the male participant have been edited to use female pronouns.

their decision to emigrate, participants were asked about working conditions at the hospitals where they were employed, about their personal economic circumstances, and about the general political and economic conditions in their country of origin.

WORKING CONDITIONS. The majority of participants stated that the hospitals where they had been posted prior to emigration had inadequate working conditions, but at least one participant from each of the three countries represented had been on the staff of a hospital or ward with adequate working conditions. The hospitals and wards described as having reasonable conditions received support from foreign donors (n=2), or had deteriorated since the time of independence (n=1).

. . . Things were good. There were linens for the patients' beds. I worked in the paediatrics ward where we had everything. There was food for the mothers. [. . .] We had a room for nurses where we could change our clothes, leave our things in the cupboard.

At the time, things weren't so bad. We didn't have a lot of [medical supplies], but it was enough to work.

Until [independence], there was everything. Some years later we still had stocks, but then we began to go without. I was chosen to work in the surgical theatre. There, we began to have some difficulties in [obtaining] material, but we got by.

Our hospitals didn't have [minimum] conditions. Many times a health professional would leave work and wouldn't have alcohol for disinfecting.

There was a shortage of medical supplies, but that shortage was for some, because those with financial means didn't suffer.

. . . We changed our clothes in the treatment room, and spent the night sitting on a chair. It was very difficult. The patients didn't have bed linens. [For] those who didn't bring them, we arranged a sheet somehow, and when they dirtied it they just laid there on the mattress. There were lots of mosquitoes there; conditions

were very bad; there was garbage in the hospital. There practically weren't cleaning staff, because the salary wasn't enough to survive. The few there were came in at 8 a.m., and at 1 p.m. they went home.

PERSONAL ECONOMIC CIRCUMSTANCES. All but one of the participants stated that the public sector salaries they received in their countries of origin were not sufficient to cover their basic living costs. Several participants said that their monthly pay funded less than one week's expenses. One noted that she often went months without receiving her pay.

A person working for the State in the area of nursing was not able to buy a decent outfit of clothing. If I did buy a decent outfit, then I wouldn't have money to buy milk for the whole month.

What I earned [from the State] barely covered transport.

If I had breakfast, I didn't have lunch; if I had lunch, I didn't have dinner.

People eat once a day. A person leaves work, makes do with a donut, a cup of milk or baobab fruit juice and nothing more, and waits up to 13 or 15 hours for a meal--until the next day.

Participants from Angola and São Tomé and Príncipe stated that their public sector salaries were adequate for basic living costs prior to 1989. Starting in 1989, inflation and currency devaluation eroded the purchasing power of their salaries to the point where they could no longer cover rent or other major living expenses.

In 1989 I earned 500,000 kwanzas, but at that time things got difficult, and that salary only bought fruit. Milk cost 70,000-100,000; a chicken was 25,000-50,000.

[After inflation surged and the value of the national currency declined], no one was able to manage the situation. Poverty

spread in such a way that a health professional working in the public sector could not survive.

Five participants described individual economic “coping strategies” they undertook to complement their public sector salaries. These strategies included working for a foreign-sponsored technical assistance project, selling food and drink, doing sewing, engaging in private practice, and working in a private clinic. For several participants, these “extras” provided more income than hospital jobs.

I sold beer at home, and food, because I had a big garden, with space where I could build another house. So I built a shack where I sold these things, and on the weekends I would go to sell at the fairground. Also, I did sewing. That is the money I spent during the month; it was quite a big struggle.

Even I, who worked in the hospital and worked part-time in another clinic, my salary didn't cover the whole month.

I did “extras” at home. [. . .] I set up a “mini health post” at home. I . . . attended to the [health problems of the residents] of the area [where I lived]. . . Beyond nursing, I did other things; I made cakes to order for parties.

GENERAL POLITICAL AND ECONOMIC CONDITIONS. When asked about their lives prior to emigrating, participants from Angola and Guinea-Bissau described hardships, fear and uncertainty associated with unstable political and economic conditions.

They have returned to war again. I don't know, only God knows [what will happen]. It is the big leaders who are provoking the war, and there we are.

Now there is war, even today it has begun [again]. I am here, but I feel so bad. It is just that I am a person who doesn't like to show my difficulties on my face. Today I phoned Dakar. I have two children there since the month of August. I spoke with them

and then I went to the supermarket, and someone said, "Did you hear the radio today? There was something about Guinea [-Bissau]. As soon as I got home [...] I turned on the television. [On the television news], there were a girl and boy crying and screaming in distress; I could even hear the sound of the bombardment. I was so distraught because I have a son there. [...] He said that he didn't want to abandon the house.

My husband worked, and we would buy a case of chicken when we could, and we kept it in the freezer. Sometimes the electricity would go out, and everything would spoil. To buy things in the black market, the price was triple or more.

Because of the conditions that the country was experiencing at the moment, no one could afford the price of a chicken or of a can of milk at the time, with the situations that were just getting worse in the country.

Emigration

REASONS. Most participants named more than one reason for emigrating. The reason most often cited was to improve their personal economic circumstances (n=5). Four participants cited marital issues - either to join a spouse in Portugal (n=2) or get away from an unhappy marital situation (n=2). Three participants said they emigrated in order to provide a better education and social environment for their children (n=3).

I came here on an official mission, but noting the situation in my country getting worse, I came with the intention to stay, because everyone has the ambition to live a better life. I took this risk; I was already a widow with six children, poor, coming from a very poor family.

Sometimes a person leaves that sacrifice that is work, arrives at home, [and] doesn't have bread to feed the children. Seeing that, I came here on an official mission and resolved to stay.

In the schools [in the country of origin], there is separation. The children of Ministers, of big entrepreneurs, of businessmen, have a school called the Portuguese School where they study French, English. These children have a different education from my child. These schools are normally private schools. My child goes to the State school and has a teacher who is not well trained. This teacher doesn't even know how to speak Portuguese. [. . .] So I saw that my child, who is the same age as the others, has an education different from the other children. With what I earn, I cannot pay for my child to go to the Portuguese School.

We are seeking a better social environment to offer to our children, a better education. In Africa, the teachers are always on strike. Because of the delay in receiving their pay, the teachers are on strike [. . .] So parents who are enlightened make the decision to emigrate, so that their children can have a better education than that in Africa. We have all come here seeking better conditions to offer to our children.

VISA STATUS AT TIME OF EMIGRATION. None of the participants had requested official permission to reside and work in Portugal at the time of emigration. Instead, they travelled to Portugal for holiday (n=4), to study (n=3), or to accompany a family member receiving medical treatment (n=1), and then remained.

Employment in Portugal

ATTEMPTS TO WORK AS A HEALTH PROFESSIONAL. Several of the nurses had applied for the official "equivalency" required for nurses with foreign training to be professionally recognised in Portugal. They had learned that to obtain equivalency they would need to complete the "12th year" (the last year of secondary school) and three years of nursing school. None of the participants had chosen to return to school.

For those who left school ten years ago, it's not logical. A person feels psychologically affected [when told to repeat nursing school]. [. . .] Even in Germany, which is more developed than

Portugal, they give you a chance. I have colleagues who went to France and Germany. They exercise their professions because they are given a chance. They ask you, "Did you do the nursing course?" A person responds yes, and they ask for the documents. Many don't even ask for the certificate. But they put you in an internship for 6 months to evaluate your capacity.

I never paid the 30,000 escudos [USD\$160] [to request an equivalency] because they were talking about the 12th year. I, already 40 years old, with three children. Life here is so hard; how could I study?

All the participants expressed anger and disappointment that they were unable to work as nurses (or, in one case, as a pharmacy technician). Discussion of professional humiliation and rejection and of the indignities experienced when attempting to work in their field predominated in the focus group and interviews to such an extent that it was difficult for the moderator and interviewer to lead the discussions into other topics.

I don't know why many times the African can't get a job here to use his technical knowledge. I feel very defeated because of this. The African has capacity, has technical knowledge. I don't know why it is that the African is not considered to have level of a nurse trained here in Portugal. Really, they say that Africans do a technical course and they do a superior course, but there is no difference.

[The Portuguese] don't value our training. For example, last week there was an inspection [at the nursing home] and we had to take blood for analyses. The nurse herself was struggling to tap a vein. [...] The patient herself said, "When I go to the hospital, they don't do it like that." I said, "Let me do this exercise." In a short time, I tied the garrote on the lady and got it right away. The patient said, "Sometimes people get mixed up. When I was admitted in Hospital E., there was a coloured lady there who was excellent at giving injections. Others would be sticking you on one side and the other, but the girl would arrive and you

would be set in an instant." I answered, "It's because here they don't value me, but in my country I worked for four years in Intensive Care, where it's life and death." Of course I know how to do it. I know how to defibrillate. But the whole time a person is here, she is stopped. Now I never do sutures, never defibrillate. What is the practice a person is going to have? Their training is going to die away. It's a shame; it's a shame.

They say that here in Portugal there is no racism, but if I were white I would already have a position [as a nurse].

The first day that I went to work [at a private clinic], an aide went to tell the boss that I was not be a nurse because I didn't know how to make a bed properly. Imagine; a person completes a nursing degree and is submitted to an exam in bed making. At the time, I had been a nurse for 20 years. I had been head nurse in the Intensive Care unit [of the capital city hospital] in my country.

[Not being able to work as a nurse] only brings psychological consequences for a person who thinks, and who has the power of reflection. Because everyone since childhood has been gaining knowledge, learning a profession in order to execute his profession correctly, to earn his bread each day, to help his family. Arriving here, we encounter certain obstacles, like not having documentation, asking for equivalency. With equivalency, they ask for [Portuguese] nationality, with nationality, they ask for other things.

PRESENT EMPLOYMENT. At the time of the interviews, none of the participants was working in her professional capacity.⁷⁹ Five participants were employed: two as aides in nursing homes, one as a cleaner, one as an aide in a community centre, and one as a manual labourer in civil construction. One of the unemployed participants had previously worked as a nurse in private

⁷⁹ Several months after the interviews, one of the unemployed participants, who had done her nursing training in Angola during the colonial era, received her nursing "equivalency" and began work as a nurse in a Portuguese health center.

clinics, but had been dismissed after a Work Inspection team found that she did not have an “equivalency.” Another participant had worked as a nurse in a Portuguese health centre on a short-term contract, but had lost her job when the Government instituted a policy prohibiting the hiring of public sector nurses on a contract basis.

Four of the five employed participants provided information on their current salaries. The salaries ranged from USD\$2,580 to USD\$8,000 annually, with a median of USD\$4,280. The participant who did not reveal her salary worked in civil construction. Personal communications with individuals familiar with this industry indicate that this participant’s annual salary is likely to be around \$8,400. If this were true, then the median annual salary of the five employed participants would be USD\$4,580.

Several of the participants described the working conditions at their actual places of employment as exploitative, principally because they were often required to work extra hours for which they were not paid. One participant noted that she had an appointment to see a doctor but feared that she would have to miss it because her employer would not allow her to be absent from work.

My work schedule is from 8 a.m. to 4 p.m., but many times I leave at 6 p.m. The boss doesn't pay me extra hours. [. . .] I live in the midst of confusion, and many times I arrive at home and say that I will not go to work the next day. My mother, my children always say, “Go [to work], because if not you will have to return to the cleaning service [. . .]”

My schedule is from 8 a.m. to 4 p.m. When 4 p.m. comes along, or 3:50 p.m., [they tell me] I have to [accompany a nursing home patient] to the hospital, and I know I am going to have to stay there a long time. [. . .] They know that the hospitals always take a long time. If I leave [the hospital] at 9 p.m. they don't pay me; they always say, “She stays at the hospital [a long time] because she wants to.”

Most of the participants raised the issue of instability in their employment due to the fact that they work on temporary contracts and lack of social security benefits—particularly short-term disability insurance.

If [my bosses] don't like me, when the contract ends they can throw me out on the street.

They can throw us out when they want to. They always have nurses willing to work for them. We don't have any other option [but to work in the nursing homes]. The hospitals don't want us. We have to put up with it, or go work in cleaning services, which is another kind of exploitation—leaving the house at 5 o'clock in the morning or 4 o'clock.

Return to country of origin

When asked about returning to their countries of origin, the participants acknowledged the difficulties of life in Portugal compared to that in their countries of origin, but also re-iterated the reasons they decided to emigrate. None expressed a firm intention to return.

The standard of living which I had back home and that which I have here are so different, in all aspects, principally at the family level. Because here I live only with my nieces. I have a child here who is in [a provincial city in Portugal] and only comes every two weeks. The older [child] is living in his house. [Back home], I had my work, I exercised my profession. But here, no. This situation worries me. I left for matrimonial reasons and because of that, I must deal with the situation I encounter here. Because I can't go back, no. One day I should return because it is my homeland. I wouldn't like to stay here as an old person; however I will not return because I want my husband to forget about me, to arrange another [wife] so that I can return. If I were to return now, he would begin to put pressure on me.

I tell my colleagues in [country of origin] that they are [surviving on their salaries] through a miracle.

Here life is more agitated. There, I liked [the work] I did. I had a more relaxed life. Whereas here, it's the opposite. I am not

satisfied with what I'm doing [professionally] and on top of that a more agitated life and the struggle to survive.

Participants were asked under what conditions they would consider returning to their countries of origin. Economic stability was the most often cited pre-requisite for return. One participant said that if a technical assistance project in his country of origin were recruiting personnel, she would return.

Discussion and conclusions

For the interview participants in this study, inadequate salaries, family reasons, and education of their children were the principal immediate factors, which caused them to emigrate from their countries of origin. In most cases, a combination of two or more of these reasons applied. This suggests that for these health professionals the decision to emigrate—like most major personal decisions—is multiply determined. One implication for policy-makers of the causal complexity among factors spurring emigration is that the marginal effect of policy reforms addressing one or more of the multiple determinants of emigration may be sufficient to retain some proportion of health professionals, even when other determinants of emigration are present. For example, improving educational opportunities for the children of health professionals may reduce brain drain even when salaries remain low and other family-related reasons for emigration remain unaltered.

All of the interview participants in this study had had to abandon their professions after immigration. The employment they were able to obtain in Portugal was generally unskilled (nursing home aide, cleaning service), and offered few social security benefits and no long-term security. Six of the eight participants were earning more than the national minimum wage of \$3,850 annually.

When asked about their views regarding their decision to emigrate, the participants expressed vehement indignation at the Portuguese legislation and bureaucracy, which they felt, was unfairly preventing them from working in their professions. The participants' comments revealed the degradation they felt in going from high-status (albeit low-paid) professional roles in their countries of origin to low-status jobs in which they have little control over their environment and are treated with little respect by their bosses and colleagues. It is clear that the participants were struggling to cope with the discordance between their present realities and the professional ethic

and pride they had developed in as elite in their countries of origin (as expressed in statements such as “nursing is universal,” and “the class of nursing is a class that we have to defend at every moment of our life”).

The results of this study offer little encouragement for Ministries of Health seeking ways to encourage the return of health professionals who have emigrated. Given the difficult conditions in the study community and the inability of the participants to secure work in their professions, it is reasonable to view these participants as among the more likely to return than, for example, other emigrants who had succeeded in working in their professions. Yet none indicated any concrete intentions to return. Even direct questions about the conditions, which might motivate them to return, stimulated only a vague response about returning “some day.”