EMIGRATION OF NURSES FROM THE CARIBBEAN: THE CASE OF TRINIDAD AND TOBAGO

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Introduction

Migration in the Caribbean has a long history. The slave trade in the 17th and 19th centuries caused the first major immigration waves into the region. After Emancipation in the early nineteenth century, agricultural workers from India were brought to Trinidad to fill in the gaps which the abolishment of slavery had left in the labour force on the plantations. The end of slavery increased the demand for workers in the entire region and consequently more people began moving within the region in search of employment or better working conditions. In the twentieth century, the movement of labour to destinations outside the region increased, particularly due to close ties with the colonial powers. With the move towards independence in the 1960s and 1970s, chances to easily move to Europe decreased. However, other windows of opportunities to reach "greener pastures" in the developed world opened: the rising demand for highly qualified people in North America and the United Kingdom has been triggering a mass exodus of professionals over the last 50 years.

Based on the most recent estimates provided by the United Nations Population Division (United Nations, 2002a) the Caribbean has lost more than five million people over the last 50 years. The present net-migration rate[1] for the Caribbean is one of the highest worldwide, however, with a great variation within the region.

Recent global and regional agreements supporting the free movement of professionals enhance these trends. The entry into force of the General Agreement on Trade in Services (GATS) in 1995 provides the framework for further liberalization of cross-border movements of professionals. The Caribbean Single Market and Economy (CSME) is currently implementing regulations for free cross-border travelling of professionals. Nurses holding a Caribbean Community (CARICOM) license[2] can practice their profession in virtually any member State

[1] *Net migration*: Net average number of migrants: the annual number of immigrants less the number of emigrants, including both citizens and non-citizens. *Net-migration rate*: *The net number of migrants,* divided by the average population of the receiving country. It is expressed as the net number of migrants per 1,000 population. (Population Division of the United Nations Secretariat, International Migration, Wallchart, 2002, ST/ESA/SER.A/219, Sales No. EO3.XIII.3).

[2] Nurses in the Caribbean write a common final nursing examination referred to as the 'Regional Nursing Examination'.

desired and are even recognized to register with the Nursing Council in the United Kingdom. The Free Trade Area of the Americas (FTAA) framework also includes a chapter on services which discusses the cross-border movement of the skilled and trained.

The departure of the best affects the sending countries in many ways. For those with a surplus of labor, emigration provides access to employment which could not be offered at home. Moreover the inflow of remittances is often welcomed as a boost to the national economy and the enhancement of skills of return-migrants is considered by many as an important asset of migration.

However, smaller islands and developing countries like the Caribbean Small Island Developing States (SIDS) can barely cope with the negative consequences of the loss of their best. Deprived of their teachers and health professionals, many nations are no longer in a position to improve or even sustain the quantity and quality of public services delivered.

Last but not least, migration affects the individual as well as his immediate family network. Particularly stunning is the impact on the social and psychological well-being of children left behind by migrating parents. These children often suffer the loss of one or even both parents, while being cared for often in a rather unstable environment of older siblings, grandparents or other relatives or a combination of such arrangements.[3]

The present paper examines the emigration of nurses from the Caribbean SIDS over the last 50 years, focusing on the situation in Trinidad and Tobago. It will make an attempt to assess the scope of the outflow of nurses by drawing on data available in Trinidad and Tobago and in the two main destination countries, the United States and the United Kingdom. The main push factors triggering this mass exodus along with the various counteracting strategies adopted will be presented. To get the complete picture various pull factors in the receiving countries will be analyzed. Since the emigration of the skilled is not a new phenomenon and its implications on the developing countries are becoming increasingly severe, various efforts have been undertaken at the regional, as well as at the global level to address this imbalance in order to find viable solutions for all parties concerned. The economic implications of the emigration of health professionals will be studied using a model currently developed by the World Health Organization (WHO). Based on the findings of this analysis, policy recommendations will be formulated for use as a guideline for concerned policy makers at various national and international levels.

DATA AVAILABILITY AND DATA QUALITY

The collection of data on migration is one of the most difficult and tedious tasks demographic and social research has to accomplish. Even with the existence of immigration rules and regulations to control and

[3] The University of the West Indies has conducted a study on the impact migration on children: Adele Jones, Jacqueline Sharpe, Michele Sogren (2003), "Children of Migration, A Study of the Care Arrangements and Psycho-social Status of Children of Parents who have Migrated", St. Augustine, Trinidad and Tobago, W.I.

track the movement of people, coherent and consistent data on migration are generally not available. Global estimates and projections on migration are published every two years by the United Nations Population Division (United Nations 2002a). These data provide a general overview of migration stocks with no further breakdown for immigration and emigration. Further more, no global statistics are available on recurrent movements, return migration or on the socio-demographic background of those concerned.

Attempts to coordinate and streamline research on migration have been hampered by inconsistent concepts to define international migration (United Nations 2002b). Basic criteria used to identify migrants are citizenship, residence, time or duration of stay, purpose of stay and place of birth. The most widely, but rather loosely defined concept is that of residency; but also legal nationality is used as an identifying factor. However, data based only on the citizenship of a person will not capture naturalized migrants, which will lead to an undercount of the actual number of immigrants in any given country.

Since in most countries immigration is much more controlled and monitored than emigration, better and more accurate data are available on immigration than on emigration. Generally information on migration can be drawn from various registers, such as the national census bureaus, labour-force offices and other official sources dealing with visa applications, work-permits and professional registration. Other valuable data sources are household surveys, labour-force surveys and surveys of living conditions and special studies on the theme. Censuses and household surveys provide data on the migrant stock in a given country. However recurrent migration as well as out-migration of whole families or individuals with no further ties to the country of origin is not covered. Censuses do not capture the full picture either, since only those registered are counted and only occasionally information is collected on the country of origin, the time spent in the host country, years worked in the profession and other demographic related aspects. Data collection for a specific subgroup within the migrant population, such as nurses, is even more difficult when they come from small countries and therefore quite often data at the country level are not provided. In addition, many data based on census as well as registration data often do not list nurses as a separate professional group, but they are included in the larger group of health professionals or 'service providers'.

Additional sources need to be tapped to estimate emigration data from the source country. Past and present nursing vacancy rates in hospitals, community health centers and other health facilities serve as proxy-indicators to capture out migration. However, these data are also quite often inaccurate since vacant posts can either be held by temporary employees, or may not be intended to be filled at all and therefore not counted as vacant. At the destination country, professional bodies collect data on entrance exams to qualify for working visas or residence. Such registers are useful sources for data on selected professions.

Apart from the lack of adequate data, access to census and registration data at the sending as well as at the receiving country is often restricted. This is due to either the lack of resources to process the required data further or as a result of legal restrictions prohibiting the release of certain information.

Given the outlined constraints and limitations in the availability of data, any

assessment of the scope of migration as well as its impact on the sending as well as receiving countries will remain a challenge for all parties involved.

Emigration from Sending Country

Nurses Emigrating: 1960-1980

The earliest data available are drawn from a study conducted by the United Nations Institute for Training and Research (UNITAR) under the auspices of the Central Statistical Office in Trinidad and Tobago (CSO 1970). This study was conducted at a crucial point in the history of Trinidad and Tobago. Until the 1960s, Trinidad and Tobago was an immigration country with more people entering than leaving the country. This changed in the early 1960s, when for the first time more departures than arrivals were registered. Increased emigration of the better-educated segments of the population and the emerging brain-drain in certain sectors such as health and education had become evident. This survey already identified the major problems in nursing in the public health system that are now culminating in the present nursing crisis. These were higher salaries, better working conditions and generally more favorable conditions for further education and professional advancement. Also growing racial tensions and increased political instability at home in the 1960s and early 1970s supported such a decision.

The study states that, in spite of the requirement to serve a two-year bonding period after graduation, many nurses left the country after graduation. Of all students who had graduated over the five-year period between 1960 – 1964, by 1969 almost 60 per cent had emigrated, 73 per cent had gone to the United States, 8 per cent to the United Kingdom, 13 per cent to Canada and 6 per cent to other countries. The following table provides a summary of the findings of the report.

Table 1
Distribution of Resigned Nurses by Country of Present Residence (August 1969) and Year of Graduation

Graduation	No. of graduates	Emigrants (total)	Emigrants (%)	Destination				
				Abroad				Trinidad & Tobago
				U.S.	U.K.	Canada	Other	Private Practice and Other
1960	64	39	61	32	3	4	-	3
1961	86	51	59	39	7	5	-	3
1962	107	66	62	49	1	14	2	2
1963	83	47	57	34	7	6	-	
1964	119	66	55	43	2	6	15	2
Total	459	269	59	197	20	35	17	10

Source: Central Statistical Office 1970: 28.

Data drawn from a survey, the second study available (Ministry of Health and Environment, 1980) conducted in the 1970s concluded that during 1976 - 1980 fewer nurses had left the country. Still, in total about one-third of all graduates had actually resigned from their duties in the public health sector to take up a position abroad (Table 2).

A look at the main factors depleting the nursing workforce clearly singles out retirement and resignation as the main causes. Both drew on the older and more experienced nurses. According to the data presented, resignation from the public health system in order to follow job opportunities abroad was the major

Table 2. Annual Loss and Gain of Nurses, 1976-1980

Year	Retire-ment	Emigration (as parth of Resignation)	Retire-ment	Death	Total Loss	No Graduated	Net Gain
1976	15	2	1	0	16	100	84
1977	13	0	8	0	21	63	42
1978	8	0	9	1	18	92	74
1979	27	5	10	1	38	120	82
1980	34	2	20	6	60	113	53
Total	97	9	48	8	154	488	335

Source: Report on the Second Quantitative and Qualitative Survey of Nursing Needs and Resources 1980, Table 20, p.38.

contributor to the nursing crises. The realistic chance of finding more attractive and rewarding work abroad had been a major reason for resignation in the 1970s. Therefore it is assumed that the estimated numbers provided are too small and more nurses than accounted for in this report have left the country in search of a better life abroad.

No data on the emigration of nurses are available for Trinidad and Tobago for the last 30 years. The most recent figures provided by the Ministry of Health for the year 2002 indicated that 120 nurses had resigned or retired and a total of 179 nurses were recruited. However, more information about recent migration trends can be derived from data published in the United Kingdom and in the United States.

Data on Migrants from Receiving Countries

Data from the United Kingdom

Two major sources in the United Kingdom provide data on foreign nurses: The United Kingdom Nursing and Midwifery Council (NMC) and the Work Permits United Kingdom Office in the United Kingdom Home Office Immigration and Nationality Directorate.

The Nursing and Midwifery Council (NMC)

The NMC is the regulatory body for the nursing profession in the United Kingdom. Prior to working as a registered nurse or midwife in

the country, registration with the NMC is mandatory.[4] This register only accounts for qualified and licensed registered nurses and does not cover the unregistered unqualified workforce that is employed as nursing assistants or auxiliaries.

However, there are limitations in using these data to monitor inflows into the United Kingdom, since this data do not provide any information whether the nurse has actually entered the United Kingdom and if she in fact has taken up employment as a nurse. Some double counting is possible, since nurses might apply to more than one part of the register (a nurse who is also a qualified midwife may also at the same time apply for registration as a midwife at the NMC register). Information concerning the country of initial training is collected, but this may not be the country of origin. The latter could cause under-reporting of nurses of certain nationalities and consequently over-reporting of those countries providing training to foreign nurses.

Recent data on foreign nurses registered (NMC 2002) point to an enormous increase in the number of overseas-trained nurses and midwives registered over the last years. The 'top 20' list of the leading source countries is led by the Philippines, South Africa and Australia. On this list, the West Indies region is the eighth largest provider with 248 nurses for the year 2001/ 2002.

The following table (Table 3) gives an overview of the number of nurses from the Caribbean that has been registered with the NMC from 1998 - 2002.

Table 3
Registered Caribbean Nurses in UK, 1998/99-2001-2002

Year	Number
1998/99	221
1999/2000	425
2000/2001	261
2001/2002	248

Source: The Nursing and Midwifery Council (2002); Statistical Analysis of the Register 1 April 2001 to 31 March 2002 United Kingdom.

Work Permits in United Kingdom

All applicants from outside the United Kingdom who wish to take up employment in the United Kingdom are required to obtain a work permit.

The following table (Table 4) presents an overview of the number of nurses and midwives from Trinidad and Tobago who have applied for work permits from 1995 to 2002.

Table 4
Work-permit Applications for Nurses and Midwives from Trinidad and Tobago, 1995 - 2002

Year	Nurses	Midwives
1995	233	30
1996	268	31
1997	239	36
1998	313	31
1999	498	38
2000	427	40
2001	362	31
2002	335	25
Total		

Source: Unpublished data, Work Permits United Kingdom, e-mail received on 14 April 2003.

[4] Re-registration is mandatory every three years.

As is the case for registration data, until the year 2000 a clear upward trend in the numbers of work permit applications for nurses and midwives can be observed. After 2000, fewer but constant numbers of nurses have applied for work-permits. The applications for the year 1999 to the year 2000 and from the year 2000 to 2001 decreased by 14 per cent and 15 per cent, respectively, which might be due to the impact of the adoption of the Code of Conduct by the Commonwealth of Nations (see pp. 45-48).

Data from both sources (the Council for Nursing and Midwifery (CNM) and Work Permit are not fully compatible since permit data cover a calendar year whereas CNM data report on an annual cycle beginning 1 April and ending on 31 March. Also, permit data refer to the date when the individual became eligible to work in the United Kingdom whereas CNM data only indicate the year of registration. None of these data provide any information if and when a person has actually started to work.

Data on Migration from the United States

Capturing data on migration of nurses and midwives to the United States is a complex task since there is no central register to keep track of foreign nurses employed in the country. The main sources for data on foreign nurses in the United States are the registers of the Commission on Graduates of Foreign Nursing Schools (CGFNS) and the National Council of State Boards of Nursing (NCSBN). The CGFNS exam is a mandatory requirement to file an application for a working visa or a green card. It basically verifies a candidate's credentials to judge whether a foreign qualification is equivalent to what a United States nursing graduate has received. Most States require a nurse to pass the NCSBN licensure exam (NCLEX) in order to obtain a license to practice nursing in that particular State.[5]

Data collected by CGFNS and NCLEX provide information on how many foreign nurses took the exam, but it is difficult to conclude, based on this information alone, if and when a successful candidate has taken up a job in the United States. However, since it may take one to two years to actually complete the formal procedures required, even the intention to migrate can hardly be used as a proxy indicator to assess the scope of emigration over a certain period of time.

Table 5 provides data on Registered Nurses (RN) and Licensed Practical or Vocational Nurses (LPN) who have taken the NCLEX exam in the years 1997 – 2000. Over the four years for which data were made available, 84 nurses from Trinidad and Tobago had taken the licensing exam and more than 50 per cent of the candidates had passed the test at their first attempt.

According to figures provided by the Commission on Graduates of Foreign Nursing Schools, 17 nurses from Trinidad and Tobago have sat the CGFNS exam in the five years from 1998 to 2002 and 40 per cent (7) have actually passed the test.[6]

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[5] For more information on CGFNS and NCSBN see pp. 45-48.

[6] Unpublished data received from CGFNS by e-mail on 15 May 2003.

Table 5
Number of First-time Candidates from Trinidad and Tobago Taking the NCLEX-RN or NCLEX-LPN Exam

Candidates	1997		1998		1999		2000		1997-2000		1997-2000	2000-2001
	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	Total	Total*
Examined	3	18	3	15	2	15	6	32	14	80	84	166
Passed	2	8	2	6	2	7	4	17	10	38	48	77
Passed %	67	44	67	40	100	47	67	53	71	48	57	46

Source: National Council of State Boards of Nursing Licensure and Examination Statistics, Annual Reports for the years 1997 – 2000 accessed on the internet http://www.ncsbn.org May 15, 2003.

Data provided by CGFNS e-mail communication 15 May 2003.

NURSING WORKFORCE IN TRINIDAD AND TOBAGO

Education and Training of Nurses in Trinidad and Tobago

Basic Nursing Training

Since 1919 the Ministry of Health and the Nursing Council have been offering apprenticeship programmes to provide basic nursing training.

In the mid-1980s it was found that the country had more trained nurses than the system could absorb and consequently the government decided to suspend basic nursing training in 1986. Already a few years later, in response to shifting health care needs and changing local and international trends, the development of a coherent and more formal and academic nursing education programme became a priority. This led to the establishment of the College of Nursing in 1990, which presently is a member institution within the College of Science and Technology and Applied Arts of Trinidad and Tobago (COSTAATT). The facility presently has the capacity to take in 90 students annually. This institute offers general as well as psychiatric nursing training at three locations in the country. These are the General Hospital in Port of Spain, the South Learning Center in San Fernando and the St. Ann's Learning Center at St. Ann's Hospital in Port of Spain. On successful completion of either of these programmes the graduate is awarded an Associate Degree in Science in General or Psychiatric Nursing.

In order to fill in the gaps resulting from the strong emigration flows of qualified nurses, the Ministry of Health in 2000 decided to resume the three-year apprenticeship programme.

The following tables present estimates on present (Table 6) and future nursing students (Table 7) and graduates trained at COSTAATT and through the apprenticeship programme from 1999 until 2008. Based on figures from the Ministry of Health, an estimated 1,695 student nurses would have been enrolled in both programmes between 1999 and 2005 and an estimated total of 1,779 students would have graduated between 2000 - 2008.

Table 6
Basic Nursing Student Population, 1999 – 2005

Institution	Year of Entry							
	1999	2000	2001	2002	2003	2004	2005	Total
College of Nursing, COSTAAT	158	126	90	100	150	300	300	1224
School of Nursing, MoH	-	120 (-9*)	- -	180 50**	130 40***	-	-	471
Total	158	237	90	330	280	300	300	1695

Source: Ministry of Health, and Environment Nursing Division 2002a: 98.

** Psychiatric nursing students.
*** Certified Midwives.

Table 7
Projected Graduates 2000 – 2008

Institution	2001	2002	2003	2004	2005	2006	2007	2008	Total
College of Nursing, COSTAAT	84	158	126	90	100	150	300	300	1308
School of Nursing, MoH			111		230	130			471
Total RN+RM	84	158	237	90	330	280	300	300	1779

Source: Ministry of Health, Nursing Division 2002a: 19.

Advanced Training for Nurses

Post Basic Education Certification Programmes

In addition to administering the basic nursing education programme, the Ministry of Health also bears responsibility for conducting post-basic nursing education. These programmes are administered by the School of Advanced Nursing Education at the three major hospitals in the country.

The School of Advanced Nursing Education provides various post-basic certification programmes for registered nurses, which are district nursing, neonatal nursing, operating theatre nursing, community mental health, dialysis, midwifery, pediatric nursing, intensive-care nursing and trauma and emergency care. Two programmes are available for Enrolled Nursing Assistants (ENA), which are training for scrub technician and home care nursing. ENAs can also participate in a midwife certification programme.

Advanced Academic Education

The University of the West Indies, Faculty of Education, offers a Certificate of Nursing Education/Administration and a Community Health Visitors training programme.

The establishment of a BSc Nursing Programme at the St. Augustine Campus at the University of the West Indies in Trinidad is currently being discussed. The degree is aimed at building on the foundation provided by the basic education programme to enhance and develop skills and knowledge applicable to present nursing practice, nursing education and nursing management. The programme intends to train 30 students per year as nurse practitioners/ clinical nurse specialists, nurse educators and nurse managers.

Issues of Critical Concern in Teaching

According to information provided by the Chief Nursing Officer at the Ministry of Health the present shortage of qualified teaching staff impacts on the quality of the training provided as well as on the number of students to be admitted. Out of 34 positions for nursing instructors, half were vacant in 2002 and the remaining posts were partly filled with temporary assignments. The situation for clinical instructors is even worse, since 80% out of 22 positions were vacant in 2002. As a result of a teaching staff shortage and inadequate classroom accommodation, less students than actually planned could register for nurse education in the years 1999 and in 2001.

Supply and Demand in Nursing

Data on vacancy rates in hospitals and health care centers for the year 2000 indicate an acute shortage of nurses. On average only every second nursing post was held by a professional nurse. The other half of the posts is either vacant or filled with retirees or with less qualified support staff. Important to note is that not all health-care facilities in Trinidad and Tobago are affected in the same way. Generally, the community health care facilities are less strained than other facilities.

According to information furnished by the Ministry of Health, half to two-thirds of all head nurses posts in the country were vacant in 2000, with the most severely affected hospitals being the Port of Spain General Hospital (68 %), San Fernando General Hospital (64%) and the Caura Hospital with only less than a quarter of its head nurses posts actually filled (23%) in 2000.

Even if the overall situation at the community level seems to be less dramatic than in the hospitals, the overall 30 per cent shortage is severely impacting the service delivery capacity in the district health facilities. Therefore, services are mainly provided at community health facilities and only limited health visits to schools and to private homes can be undertaken.

More recent data (Ministry of Health and Environment 2002a) for the year 2002 indicate a slight improvement in the general staffing situation in hospitals, but with still an overall vacancy rate of approximately 40 per cent.

The report suggests the following explanations for these slight improvements:

- Availability of College of Nursing graduates
- Increased numbers of nursing assistants employed
- Reassignment of certified midwives from maternity units to hospitals
- Reduction of foreign recruitment of nurses as a result of international policies (Code of Conduct in the

United Kingdom)[7] and the policy changes in the United States as a consequence of the events of 11 September 2001

- Employment of additional PCAs (Patient Care Assistants)
- To a limited extent, employment of returnees and retirees
- Payment of a retention allowance and an increase in salaries.

The conditions of staff supply at the community level however did not improve. Trained community health staff were not released from the hospitals and increasing numbers of nurses have been retiring.

Presently workforce data are only available at the institutional level with no further breakdown for smaller entities. To efficiently plan and manage the labor force, the use of a modern human resources management system is crucial.

Future Staffing Needs

The data provided by the Ministry of Health on future staffing needs were estimated based on present vacancy rates and estimated future retirement and attrition rates. Generally present vacancies as well as projected retirement rates can be easier estimated whereas resignations are by far more uncertain and thus less accurate to model.

The following assumptions were made to forecast the future needs:

Table 8
Projected Demand for Nursing Personnel for 2005

Category of Staff	Total Staff (estimated)	Retire-ment	Vacancies Dec. 2001	10% Attrition	Total Points	Total Demand	Demand as % of Total
Reg. Nurses/ Midwives	1450	234	1093	145	2543	1472	58
Certified Midwives	50	26	65	5	115	96	83
Health Visitors	100	41	53	10	63	104	68
District Nurses	80	9	17	8	25	34	35
Nurses Educators	50	7	20	5	25	32	46
Enrolled Nursing Ass.	1380	175	326	138	464	639	37
Nurses Aids	190	19	7	19	26	45	23
TOTAL	3300	511	1581	330	4881	2,422	50

Source: Ministry of Health, Nursing Division 2002a: 17.

[7] For more information on the Code of Conduct and other global strategies to curb nurse migration from the regions see pp. 45-48.

(a) About one sixth of the nursing personnel workforce (as of December 2001) at hospitals would have retired by 2005 and

(b) Ten per cent of the present nursing staff (as of December 2001) would have left the public health sector prior through retirement by 2005.

Based on these assumptions the following needs were projected for the year 2005 (Table 8).

The table above provides an overview of the present staffing situation and the projected future needs. The Ministry of Health suggests that the gap of 1,472 vacant posts (column 7) could be filled mainly with graduates from the domestic nursing schools. This will not solve the staffing problem, since retirement and emigration draw on more senior and experienced nurses and new graduates from basic training programmes cannot be expected to have the same capacities.

In spite of the fact that no systematic analysis of the impact of the staffing shortage of qualified nurses has been conducted in the country, there is evidence that the loss of skilled health professionals is seriously impacting on the efficiency of the public health system. Wards need to be merged and part-time staff and nursing students are used to fill the gaps.

PAST AND PRESENT GOVERNMENT POLICIES TO ADDRESS NURSING CRISIS

Problems Identified and Policies Adopted in the 1960s

The UNITAR study (CSO 1970) on the emerging brain-drain already identified the changing patterns in migration and the transition of the country from an immigration to an emigration country. For most of its history, Trinidad and Tobago has been an immigration country.

To stem the outflow of nurses various policies to improve the overall work-environment were adopted. Salaries were raised and more advanced training institutionalized and efforts were made to institutionalize bonding. To provide relief to the overworked labour force in the public health sector foreign nurses were recruited.

However, already in the 1970s it appeared that any actions, short of repressive measures would not suffice to counter the strong pull factors attracting people to the large rich countries in the North.

Problems Identified and Policies Adopted in the 1970s and 1980s

The survey on nursing needs (Ministry of Health 1980) conducted in the 1970s could identify areas where improvements had been made. More advanced education had been institutionalized and better pay and entitlement packages were offered. Based on the International Labour Organisation (ILO) recommendations, the work-week was regulated and sick and compensatory leave for nightshifts had been introduced in 1974. To relieve nurses in hospitals and health centers, more nursing assistants were hired.

While progress had been made in selected areas, the major weaknesses identified earlier persisted and new problems, such as the ageing of the workforce, had begun to emerge.

In some cases good intentions resulted in additional problems. For example, the enhanced entitlements for leave meant a decrease in the

number of nurses available for patient care and consequently a heavier workload for the fewer nurses on duty. Lack of career-opportunities and the failure to recognize experience and qualification as a basis for promotion contributed further to the frustration of nursing staff. Another negative aspect identified was a weak administrative system with no clearly defined lines of authority and accountability.

In spite of the persisting problems in human resource management, it seems that in the early 1980s working conditions had somewhat improved and better payment schemes and revised benefits packages became increasingly attractive to nurses in the country as well as abroad. The global economic recession in the 1980s and the declining resources available for the public health sector in the developed countries possibly decreased the chances for nurses to find work abroad. Thus staying or even coming back became an attractive alternative. This led to an oversupply of nurses in the 1980s and consequently the government decided to suspend basic training programmes for nurses in 1986.

Recent Policies

In the framework of the comprehensive health sector reform, which Trinidad and Tobago embarked on in 1994, the loss of qualified health professionals was identified as a major concern. This reform process aimed at the:

(a) Development of modern management systems within a decentralized model of health services

(b) Overhaul of the national training programme and address the need to retrain qualified staff

(c) Upgrade the primary health care facilities countrywide to increase the range, quality and quantity of services offered.

Strategic Plan for Nursing and Midwifery, 2002-2007

In line with the Health Sector Reform, the Strategic Plan for Nursing and Midwifery designed in 2002 by the Ministry of Health (Ministry of Health and Environment 2002b) aims to address the strategies for its improvement. The main weaknesses identified were:

- Lack of infrastructure
- Absence of autonomy in the management of nursing affairs
- Lack of retention policies and programmes
- Lack of professionalism
- Need to improve quality in nursing education and practice
- Staff loss due to external recruitment.

To efficiently and effectively address the current staffing crisis in the public health sector and to improve the services rendered by public health facilities, the report suggests that the following critical areas should be addressed and the suggested corrective measures should be put into place:

(a) The five-year strategic plan for nursing and midwifery adopted in 2002 aims to improve human resource management by establish-

ing a system for identifying, monitoring and forecasting the nursing and midwifery workforce. In particular, a nursing and midwifery human resources database and an automated workload management system plan was to be implemented in 2004. To further improve human resource management performance-based appraisal review systems and career development schemes need to be established.

(b) The plan promotes the development of national policies and plans to strengthen the nursing and midwifery profession by promoting the participation of nurses and midwives in the policy formulation, implementation and monitoring process and to advocate public-private partnerships in the formulation of national health policies.

(c) In order to provide adequate numbers of nurses, midwives and other nursing personnel with the competencies to meet the health care needs, a series of initiatives is envisioned. Among those are an overhaul of the education and training system, enhancement of general working conditions along with improved benefits and pay. Human resources development management is a core element in the strategies outlined.

Further initiatives to address some of the difficulties under which nurses are performing their duties are currently being developed by the Chief Nursing Officer. These are the provision of professional counseling services to nurses in crisis situations and the establishment of a mentor system to provide guidance, particularly to younger nurses.

Health Services Quality Act

The draft version of the Health Services Quality Act (Ministry of Health and Environment 2003), is being discussed by national policy makers and health professionals. Suggestions to improve the present human resources management system in the public health sector are being outlined in the section on 'Model Regional Health Authority By-Laws, Part 7'.

GLOBAL IMBALANCE OF THE HEALTH WORKFORCE AND INTERNATIONAL RECRUITMENT

Supply and Demand of Qualified Nurses in the United States and United Kingdom

The ageing of the workforce, declining enrolment ratios in nursing schools, concerns about working conditions and growing numbers of "burnt-out" senior nurses resigning from the job are contributing to the inability to meet the demands of staff in the public health sector in the developed and, increasingly, in the developing world. Low pay and little recognition of the profession as well as steadily increasing workloads for those remaining make it difficult to attract new staff to the profession and to retain those already on board. Consequently, high nurse turnover and increasing vacancy rates are affecting access to health care services. Many hospitals are in the process of merging units and understaffed units are being closed down. Certain treatments cannot be provided and waiting times for others increase considerably. Changing demographic and epidemiological conditions even further expand the demand for nursing services and thus increase the stress on those who are currently in the system. Nursing has become less attractive since more rewarding

career opportunities have become available for women that, apart from better pay and better status, also make it easier to combine work and family life.

Supply and demand projections for nursing personnel in North America and in the United Kingdom show wide gaps which cannot be filled with the domestic supply of nurses. The Human Resources and Services Administration (HRSA) of the United States Department for Health and Human Services estimated the supply of registered nurses in the United States at 1.89 million while the demand was estimated at 2 million,[8] a shortage of 110,000 or 6%. Present trends in the supply of registered nurses will not meet the anticipated demand, thus the shortage is expected to grow considerably over the next 10 – 20 years and will, if current trends continue, reach about 30 per cent by the year 2020. The same report suggests that presently 30 States in the United States are estimated to experience a severe shortage of registered nurses. This shortage is projected to intensify over the next two decades with 44 States expected to lack the nursing resources needed by the year 2020.

Other data point to the same direction. According to American Hospital Association's figures,[9] 75 per cent of all hospital personnel vacancies are for nurses and 126,000 nurses would have been needed in 2001 to fill the present vacancies in the United States hospitals. Figures released by the National Council of State Boards of Nursing clearly show that the number of first-time United States-educated nursing school graduates who sat the National Council Licensing Examination for Registered Nurses (NCLEX-RN)[10] for all entry-level registered nurses, decreased by 28.7 per cent in the six years from 1995 to 2001. A total of 27,679 fewer candidates took this test in 2001 as compared with 1995. Projections from the United States Bureau of Labor Statistics published in November 2001 in its Monthly Labor Review show that more than one million new nurses will be needed by the year 2010.

Data from the United Kingdom suggest similar shortages. A survey[11] conducted by the Office of Manpower in the United Kingdom in 2001 reported that employers in England and Wales had serious difficulties with the recruitment and retention of qualified nurses and midwives. Therefor international recruitment is considered a rather successful and cost-effective solution to these pressing shortages.

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[8] US Department of Health and Human Services, (HRSA), July 2002, Projected Supply, Demand, and Shortages of Registered Nurses: 2002-2020, Washington.

[9] *TrendWatch*, American Hospital Association, June 2001.

[10] For more information on the NCLEX-RN exam see p. 43.

[11] Office of Manpower Economics annual survey (2001). Published in Review Body for Nursing Staff, Midwives, Health Visitors and Professionals Allied to Medicine Nineteenth Report, December, London.

National Strategies in United States

Numerous efforts have been undertaken to increase the attractiveness of the nursing profession. Various advocacy initiatives have been launched by different health care groups in the public and private sector to promote nursing.[12]

Apart from strategies adopted to mobilize the national workforce, various policies are currently under review to attract foreign nurses to the United States labour market. Since the early 1990s the United States public health system has been depending on the recruitment of foreign nurses to solve the acute domestic nurse shortage and to be in a position to continue to provide efficient and reliable public health services. With the growing gap between domestic supply and demand, various efforts have been undertaken to draw on foreign-trained health professionals. There are mainly two ways for a registered nurse to gain access to the United States labour market, either by applying for a temporary visa to work as a registered nurse in a disadvantaged area (H-1C Visa) or to pass licensing exams to qualify for long-term or permanent residency.

H-1C Visa for Nurses in Disadvantaged Areas

The Nursing Relief for Disadvantaged Areas Act of 1999 (NRDAA) allows qualifying hospitals to temporarily employ foreign workers (non-immigrants) as registered nurses for up to three years under H-1C visas. Only 500 H-1C visas can be issued each year during the four-year period of the H-1C program (2000-2004).

Commission on Graduates from Foreign Nursing Schools (CGFNS)

The CGFNS was established in the United States in 1960 to assess graduates who received their nursing education outside the United States. The CGFNS analyses the education and licensure of an applicant earned outside the United States in terms of comparability to United States standards and expectations. Each applicant will have to pass the CGFNS qualifying exam of nursing knowledge to receive a certificate, which is accepted by United States immigration officials to qualify for certain occupational visas and for green-card applications.

In order to work in the public health system in the United States, almost all States require candidates for licensure to pass another test that measures the competencies needed to practice nursing in a given state. For this purpose, the NCSBN developed the NCLEX-RN as a tool to test candidates accordingly. This exam is based on a similar framework as the CGFNS, i.e. to assess competencies across all settings and their compatibility with domestic education programmes.

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[12] One major initiative is the 'Campaign for Nursing's Future', a multimedia initiative to promote careers in nursing that includes paid TV commercials, a recruitment video, Web-sites and brochures launched by Johnson & Johnson in February 2002. The Government of the United States has introduced legislation to address the nursing shortage. The Nurse Reinvestment Act (HR 3487 and S 1864), was passed in December 2001 with the aim to attract more students to nursing by providing funding for scholarships and student loan programmes as well as offering grants for internships.

The nursing licensing exam is currently only administered in the United States and its overseas territories, which forces nurses to make costly trips to take this exam. In order to facilitate participation at the licensing exam, the NCSBN has recently decided to start offering the exam at overseas sites by October 2004.

National Strategies in United Kingdom

Since the early 1990s the Royal College of Nursing (RCN) has raised the issue of the nursing shortage in the country. Consequently the Government of the United Kingdom has launched a series of initiatives to increase the incentive for nursing and to retain qualified staff in the profession. National health authorities have identified various areas for interventions, such as attracting more applicants to nursing education, encouraging returnees and improved career structures. Programmes to improve staff training and development as well as flexible working hours to allow nurses to combine work and family life have also been introduced.

However, national strategies alone do not seem to be successful in attracting and retaining a sufficient number of qualified nurses to maintain the national standard of public health services. Thus searching for nurses abroad has been seen as a reasonable and efficient solution to these pressing problems.

Immigration Policies in United Kingdom

To enhance the inflow of foreign nurses, the United Kingdom has introduced immigration procedures. This is evidenced by the fact that at the end of the 1990s every sixth nurse who registered for work for the first time came from overseas. Generally all applicants from outside the United Kingdom (including the European Union/European Economic Area (EU/EEA) who wish to take up employment in the United Kingdom are required to obtain a work permit. However, the shortage of qualified and skilled workers in certain occupations has led to the adoption of a 'shortage category list' which also includes nurses and midwives. For all applicants with the required skills simplified procedures to obtain a work permit have been put in place.[13] Caribbean nurses holding a CARICOM nursing license are generally accepted for registration without the need to undertake further training or supervised practice.

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[13] To qualify for a nursing work permit an individual is expected to have the following qualifications:

(a) A United Kingdom equivalent degree level qualification;

(b) For certain professions where the person has to be registered with a United Kingdom professional organisation, for example, doctors, dentists and nurses the person's registration number instead of statements from previous employers will be accepted. The Nursing and Midwifery Council (NMC) is the regulatory body for the nursing profession in the United Kingdom. Prior to starting work as a registered nurse or midwife in the United Kingdom, registration with the NMC is mandatory.

Source: www.workpermits.gov.United Kingdom as accessed on 7 May 2003.

The Department of Health recognizes that international recruitment is a small, but essential and significant part of the various initiatives undertaken to build and maintain the national workforce to ensure that continuous high standards of health care can be provided. However, government officials are well aware of the negative impact outflows from developing countries can have on their already drained healthcare systems. Therefore the Department of Health and the Department for International Development work closely with developing countries to ensure that United Kingdom recruitment policies follow best practice.[14]

REGIONAL AND GLOBAL INITIATIVES TO MANAGE MIGRATION OF NURSES

The global imbalance in the health workforce is a major challenge for policy makers at the national, regional and global level. A balance needs to be established between an individual's right to free movement and the recognition of the value of sharing ideas and cultures and the negative impact of the brain-drain on the less developed countries.

The need to develop policies and strategies to manage international recruitment, to retain qualified health workers and to make the profession an attractive choice has been recognized and a number of initiatives have been launched. 'Managed migration' is the key word for efforts to retain nurses in the Caribbean, whereas countries overseas have been adopting ethical 'Codes of Conduct', which have been initiated by the Commonwealth Secretariat to refrain from recruiting from countries which already suffer a severe shortage of health professionals.

Managed Migration

Experience in other sectors of the economy[15] in responding to labour shortages in the United States and Canada show that properly managed migrant worker movements contribute to the economic and social development in both the sending and the receiving countries.

Based on the fact that the subregion has been losing its doctors and nurses, it was recognized that it would be better to manage migration than to simply allow recruiters to come in and to find the public health system with fewer nurses and other health professionals. In 2001 nursing leaders, national professional nursing associations, training institutions, government agencies and regional institutions in the Caribbean drew up a concept to retain competent nurses in the region and, at the same time, respect the right of professionals to choose where they wanted to live and work. 'Managed migration' was recommended as an approach to comprehensively address the nursing shortage in the subregion in the areas of recruitment, utilization, retention and succession planning.

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[14] Department of Health (2001), Code of Practice for NHS Employers involved in International Recruitment, London.

[15] Organized movement of labour, predominantly in the agricultural and service sectors to the United States and Canada, has provided mostly unskilled workers from Mexico and the Caribbean to meet the seasonal needs of employers in agriculture and in tourism when shortages of domestic workers have occurred.

The following critical areas were identified as needing immediate attention and improvement:

- Terms and conditions of recruitment
- Education and training
- Value of nursing
- Utilization and deployment
- Good governance
- Public health sector reform.

In April 2002 the Regional Nursing Body[16] forwarded this proposal to the CARICOM Council of Human and Social Development (COHSOD) Ministers, which supported, endorsed and approved it. National health authorities endorsed the need for a strategy to plan for the emigration of a certain percentage of their health professionals. Innovative ways to allow migration on a rotating basis, where professionals would go away for a certain period of time and return to their country of origin should be explored.

It was noted that training is a very expensive component in human resource development and that the brain-drain represented a further drain on public finances. Therefore COHSOD strongly recommended the establishment of bilateral agreements with these countries recruiting Caribbean professionals to seek financial support for basic nursing training.

At present the governments of the CARICOM member States are working on the translation and implementation of this endeavor at the national level.

Magnet Hospital Initiative

Worldwide efforts are undertaken to retain qualified nurses and other health professionals in the national health service institutions. One such endeavor is the 'Magnet Recognition Programme',[17] which was developed by the American Nurses Credentialing Center in 1994 to recognize health care centers that provide the very best in nursing care. This concept is now being adopted by other countries in the developed as well as in the developing world. In the framework of the Managed Migration programme in the Caribbean, the Pan American Health Organization Caribbean Programme Coordination Office (PAHO/CPC) has taken the lead to initiate similar activities in the subregion. At present, PAHO/CPC is exploring possibilities to establish partnerships between Magnet Hospitals in the United States and

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[16] The Regional Nursing Body (RNB) comprises Chief Nursing Officers from each CARICOM country and is accountable to the Caribbean Health Ministers Conference. The RNB is attached to the Health Section of the CARICOM Secretariat in Guyana. One of the key aims of the RNB is to set and maintain standards of nursing education in each country through regional cooperation. It also aims to ensure that each country has a sufficient number of adequately trained and educated nursing personnel, to meet the needs of the national health care system.

[17] The Magnet Recognition Programme is a formal appraisal process for which the applicant hospital provides documentation and evidence that support and verify the implementation of the global standards for nursing administrators. The applying hospital must meet a set of selection criteria to become eligible for the evaluation process.

hospitals in the Caribbean. These partnerships could provide the framework for staff exchange programmes to provide opportunities for continuous learning, skills development and enhancement of professional nursing management.

Year of the Caribbean Nurse

The Year of the Caribbean Nurse, 'Nurses Lighting the Way,' has been launched as a collaborative effort by the Regional Nursing Body (RNB), Lillian Carter Center for International Nursing and the PAHO/CPC Office in May 2003 in Saint Vincent and the Grenadines. Until July 2004 all islands in the Caribbean are expected to participate in this effort by organizing various national activities to support and market nursing in the region. To support this campaign, Johnson and Johnson has financed the production of a video on nursing in the Caribbean, which will be used as a tool to promote the profession.

Commonwealth of Nations Code of Conduct

While it is crucial to acknowledge an individual's right to move freely and to work anywhere he or she likes to, it is also important to protect the interest of the public health systems in the poorer countries. A number of internationally recruiting countries has therefore put forward strategies to limit recruitment of health professionals from countries that are the most severely affected by this shortage.

In 1999 the Department of Health in the United Kingdom issued guidelines on 'ethical' international recruitment practices, which provide an outline for the international recruitment of health workers taking into account the potential impact of such recruitment on services in the source country. These guidelines, referred to as "The Commonwealth Code of Practice for the International Recruitment of Health Workers" were prepared by the Commonwealth Secretariat at the specific request of the Ministers of Health of its member countries. However, they do not advocate limiting or hindering the freedom of individual health professionals to choose where they wish to work but intend to discourage recruitment of health workers from countries which are themselves experiencing severe shortages, such as South Africa and the Caribbean. The 'Code of Conduct' promotes transparency, fairness and mutuality among the member States as well as between recruits and recruiters. However, one main limitation of these guidelines is the fact that they do not cover private sector recruitment agencies and employers. Global data published by the Nursing and Midwifery Council (NMC) for the years 1998-2001 suggest that this initiative might have had some temporary effect in reducing recruitment from these countries, but that enforced recruitment took place in other developing countries. More recent figures show that these countries again have been targeted for recruitment in the years after.

International Council of Nurses (ICN) and International Recruitment

At the global level, the International Council of Nurses[18] (ICN) has adopted a position statement calling for a "regulated recruitment process based on ethical principles that guide informed decision-making and reinforce sound

[18] The ICN is a federation of 124 national nurses' associations representing millions of nurses worldwide. Since 1899 the ICN is the international voice of nursing and works to ensure quality care for all and sound health policies globally. Website: www.inn.ch

employment policies on the part of governments, employers and nurses, thus supporting fair and cost-effective recruitment and retention practices."[19] While the ICN recognizes the right of an individual nurse to migrate and work anywhere she/he chooses, it also acknowledges the adverse impact of a mass-exodus on the domestic healthcare service provision of that country. The ICN supports calls for an ethical framework for nurse recruitment providing guiding principals for international recruitment of nurses.

ECONOMIC IMPLICATIONS: COSTS AND BENEFITS OF NURSE MIGRATION

Measuring the Costs of Out-migration

Assessing the exact impact of the loss of nurses on the national budget is extremely difficult, since various costs need to be taken into consideration and data available are weak. Further no set of indicators to monitor these losses has as yet been established. The costs vary from direct losses such as training expenses to indirect costs, like the decrease of the quantity and quality of services delivered to patients and consequently the loss of productivity for the national economy.

In an effort to assess costs of out-migration of health care professionals the WHO is currently supporting a study in Ghana.[20] It is hoped that the findings of this research will provide a model to be used by other countries.

The model attempts to integrate various dimensions of direct as well as indirect costs and benefits of a monetary as well as non-monetary nature. The main aspects to be integrated into the model would be:

- The monetary value of loss of training and leadership
- The monetary value of job experience and seniority
- The financial impact of higher morbidity and mortality rates due to understaffing on the domestic economy in terms of lost productivity and investments
- Search and recruitment cost for foreign nurses to fill in the gaps
- Higher costs encountered by patients who seek to buy services from the private sector
- Increased efficiency of the health care system due to professional upgrading of returning migrants.

Not much is known about the financial implications of the brain-drain on the health sector in Trinidad and Tobago. PAHO estimates the total loss of government investments to educate nurses to the basic level for the whole subregion to be about US$16.7 million per year.

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[19]ICN, 2001: Position Statement – Ethical Nurse Recruitment, accessed on the internet: www.icn.ch/psrecruit01.htm as of 8. May 2003.

[20]Project Proposal: Measuring the costs of out-migration of health care personnel in Ghana. Received via e-mail from WHO on 9 May 9, 2003.

Table 9
Summary of Costs of Out-migration

Investment or Benefits Side	Where	Cost or Benefit	Indicators
Investment cost	Government	Budgetary cost of training	Training cost by category of staff or reference year
	Trainee/ Family	Fees and support cost	Reported payments by families
Benefits lost/current costs	Remaining staff	Overload and exhaustion	Reported probability of leaving
		Frustration and loss of morale	Sickness rates, decline in probity
	Health care system	Loss of outputs	Lover service levels: e.g. routine surgery, supervised deliveries
		Loss of quality	Higher levels of complications, higher fatality rates, loss of preventive activity e.g. immunization
	Patients and Community	Loss of Access	Rising exclusion when ill
		Loss of time	Higher waiting times
		Higher mortality	Higher death rates from lack of service delivery or delay
		Higher morbidity	Higher morbidity from untreated complaints and loss of prevention
Benefits gained	Doctor or nurse/ family	Remittances	Level of remittances
		Skills and networking	Reported skills of returnees
	Health care system	Professional upgrading	Reported skills of returnees compared to leavers

Source: Biritwum and Mackintosh 2003: 5.

Remittances

Remittances play a vital role in most countries with a considerable proportion of their population living overseas. Contributions from family members abroad provide vital support to families and whole communities and are quite often an essential contribution to local community development. Apart from the direct impact on the wellbeing of left behind family members' remittances constitute a considerable share of a country's national Gross Domestic Product (GDP). This is particularly the case for Haiti, Jamaica and the Dominican Republic, the three countries in the region, which receive some of the highest remittance transfers worldwide in relation to their national GDP. Remittances constitute 25% in Haiti, 15% in Jamaica and 10% of the annual GDP (IMF 2001) in the case of the Dominican Republic. Remittance sent to Trinidad and Tobago is considerably lower than those received by many other countries in the region.

Although data on remittances are available for most countries, they are rarely broken down by country of origin and they do not provide any additional information on the remitter. Since remittances can be monetary and in kind, a complete assessment of the flows is very difficult. Quite often they are not transferred through the regular banking system, but sent in cash and kind.

Summary/Recommendations

The analysis of the nursing situation in Trinidad and Tobago has shown that the present nursing crisis is not a new phenomenon but evolved over several decades. Although no coherent analysis of the emigration of nurses from Trinidad and Tobago is available, this study could identify the critical issues which have contributed to the present crisis.

A general weakness in the Caribbean is the lack of timely and reliable data. Particularly difficult was the task of gathering information on migrating nurses from various sources in the home and destination country. Data collection systems are weak and the available data do not allow for further in-depth analysis of the current nursing crises. No data are available on return migration, which would be essential for monitoring. Without such a tool, sound human resources planning is almost an impossible task to accomplish.

Data from the early 1970s already point at the main weaknesses of the public health system. Over the years some efforts have been initiated to improve the situation. It is assumed that the implementation of selected policies along with the worldwide economic recession in the 1980s seems to have temporarily slowed down global international recruitment. The world-wide economic boom in the 1990s, with increasingly more funds available to public administrations in the North, along with the growing shortage of nurses in the developed countries created the basis for enhanced international recruitment of nurses. As shown in the study international initiatives to control recruitment from already drained countries seem to have had only temporary impact, since international recruitment also from already severely affected countries has resumed and fast track immigration procedures have been put in place in many developed countries.

In summary, the main push-factors identified in the present study are:

- Inadequate remuneration and benefits
- Unfavorable working conditions
- Lack of management and leadership

- Insufficient training and professional development
- Insufficient career-perspectives
- Under-utilization of acquired skills
- Burn-out due to increased workload as a consequence of resignations
- Lack of recognition of profession

The pull factors already identified in the early 1960s have become stronger over the past decades and recently more incentives have been added by the recruiting countries:

- Attractive payments and benefits
- Modern human resources management
- Professional work-environment
- Possibility of permanent residency in the receiving country (Green-card in the United States)
- Financial support for registration and immigration procedures provided by foreign employers
- Supportive network of family and friends
- Opportunities for professional development and career advancement
- Professional Recognition
- Improved quality of life for self and family.

The main policy recommendations to be considered by the national government are based on a set of recommendations designed by WHO (2001) to address the current global nursing crisis:

- Strengthen national health policies, plans and systems
- Establish comprehensive health workforce planning that will ensure that the nursing and midwifery human resources can meet the actual demands for services
- Engaging in dialogue with internal and external entities to seek solutions to the low levels of remuneration and strengthen the incentives for effective recruitment, development and retention
- Identify priority areas in which solid evidence is needed to inform national health policy makers and invest in systematic data collection, analysis and dissemination systems for best practices
- Increase the opportunities to build leadership for nurses and midwives and strengthen their involvement in management of the health system and in health policy development and the decision-making process
- Set up a national steering committee of crucial stakeholders, such as national nursing representatives to develop a comprehensive strategic plan
- Provide opportunities for professional growth and development and establish

supportive work environments and compensation commensurate with roles and responsibilities

- Enforce bonding, also for graduates from higher-level programmes

- Protection of particularly young and desperate nurses from unscrupulous recruitment agencies that take advantage of uninformed nurses. A national clearing house for international recruiters needs to be set up and a body that regulates and/or monitors the contents of contracts offered needs to be designated

- Develop a national action plan in collaboration with all important stakeholders in the public and private sector as well as with the support of international and regional organizations

- Since nurses play a crucial role in caring for our beneficiaries, the issue of nurse staffing needs to be dealt with the utmost priority by concerned governmental authorities.

On the regional and international recruitment level more collaboration and coordination is needed with the main recruiting countries and their national machineries. A properly structured partnership approach between the developed and the developing world could result in increased staffing for developing countries' health systems while at the same time facilitating subsequent recruitment of paramedical personnel to the developed world.

- Increased collaboration of the countries within the subregion and the region is necessary to further implement already existing mechanisms, such as 'Managed Migration' in the Caribbean.

- More collaboration is needed between the recruiting and the source country to cover the costs of basic and advanced nursing training. Bilateral agreements on cost-sharing arrangements need to be put into place. Industrialized countries must recognize their responsibility to provide financial assistance to developing countries to train nursing staff, since many will ultimately work in the more developed world.

- More awareness of the impact of the brain drain on the well-being of SIDS caused by the departure of even small numbers of health professionals is needed on the part of the recruiting countries.

- Global initiatives to guide international recruitment of nurses, such as the 'Code of Conduct' adopted by the Commonwealth of Nations provide ethical guidance for international recruitment. These guidelines should be applied more strictly and should also include private sector recruitment activities.

To address this eminent shortage of nurses and to improve the capacity to deliver health services throughout the public health system, the interests of various stakeholders at the national, regional and international level need to be taken into consideration. The international recruitment and placement of nurses and other health professionals is a fairly economic process, which inflicts costs on the sending as well as the receiving countries. Presumably only such

approaches which consider the interests of all stakeholders will lead to sustainable solutions for all parties concerned in the long term. However, various measures could be adopted at the national level in both the sending and receiving countries to address the scarcity of health workers. Structured partnership approaches involving both developed and developing countries equally, could be laid out and international agreements involving multiple stakeholders could provide the framework for regional and bilateral agreements. The credibility of these approaches, their strength and universality will directly depend on the political will of health sector stakeholders at all levels.

The need to address the present nursing crisis is crucial since with the ageing of the population and emerging HIV/AIDS crisis the demand for more nursing care will increase considerably in the near future. Today every tenth person in Trinidad and Tobago is 60 years and older and in about 20 years according to projections every fifth person will belong to this age group. The projected infection rates for HIV/AIDS are soaring. Based on estimates from UNAIDS (UNAIDS/WHO 2002) currently about 3% of the population of Trinidad and Tobago is HIV/AIDS positive with rapidly growing infection rates projected.

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