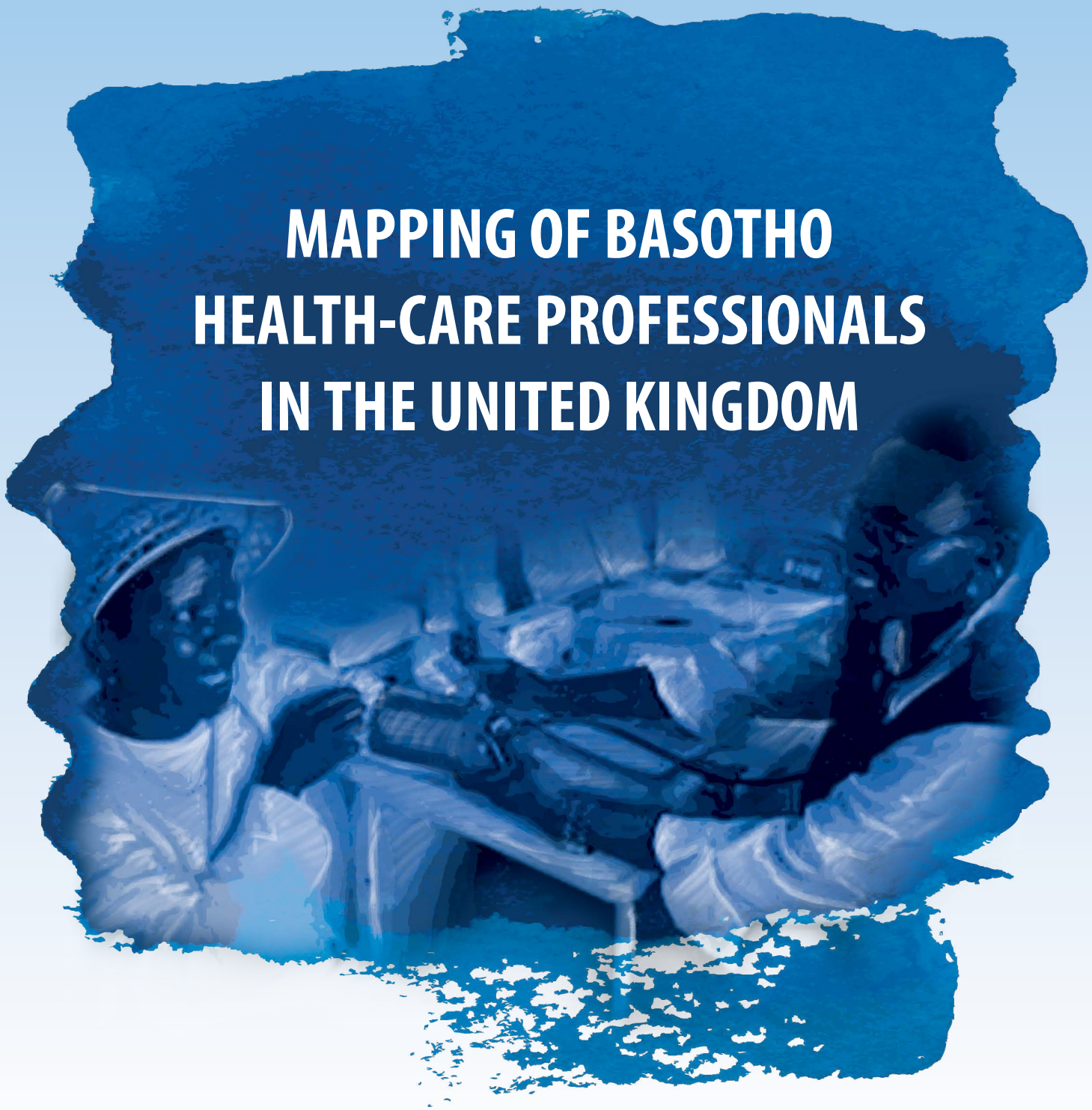
MAPPING OF BASOTHO HEALTH-CARE PROFESSIONALS IN THE UNITED KINGDOM



AFFORD

African\
Foundation\for\
Development\

International Organization for Migration (IOM)

IOM is committed to the principle that humane and orderly migration benefits migrants and society. As an intergovernmental organization, IOM acts with its partners in the international community to: assist in meeting the operational challenges of migration; advance understanding of migration issues; encourage social and economic development through migration; and uphold the human dignity and well-being of migrants.

Opinions expressed in the chapters of this book by named contributors are those expressed by the contributors and do not necessarily reflect the views of IOM.

Confidentiality
Respondents were requested to provide personal details, particularly for future communication purposes. Such personal data are excluded from this report and protected by the standard data protection principles.

Disclaimer
The mapping team that conducted this exercise and developed the report on behalf of the International Organization for Migration (IOM) has taken every effort to ensure accuracy in its reporting. IOM is not responsible for any omissions or inaccuracies.

Publisher: International Organization for Migration
17 Route des Morillons
1211 Geneva 19
Switzerland
Tel.: +41 22 717 91 11
Fax: +41 22 798 61 50
E-mail: hq@iom.int
Internet: www.iom.int

23_15

MAPPING OF BASOTHO HEALTH-CARE PROFESSIONALS IN THE UNITED KINGDOM

Kekeletso Mokete

African\
Foundation\for\
Development\

International Organization for Migration (IOM)

Acknowledgements

The mapping team expresses gratitude to the numerous individuals within the Basotho diaspora in the United Kingdom, as well as returnees to Lesotho who participated in this study and those who attended the focus group discussions.

Special thanks goes to the members of the Basotho-UK Committee for their tireless efforts in assisting in the snowballing process and focus group discussions.

Equally appreciated are those who participated in the key informant interviews, based both in the United Kingdom and Lesotho.

Special appreciation also goes to Dr Kelello Lerotholi for his invaluable contributions, technical expertise and constructive suggestions during the planning and development of the mapping exercise.

Contents

List of acronyms

AFFORD	African Foundation for Development
CCWSCW	Care Council for Wales Social Care Workforce
CHW	Community health worker
DFID	Department for International Development
EU	European Union
FGD	Focus group discussion
GDP	Gross domestic product
GOC	General Optical Council
GMC	General Medical Council
GMOD	Global Migrant Origin Database
GPhC	General Pharmaceutical Council
HDR	UNDP Human Development Report
HRH	Human resources for health
IOM	International Organization for Migration
ITP	Intention to practice
LeBoHA	Lesotho-Boston Health Alliance
LHC	Lesotho High Commission
LMDPC	Lesotho Medical, Dental and Pharmaceutical Council
LNC	Lesotho Nursing Council
MIDA	Migration for Development in Africa Programme
MOH	Ministry of Health
NGO	Non-governmental organization
NHS	National Health Service
NISRA	Northern Ireland Statistics and Research Agency
NMC	Nursing and Midwifery Council
NRS	National Records of Scotland
ONS	Office for National Statistics
PHC	Primary Health Care
PSNI	Pharmaceutical Society of Northern Ireland
SAMP	Southern African Migration Programme
TOR	Terms of reference
UK	United Kingdom of England, Wales, Scotland and Northern Ireland
UNDP	United Nations Development Programme
WHO	World Health Organization

Executive summary

The International Organization for Migration (IOM) commissioned this study, which the African Foundation for Development (AFFORD) conducted between February and May 2014 among Basotho health-care professionals working and living in the United Kingdom. The purpose of the study was to map the demographic and social characteristics of these health professionals, their migratory trajectories, as well as potential for contributing to the development of the health sector in Lesotho.

Two approaches were enlisted to obtain relevant information in the study, namely a desk-based literature review and primary data collection. Primary data collection involved a three-pronged methodology, using an online survey, focus group discussions (FGDs), as well as key informant interviews.

The study findings indicate a strong attachment among Basotho health professionals to Lesotho. Virtually all the respondents/participants showed willingness to engage in development initiatives. The population of Basotho diaspora in the United Kingdom is relatively low compared to other Southern African countries. There is one major forum to which the general Basotho diaspora affiliates, which is the Basotho-UK. Basotho health professionals affiliate to this voluntary organization, which is open to all Basotho living in the United Kingdom. The forum has taken a number of initiatives towards development in Lesotho, though not necessarily related to the health sector. Such initiatives include sponsoring the education of needy children and supporting orphans in Lesotho. There have also been various plans to support the health sector in Lesotho in different ways, which have unfortunately been hampered by bureaucratic hurdles in the country. This indicates the need for more focused and strategic intervention, as well as cohesive collaboration with the Government of Lesotho as this could potentially lead to the "brain gain" scenario that is now associated with international migration.

The report is structured as follows:

Chapter 1 summarizes the main findings from the literature review undertaken for this study. It sets out a brief introductory background on Lesotho, as well as its health-care system and the phenomenon of migration of health professionals from Lesotho to other countries. The chapter further sets out census statistics of Basotho health professionals in the United Kingdom.

Chapter 2 explains how primary data were collected and the methodological issues involved. It elaborates how questionnaires, FGDs and key informant interviews were used to collect data from a sample of the Basotho diaspora population. It also sets out the research limitations and challenges, as well as how they were effectively dealt with.

Chapter 3 presents the field research and findings in detail with the use of graphs and narrative. The chapter also reflects initiatives undertaken and planned by the Basotho diaspora in relation to engagement in development activities back home.

Chapter 4 sets out the findings from the FGDs involving the Basotho diaspora health-care workers. The chapter further amalgamates the findings from questionnaires and the above-stated interviews.

Chapter 5 presents the findings from key informant interviews.

Chapter 6 sets out two case studies carried out as part of the study, which give more in-depth exploration of some of the issues related to the migration of Basotho health-care professionals.

Chapter 7 sets out the observations and recommendations emerging from chapters 3 to 6.

Recommendations

The study makes the following observations and recommendations:

1. There is strong willingness among Basotho diaspora health professionals to contribute to Lesotho's health sector.

2. The majority of diaspora health professionals of Lesotho origin who are based in the United Kingdom are female nurses.

3. Health professionals in the diaspora are spread around the country with small clusters in different areas, such as Basingstoke, Birmingham and London.

4. Most respondents indicated a high preference to participate in short-term activities, voluntary or otherwise.

5. Clear strategies and policies with specific programmes to engage diaspora health professionals should be developed.

6. Programmes and policies should be tailored to include retirees/returnees who are based in Lesotho or those who wish to return upon retirement.

7. It is important to look at, and learn from, best practice in Africa and other parts of the world, in terms of programmes for diaspora engagement in Lesotho.

8. The case of diaspora health professionals should be used as a pilot with the intention of rolling it out to cover all aspects of development of the country.

9. Members of the Basotho diaspora expressed desire for the possibility of dual citizenship to prevent them from having to choose between Lesotho and the United Kingdom. There is evidence in the literature that dual citizens remit and engage more with their countries of origin.

10. The local stakeholders in Lesotho should play an active part in promoting the role and benefits of diaspora engagement in local activities to help prevent misunderstandings.

11. Members of the Basotho diaspora would like to see priority being given to a unified structure/ body to address the red tape that hampers diaspora participation.

12. Clear protocols for the handling and transfer of medical equipment for use in charitable projects should be established.

13. Strategies for mitigation of travel and subsistence costs in the case of defined programmes should be developed.

CHAPTER 1 – Overview

1.1 Introduction

Lesotho has significant health challenges in the form of HIV/AIDS, tuberculosis, diabetes and hypertension, which account for high morbidity and mortality rates. There is an acute shortage of expertise within the health sector with many posts on the Establishment List[1] of the Ministry of Health (MOH) remaining unfilled.[2] A number of factors have been associated with this, such as local circumstances that negatively impact on training, pay, infrastructure and working conditions. Other factors are external and include more competitive opportunities for better pay and career development and advancement outside of Lesotho. Although Lesotho has, in recent years, made an effort to improve the conditions prevailing in the health sector, a sizeable proportion of Basotho health-care professionals live and work abroad, resulting in the scarcity/dearth of human resources for health (HRH), which in turn greatly hampers effective health-care delivery in Lesotho.

In a bid to address this issue, the International Organization for Migration (IOM) has recently launched the project, Mobilizing Diaspora Resources for Lesotho, which aims to attract and mobilize health professionals in South Africa, the United Kingdom and the United States to fill critical labour shortages in Lesotho's health sector. To this end, the IOM has commissioned the African Foundation for Development (AFFORD) to carry out a survey to determine the skills and competencies of Basotho health-care professionals in the United Kingdom and establish means for them to contribute their skills for the development of the health sector and other sectors in Lesotho. The study also identifies barriers that could hinder health workers in the diaspora from engaging in investment, skills transfer and other related developments in Lesotho.

1.2 Literature review

1.2.1 The global picture on migration of health professionals

International migration of health-care workers has served to contribute to the HRH crisis in many countries in sub-Saharan Africa. The definition of health workers based on the World Health Organization (WHO) definition is set out in Annex I. The flow of health professionals from low- to high-income countries has received much attention over the past few decades and is considered to be a significant contributor to the further weakening of already fragile health systems.[3] Indeed, the WHO's 2006 World Health Report estimated a global shortfall of almost 4.3 million health personnel, with 57 countries (most in Africa and Asia) facing severe shortages.[4] Today, nearly all sub-Saharan African countries show increasing outflows of health workers, while also the variety of destination countries has largely expanded. Migration of health professionals occurs due to several reasons, including: (a) relatively low wages; (b) poor working conditions and lack of further professional development opportunities in countries of origin; and (c) growing demand for health professionals in developed countries, as a result of accelerating demographic changes combined with inadequate domestic health workforce planning and investment.[5] Pull factors include better remuneration, better working conditions and opportunities for professional development.[6] Poppe (2014:1) sets out that although globalization plays a part in increasing migration flows, active recruitment policies in high-income countries are an important contributor to the "brain drain" context in the health sector. The IOM (2012) considers that it is:

1 The Establishment List is an official listing of all positions budgeted for in a financial year for the MOH in Lesotho.
2 T. Mwase et al., *Lesotho Health Systems Assessment 2010* (Health Systems 20/20, Bethesda, MD, Abt Associates Inc., 2010), p.43.
3 A. Poppe et al. (2014) "Why sub-Saharan African health workers migrate to European countries that do not actively recruit: a qualitative study post-migration", *Glob Health Action*, 7:24071. Available from www.globalhealthaction.net/index.php/gha/article/view/24071
4 IOM, *Diaspora Engagement Projects in the Health Sector in Africa*, Department of Migration Management, Migration Health Division (2012). Available from http://diaspora.iom.int/sites/default/files/infosheet/dehpo.pdf
5 Ibid.
6 A. Poppe et al. (2014), p. 2.

> … incumbent on countries of destination and origin to strive to harness the development potential inherent in the health profession diaspora abroad. While usually the negative aspects of the mobility of health professionals are highlighted, migrants and their families generally benefit from migration through for instance increased earnings and better opportunities for education and training. Diaspora health professionals can moreover contribute to the development of their home countries in multiple ways: e.g. by sending financial remittances to their families left behind, or by sharing newly gained knowledge and expertise with friends and colleagues via telecommunication devices or when visiting. Foreign health professionals can also provide needed cultural mediation to migrants from similar backgrounds in accessing health services in their new countries of residence.[7]

To this end, the IOM's *Migration for Development in Africa (MIDA) Programme* seeks to encourage and channel the positive impacts of migration by mobilizing members of the African diaspora residing in Europe and North America to contribute to the development of their countries of origin. Within the programme's framework, IOM has started a number of capacity-building initiatives to assist African countries to benefit from the skills of their nationals in the diaspora. Several MIDA projects specifically target health professionals. The potential evidence in this approach has partly contributed to the decision to undertake this exercise on Basotho diaspora health professionals in the United Kingdom.

1.2.2 Background on Lesotho

The Kingdom of Lesotho is one of only three countries in the world that is an enclave of another. Lesotho has a surface area of 30,355 km^2 and is landlocked and surrounded by South Africa. It is a mountainous country, more than 80 per cent of which is 1,800 m above sea level. This presents difficult topography and seasonal severe winters that are a challenge to health service delivery.[8] The population of Lesotho, estimated at 1.9 million has a declining annual growth rate (from an annual growth rate of 1.5% during the intercensal period 1986–1996 to 0.08% in 1996–2006).[9] This decline in growth has been attributed in part to increasing HIV/AIDS deaths.[10]

Research shows that Lesotho is one of the most migration-dependent countries in the world. Migrant remittances are the country's major source of foreign exchange; according to the World Bank, in 2012, Lesotho was the third highest recipient of remittances as a proportion of the GDP (25%).[11] A large proportion of the population (76.2%) resides in rural areas where poverty is most prevalent. The economy of the country depends mainly on manufacturing, subsistence farming and remittances from migrant labour based in South African mines. The level of poverty remains high, and about 50.2 per cent of the population is living on less than USD 1 a day. This is further compounded by a high level of unemployment, which stands at about 25 per cent (2008), despite the adult literacy rate being high at 87.4 per cent, according to the Lesotho Bureau of Statistics.[12] In response to these challenges, the Government of Lesotho has a National Strategic Development Plan that guides the government's efforts towards improving the current socioeconomic situation.[13]

Out of a population of about 2 million people, over 240,000 were recently estimated to be outside the country.[14] Up until the 1990s, the vast majority of migrants from Lesotho were young men working in

7 IOM (2012).

8 World Health Organization, Country Cooperation Strategy at a glance, Lesotho, 2008. Available from www.who.int/countryfocus/cooperation_strategy/ccsbrief_lesotho_en.pdf

9 Lesotho Bureau of Statistics, Ministry of Development Planning, Government of Lesotho, Demographic Survey 2011. Available from www.bos.gov.ls/nada/index.php/catalog/6 (accessed on 9 April 2015).

10 WHO, WHO Country Cooperation Strategy, Kingdom of Lesotho 2004–2007 (2007). Available from www.afro.who.int/index.php?option=com_docman&task=doc_download&gid=1422 p. 9.

11 World Bank, Migration and Remittance Flows: Recent Trends and Outlook, 2013–2016, Migration and Development Brief 21 (2 October 2013). Available from siteresources.worldbank.org/INTPROSPECTS/Resources/334934-1288990760745/MigrationandDevelopmentBrief21.pdf p.5.

12 Lesotho Bureau of Statistics, Integrated Labour Force Survey 2008 Report. Available from www.bos.gov.ls/New%20Folder/Copy%20of%20Demography/2008_ILFS_report.pdf

13 Government of Lesotho, Ministry of Finance and Development Planning, *National Strategic Development Plan 2012/13–2016/17: Growth and Development Strategic Framework* (2012). Available from www.imf.org/external/pubs/ft/scr/2012/cr12102.pdf

14 J. Crush et al., "Migration, remittances and development in Lesotho", *SAMP Migration Policy Series* 52 (Institute for Democracy in Africa, Cape Town/Queen's University, Canada 2010).

the South African gold mines and over 50 per cent of households had a migrant mineworker. Since the early 1990s, with the advent of the new democratic rule in South Africa, patterns of migration from Lesotho have changed dramatically. The most significant changes include: (a) huge increase in border movement between Lesotho and South Africa; (b) declining employment opportunities for Basotho men in the South African gold mines due to heavy retrenchments of foreign mine workers in the mining industry; (c) increased female migration from Lesotho; increase in skilled migration from Lesotho (including in the health sector); and (d) growth of HIV/AIDS-related migration in Lesotho.[15] There has also been an increase in skilled labour migration to countries other than South Africa, including the United Kingdom, as research reveals.

Contrary to what prevailed during the apartheid era, South Africa's 2002 Immigration Act has made it easier for skilled migrants to work in South Africa and the number of skilled Basotho working in South Africa has accordingly risen. According to Crush et al. (2010), this brain drain in South Africa (and beyond) is very likely to accelerate in the future. A survey by the Southern African Migration Programme (SAMP) of final year students in Lesotho's technical colleges and the National University of Lesotho showed that interest in leaving Lesotho, either temporarily or permanently, is very high. Nearly a third of the students (31%) believed they would end up working in South Africa. Other desired destinations include Botswana (25%), the United Kingdom (10%), Europe (9%) and the United States (7%).[16] If anything, this highlights the importance of developing HRH strategies that take into account a crucial role that can and ought to be played by Basotho diaspora in their country of origin.

In a bid to partially address the dearth of human resources in Lesotho's health sector, there has been a long-standing practice of diversifying the skills mix to harness the potential of non-physician clinicians and community health workers. Their credentials are typically recognized only in their own country, making them less likely to migrate abroad for professional reasons.

Lesotho has a long history with the United Kingdom, having been a British protectorate and gaining independence in 1966. There is a history of close interaction between the two countries in various sectors of the economy, including education and health. For instance, the Department for International Development (DFID) was the seventh largest donor of gross Official Development Assistance in Lesotho during the period 2000–2005.[17]

1.2.3 Dual citizenship and diaspora engagement

There is an abundance of literature on dual citizenship, which, in the context of brain gain, indicates that holding dual or multiple citizenship provides an important link between those in the diaspora and their home countries. According to Plaza and Ratha (2011:23), dual or multiple citizenship can also improve both a diaspora's connection with its origin country and its integration into the destination country.[18] They continue to state that citizenship and residency rights are important determinants of a diaspora's participation in trade, investment and technology transfer with its origin country and make it easier to travel and own land. More importantly, for the context of this study on Basotho health-care workers, Plaza and Ratha (2011:24) point out that countries of origin that allow dual citizenship also benefit because their migrants are then more willing to adopt the host country's citizenship, which can improve their earning and thus their ability to send remittances and invest in the country of origin. This is crucial given that in the past, remittances to sub-Saharan African countries have been estimated to be larger than global development aid.[19] In addition, the flow of capital (in the form of remittances) back into the economy generates both tax revenue and a healthier economy overall, due to the increased available funds circulating in the economy.[20] If dual citizenship encourages more remittances, it follows that it could be a good thing for Lesotho.

15 Ibid., p. 10.
16 Ibid., p. 23.
17 J. Gayfer, M. Flint and A. Fourie, *Evaluation of DFID's Country Programmes: Country Study Lesotho 2000–2004*, Evaluation report EV657, Department for International Development (UK, 2005) p. ix.
18 S. Plaza and D. Ratha, *Diaspora for Development in Africa* (World Bank, Washington, D.C., 2011).
19 R. Groenhout (2012), "The 'brain drain' problem: Migrating medical professionals and global health care", *International Journal of Feminist Approaches to Bioethics* 5(1):9.
20 Ibid.

Plaza and Ratha (2011:24) state that recent studies show that integration of migrants in destination countries amplifies their involvement in the development of their countries of origin. They also point out that a number of countries have increased acceptance of dual citizenship, with about half of the African countries with available information allowing for dual citizenship. They point out further that the acceptance of laws allowing dual citizenship in India and Kenya, for instance, was due to pressure from diaspora groups. The potential gains for countries such as Lesotho are limited because dual citizenship is not permitted.

According to Plaza and Ratha (2011:26), some countries do not allow dual citizenship but offer identification card schemes in destination countries and that in certain cases, these cards grant visa rights to the diaspora. They give the example of Ethiopia, India and Mexico, which offer special identification cards that entitle migrants to specific rights. In the specific case of Ethiopia (a fellow African country to Lesotho that does not allow dual citizenship), a law was enacted in 2002 to permit Ethiopian migrants with foreign citizenship to be treated as nationals if they hold a Person of Ethiopian Origin card, locally known as the yellow card. This card entitles the holder to most of the rights and privileges of an Ethiopian citizen, such as entry into Ethiopia without a visa, the right to own residential property, and the right to live and work in the country without additional permits. Yellow card holders may however, not vote, be elected to political office, or be employed in national defence, security or foreign affairs.[21]

Dual citizenship is constitutionally forbidden in Lesotho.[22] This is the case despite the unique situation of being an enclave of another country, thus being economically dependent on South Africa. This dependency, as discussed earlier, is mainly due to lack of natural resources and the country's reliance on labour as a main resource. For this reason, Lesotho is also highly dependent on remittances from outside the country, as it exports a lot of labour, as alluded to earlier. It is therefore important to bear in mind that Basotho professionals tend to migrate not necessarily for their survival, but primarily for the sake of better opportunities they can find in South Africa and elsewhere.

It has been argued in the context of Lesotho that the constitutional provisions prohibiting dual citizenship could be a hindrance, especially where the duality could have a developmental advantage (such as improvement of working conditions and attendant higher wages resulting in more remittances sent to Lesotho).[23] According to Petlane (2013), because Lesotho forbids dual citizenship (requiring people who hold citizenship of another country or qualify for it to choose one or the other), many of its citizens who are also citizens of other countries have kept this fact hidden.[24] He also states that Lesotho insists on single citizenship despite having a significant number of its people who cannot (or are unwilling to) shed their second citizenship (such as South African), and those that do stand to forfeit opportunities unavailable in Lesotho.

1.2.4 Migratory patterns of Basotho health-care workers

According to Cobbe (2012), there is a long history of constant and debilitating brain drain from Lesotho to South Africa and, to some extent, to Botswana and other African countries.[25] This emigration includes skilled workers, especially those in the professional and technical fields. A key to understanding migration in and out of Lesotho is that, while exact numbers are difficult to gauge, more ethnic Basotho live in South Africa than in Lesotho.[26] As pointed out earlier, the current migration of skilled labour, including in the health sector, is relatively recent, as compared to that of migrant mine workers. It was after 1994 (following the end of apartheid) that there was a noticeable number of professional

21 S. Plaza and D. Ratha op. cit., citing *Federal Negarit Gazeta* (2002), p. 26.
22 Constitution of Lesotho (1993), Section 41.
23 Women and Law in Southern Africa (WLSA), Africa Discrimination and Citizenship Audit Lesotho Report, Transformation Resource Centre (n.d.), WLSA (Lesotho), 23 Motsoene Road, Dolphin House, Industrial Area, P.O. Box 0961, Maseru 105, Lesotho (Unpublished) p.16.
24 T. Petlane, "African Integration: What do New National IDs in Lesotho and South Africa mean?", *South African Institute of International Affairs*, 25 July 2013. Available from www.saiia.org.za/opinion-analysis/african-integration-what-do-new-national-ids-in-lesotho-and-south-africa-mean
25 J. Cobbe, "Lesotho: From Labor Reserve to Depopulating Periphery", Online journal of the Migration Policy Institute, 2 May 2012. Available from www.migrationpolicy.org/article/lesotho-labor-reserve-depopulating-periphery
26 Ibid.

Basotho obtaining employment in South Africa.[27] Cobbe (2012) pointed out that such professionals normally had to either claim South African citizenship or some other basis for legal residence (such as a spouse with legal residence). He continues that many of these professionals and other high-skilled Basotho migrants privately express every intention of eventually returning to Lesotho, but to retain their employment in South Africa, they have to categorize themselves as permanent migrants.

In terms of health worker migration, the World Bank estimates that one third of Lesotho-born physicians have emigrated.[28] A large salary differential exists between Lesotho and South Africa, which remains today, resulting in Lesotho's continuing shortage of doctors, nurses, accountants and engineers, among others. As pointed out by Cobbe (2012), although Basotho have high qualifications, they continue to seek better opportunities across the border, or in the case of medical personnel, further afield, with many Basotho nurses being recruited for employment in the United States and the United Kingdom.[29]

Currently, Lesotho has over 80 per cent qualified Basotho doctors who have left the country, and some 75 per cent of Basotho qualified doctors are working in South Africa. Furthermore, the situation in the nursing profession is similar.[30] Ambrose (2005) stresses that:

> Because of the scourge of AIDS, never has there been a greater need for nurses, but the reality is that also never have there been so many vacant positions, particularly for experienced nurses and nurse practitioners. Thus many rural clinics are without qualified nursing staff. It is estimated that over 70% of qualified Basotho nurses are working outside Lesotho. Some work in countries such as the United Kingdom and United States, countries for which recruiting agencies advertise in local newspapers, but the majority of nurses working outside Lesotho are working in South Africa.[31]

Anecdotal evidence shows that some Basotho who emigrate to South Africa and then migrate further afield, such as to the United Kingdom, travel on South African documents and would therefore be registered as South African and not from Lesotho, despite strong family links and/or property ties to Lesotho.

1.2.5 Health care in Lesotho

According to the United Nations Development Programme (UNDP), the population of Lesotho has historically had better health than many sub-Saharan African states.[32] Research shows Lesotho achieved gains in life expectancy, infant mortality and maternal mortality from 1970 through the mid-1990s. However, the advent of HIV/AIDS dramatically reversed the gains Lesotho achieved in health indicators, especially with respect to life expectancy, which dropped from 59 in 1990 to 44 in 2010. Currently, HIV/AIDS (with a prevalence rate of 23.2%) and tuberculosis remain the foremost challenges to human and economic development in the country.[33] In addition, diabetes and child mortality are of major concern in the country and constitute two of the priority programmes of the MOH.[34]

Despite these drawbacks, however, it has been argued that the country has a fairly robust health system in that, compared to its peers, Lesotho spends USD 54 per capita on health, which is higher than the USD 34 per capita required to provide a minimum package of health interventions.[35] A Health Systems Assessment carried out in 2010 revealed that Lesotho does not suffer from inadequacy of funds, but rather from chronic under-spending of health resources, as well as from a less-than-optimal allocation of health resources.[36]

27 Ibid.
28 Ibid.
29 Ibid.
30 D. Ambrose, "Lesotho health sector in crisis", *Summary of Events in Lesotho,* 12(1), First Quarter 2005.
31 Ibid.
32 UNDP, Lesotho Millennium Development Goal (MDG) Report – 2013, 23 July 2014. Available from www.ls.undp.org/content/lesotho/en/home/library/mdg/lesothomdgreport2013/
33 Mwase, T. et al. (2010).
34 Ibid.
35 Ibid., p. xvii.
36 Ibid., p. xvii.

As research shows, adequate HRH are a critical component in health systems and services for any country. The incidence of HIV/AIDS, increased poverty and food insecurity add to the high workload on health workers in the country. The reality today is that Lesotho faces an acute scarcity of skills in relation to the medical and allied health professions, which in turn exacerbates the existing public health crisis. Inadequate human resources apply both in terms of skills and numbers.[37] Research shows there is a shortage of human resources in the public service, mostly in the remote and mountainous areas of the country. Although it is difficult to find recent data on HRH in Lesotho, according to the last census carried out by the WHO African Work Observatory in 2000, there are 0.05 physicians per 1,000 population and 0.62 nurses and midwives per 1,000 population. Both ratios are far below the WHO African region of 2.4 and 10.9 respectively.[38] What is of great concern is that brain drain from the public sector is also an aggravating factor due to poor human resource management and difficult working conditions. About a quarter of the doctors are in private practice and inaccessible to the most vulnerable.[39]

There is a significant amount of brain drain in Lesotho. Health professionals, mainly nurses and doctors, form the single largest group of professionals emigrating from the country.[40] In recent years, Lesotho has seen growth in the migration of skilled health workers mainly to South Africa and to a lesser degree, further abroad. For instance, research shows that in 2000, there were 8 doctors and 5 nurses in the United Kingdom and no doctors but 6 nurses in the United States, whereas statistics from the United Kingdom's Nursing and Midwifery Council (NMC) shows that there are currently 79 nurses/midwives from Lesotho on its register. A general shortage of highly skilled human resources is being experienced, leading to a compromised quality of health services in Lesotho.[41]

In a bid to address these shortcomings, Lesotho has committed itself to significantly reforming the health sector for over a decade through the development of the Health Sector Strategic Plan (HSSP) 2012–2017, which builds on initiatives of the health sector reforms implemented in Lesotho between 2000 and 2011 (based on the original 2000–2010 HSSP).[42] The 2000–2010 HSSP was aimed at addressing the critical shortage of human resources in the health sector, among others, and the 2012–2017 HSSP phase will continue to address HRH where the initial plan was not successful, with the stated objective to increase access to, and quality delivery of, essential health services. In a nutshell, the Health Systems Report of 2010 states:

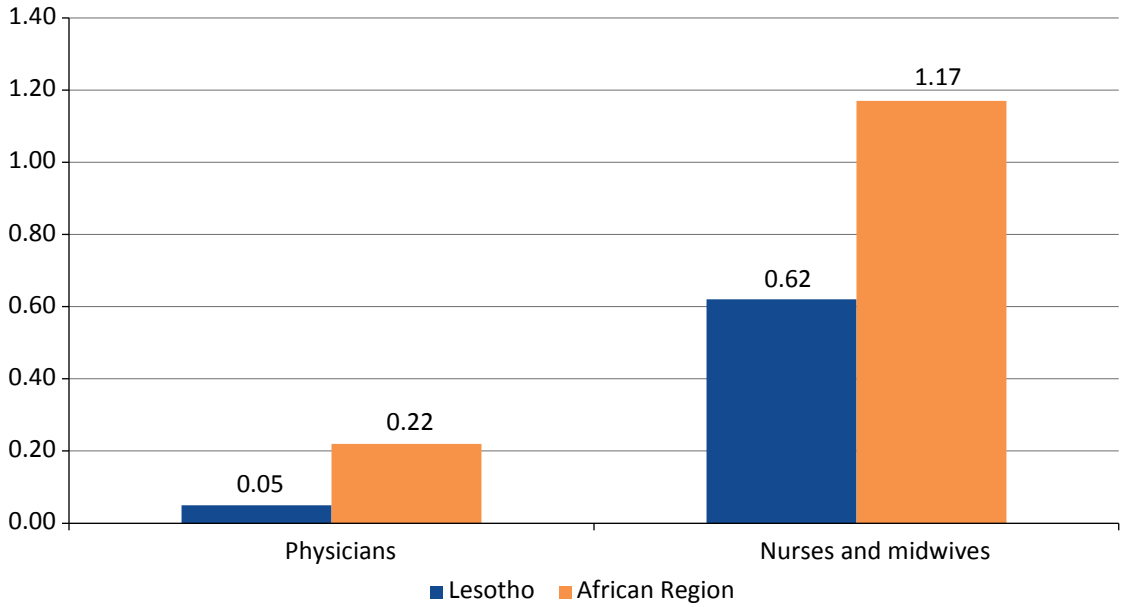
> Lesotho adopted a Primary Health Care (PHC) strategy in 1979 by creating 18 health service areas (Ministry of Health and Social Welfare 2005). To address challenges posed by an insufficient number of HRH, Lesotho was among the first countries in the region to create a nurse clinician cadre. The country also introduced and expanded the Community Health Worker (CHW) cadre to help reach PHC goals. On the service delivery front, the country created filter clinics, which were used to triage and lower patient loads at main hospitals. These measures had an impact on the provision of health services and the improvement of health indicators of the Basotho people.[43]

Despite these efforts, however, the report goes on to state that the health sector in Lesotho is facing a scarcity of skills in the medical and allied professions. The MOH does not have any current and complete data on HRH. The WHO's African Work Observatory carried out the most recent census, involving the assessment of human resources in the health sector in Lesotho in 2005.[44] Figure 1 (from this report) illustrates the results of the census, comparing the densities of physicians, nurses and midwives per

37 Government of Lesotho, MOH, HSSP 2012/13–2016/17, April 2013. Available from www.nationalplanningcycles.org/sites/default/files/country_docs/Lesotho/19_04_2013_lesotho_hssp.pdf; p. 25.
38 Ibid., p. 18.
39 WHO, Health Action in Crises: Lesotho, September 2005. Available from www.who.int/hac/crises/lso/background/Lesotho_aug05_rev.pdf; p. 2.
40 WHO (2007), p. 20.
41 Ibid.
42 Government of Lesotho, MOH (2013).
43 Mwase, T. et al. (2010), p. 43.
44 Ibid, p. 44.

1,000 population in Lesotho and the African region. It is taken from the WHO's Africa Health Workforce Observatory HRH Worksheet on Lesotho.[45]

Figure 1: Density of physicians, nurses and midwives per 1,000 population in Lesotho and in the African Region, 2005



At the time the study was undertaken, Lesotho had no medical school, thus all doctors had to be trained outside the country, with few of them returning upon qualification.[46] The National Health Training College, which falls under the auspices of the MOH, offers training programmes at diploma level in the areas of nursing, pharmacy, environmental health and medical laboratory technology.[47] Outside the Government, the Christian Health Association of Lesotho also provides nursing training.[48]

1.2.6 Statistics on Basotho living in the United Kingdom

In attempting to determine the magnitude of Basotho diaspora in the United Kingdom, as well as the "health professionals component", the researchers carried out enquiries to numerous organizations and professional bodies, as set out below. Enquiries indicated that the relevant authorities in Lesotho – National Bureau of Statistics, Lesotho Medical, Dental and Pharmacy Council (LMDPC), Lesotho Nursing Council (LNC) – do not have reliable statistics on the number of Basotho health professionals who have migrated to the United Kingdom. Officials at the LMDPC indicated they had not had any requests for a Certificate of Good Standing for any doctors registered with them moving to the United Kingdom in over 10 years. It was also pointed out that existing data on people migrating to South Africa could be unreliable, as some take up South African IDs/passports through their relatives in South Africa and do not necessarily register as Lesotho citizens. When such professionals then migrate further, for instance to the United Kingdom, there would be no record of them as Basotho in the host country.

The United Kingdom's Office for National Statistics (ONS) was unable to provide statistics on the number of Basotho in the United Kingdom for the following reasons. First, the United Kingdom does not track individuals leaving or entering the country. Second, the sample number available on Basotho was too small to publish due to confidentiality issues. However, the Global Migrant Origin Database (GMOD, March 2007) indicates that there were 373 Basotho nationals in the United Kingdom in 2007. The Lesotho High Commission (LHC) had about 173 Basotho nationals on its register, with the overall population of Basotho living in the United Kingdom being estimated to be about 300 (which roughly

45 Available from www.hrh-observatory.afro.who.int/en/country-monitoring/66-lesotho-monitoring.html
46 Lesotho-Boston Health Alliance (LeBoHA), "Stemming and reversing the out-migration of human resources for health in Lesotho", Global Health Workforce Alliance (WHO, 2014), Available from www.who.int/workforcealliance/forum/2011/hrhawardscs33/en/; p. 18.
47 Government of Lesotho, MOH (2013), p. 18.
48 Ibid.

corroborates the GMOD quoted above). The register neither indicates where in the United Kingdom such people live, nor what their professions/occupations are.

Based on the statistics of health professionals, 79 Basotho were registered either as a nurse or midwife on the United Kingdom's NMC. The following professional bodies in the United Kingdom either did not have Basotho on their register or did not provide information as requested: the General Medical Council (GMC), the General Optical Council (GOC), the General Pharmaceutical Council (GPhC), the Northern Ireland Statistics and Research Agency (NISRA), the National Records of Scotland (NRS), the Pharmaceutical Society of Northern Ireland (PSNI) and the Care Council for Wales Social Care Workforce (CCWSCW).

1.2.7 Basotho-UK

The main organization in the United Kingdom to which Basotho in the diaspora affiliate is the Basotho-UK, which is coordinated by a committee comprising Basotho from various professions/occupations. At its inception, the main aim of the group was to bring together Basotho in the United Kingdom as a social grouping. It then moved on to charity work, initially raising funds through football matches with a British local club, to support small independent charities in Lesotho, as well as other development work. The committee is the main point of contact between the diaspora and the LHC for matters of general nature relating to the diaspora. The committee meets with the office of the High Commissioner on a regular basis. The committee estimates that there are about 300 Basotho diaspora members in the United Kingdom and about 50 to 80 Basotho diaspora health-care workers that are members of Basotho-UK.

CHAPTER 2 – Methodology

2.1 Design

This study presents data collected through an online survey questionnaire, semi-structured focus group discussions (FGDs), key informant interviews and individual case studies, in some instances. The data relates to demographics and competencies of Basotho diaspora health-care professionals in the United Kingdom, as well as their willingness to contribute their skills for the development of the health sector in Lesotho. It also sets out identified barriers to investment, skills transfer and other related development initiatives by the diaspora in relation to Lesotho. A decision was made to use more of a qualitative approach based on two aspects: (a) the small size of the population of Basotho diaspora as a whole in the United Kingdom (approximately 300, a part of which are health-care professionals) made it difficult to rely heavily on a quantitative approach; and (b) migration experiences and individuals' willingness or not to engage in development strategies, as well as perceived barriers to engagement are expected to be diverse. It was felt that a qualitative approach offers the opportunity to identify reasons for migration and can acquire views and opinions on willingness and/or barriers to engage that cannot be obtained using quantitative research methodologies.

2.2 Participants

Participants were selected according to the following inclusion criteria:

1. Of Lesotho origin;

2. Health-care professionals living and working in the United Kingdom (including dentists, optometrists, students, retirees, those in administrative and allied roles, as well as care work). (The definition of health workers based on the WHO definition is set out in Annex I.)

Participants did not have to work as health professionals in the United Kingdom because circumstances are such that a lot of qualified health professionals from Lesotho work in the care sector rather than directly in hospitals/clinics and others. Different recruitment strategies were used to identify potential participants for the FGDs, survey questionnaire and key informant interviews. Several organizations in both the United Kingdom and Lesotho were contacted. In Lesotho, the following were contacted: the Lesotho Medical, Dental and Pharmacy Association, the Lesotho NMC, and the National Bureau of Statistics. It became clear early in the enquiries that these organizations do not have reliable statistics on the number of Basotho health-care professionals that have migrated to the United Kingdom.[49] With the exception of Basotho-UK, organizations approached in the United Kingdom could not provide names and addresses for reasons of confidentiality. Neither could they provide information on numbers of Basotho nationals for various reasons, but mainly the dearth of statistics on Basotho health-care professionals in the United Kingdom.

The call for participants was mainly distributed through Basotho-UK, which was immensely helpful in reaching out to diaspora health-care workers on their database. The Basotho-UK forum appears to be the sole organization to which Basotho diaspora in the United Kingdom affiliate.

Finally, snowballing technique and informal networks were used to identify potential participants. The majority of participants were recruited with the help of the Basotho-UK Committee and other intermediaries (contacts personally known to the researchers, as well as other respondents).

49 In the United Kingdom, contacts were made with the GMC, GOC, GPhC, LHC, ONS, NMC, NISRA, NRS, PSNI, CCWSCW and the General Dental Council..

2.3 Sampling procedure

The researchers initially wrote to the Basotho diaspora on the existing contact list, inviting them to respond to the survey and also tried snowballing the survey through them to acquire as many health workers as possible. At the onset, the researchers also engaged with the Basotho-UK Committee members, who were helpful in spreading the word about the survey. In addition, the researchers targeted different meetings/gatherings involving Basotho, with a view to increase the response rate. The researchers also used contacts who had responded to the survey to further snowball the process to their known links.

Given the limited time frame, the survey on Survey Monkey was sent out to about 175 individuals, (the majority of whom were on the Basotho-UK's database), with the knowledge that not everyone works in the health sector, but with the prospect of acquiring as many health-care professionals as possible, since the database does not have information on people's professions or occupations. The survey emphasized that it was specifically targeted at health-care professionals to ensure that only health professionals of Lesotho origin were included. Survey Monkey reminders were sent out through the period, while a concerted effort was also made to contact potential respondents by e-mail, telephone and in person to encourage and remind them to respond to the survey. The planned survey period was extended to acquire more respondents. In the end, there were 31 responses to the survey (with one wholly incomplete and a few only partially completed) between March and May 2014.

To determine the venue of the FGDs, the researchers established (through the Basotho-UK) that there were small clusters of Basotho diaspora health-care workers in Basingstoke, Birmingham and London. Three FGDs were held altogether. Each FGD was meant to comprise a maximum of 8 individuals, with a total of 24. However, given that the total number of individuals who responded to the survey was 31, coupled with the short time frame for convening the groups, it was not possible to attain the maximum attendance at some of the FGD sessions. The three FGDs comprised 6, 9 and 7 participants respectively. The number of participants in the focus groups is reflective of the difficulty in identifying health-care workers in different parts of the United Kingdom, especially given the minimal response to the main survey itself, and the nature of shift work by the different participants. Deliberate efforts were made to capture a mixed profile of health-care professionals to ensure robust discussions.

The first FGD was held in Basingstoke and comprised six nurses, all of whom were female with different specializations. The second was held in London and comprised nine participants, three of whom were male and six female. There were six qualified nurses with varying specializations and three trainee nurses working in care. The third FGD was also held in London and comprised one male doctor, four female nurses, one male nurse and a female public health professional currently undertaking a doctorate in public health. Basotho-UK Committee members were helpful in identifying and recruiting participants to the FGDs and respondents to the survey.

Participants in all the FGDs were engaging, showed real interest in the subject matter and came up with interesting recommendations, although there was some scepticism and suspicion, in particular, as to whether anything would come of this study.

Six key informant interviews were held with lead respondents who have informed opinions on the subject matter. The first is an expert in migration and based in Lesotho. He has an extensive research background on migration in Lesotho and Southern Africa. The second is a Mosotho-born doctor based in the United Kingdom as a consultant surgeon. The third is a nurse who worked in Lesotho for over 20 years, moved the United Kingdom to work for several years, and then returned to Lesotho to set up a clinic together with other returnee colleagues. The fourth is a nurse with special interest in diaspora issues who worked in Lesotho for a period before migrating to the United Kingdom and has been working in the National Health Service (NHS) for over 10 years. The fifth is a member of the Basotho-UK Committee who has extensive experience working with Basotho in the diaspora and a great interest in diaspora engagement. The sixth is a nurse who has worked in the United Kingdom's health sector

for over 20 years, having migrated to the country for family reasons. She has met and worked with numerous Basotho diaspora health-care professionals over the years.

This report also reflects some case studies relating to the trajectory of migration patterns of Basotho diaspora health professionals, willingness to contribute and barriers relating thereto.

The FGD questions, as well as the key informant interview questions, were designed to encourage open-ended answers and narrations, as is the aim in semi-structured interviews. The discussions and interviews were conducted in both English and Sesotho. The FGD took between 90 and 120 minutes, while the interviews took between 45 and 60 minutes. Information collected from both FGDs and key informant interviews included the trajectory of Basotho migrants in the United Kingdom, engagement efforts of diaspora members, their willingness to engage in their home country, barriers relating thereto, as well as recommendations on the way forward on effective engagement strategies.

2.4 Data collection methodology and process

2.4.1 Primary data

A survey questionnaire (Annex II) on Survey Monkey, comprising 74 questions, was distributed through e-mail and web links to a wide list of respondents identified as health professionals of Lesotho origin working in the United Kingdom's health-care sector. Hard copies of the questionnaire were also distributed to a small category of respondents who could not complete them online.

Three FGDs were held in different locations in London and Basingstoke. The entire process was moderated by the AFFORD research team using the Focus group discussion guide (Annex III).

Six key informant interviews were carried out with informants who have in-depth knowledge and/or experience working with Basotho diaspora health-care workers. A key informant guide highlighting the major questions of the survey was used as the framework (Annex IV).

2.4.2 Secondary data

Secondary data collection started at the beginning of the process and continued throughout the course of the survey. This comprised an extensive literature review on migration and engagement of health professionals with their home countries, with particular focus on the case of Lesotho.

2.4.3 Data analysis

Survey Monkey generated a Microsoft Excel spreadsheet of the collated data, including graphs. No additional statistical analysis was required as the data was mostly of a descriptive nature. The sample size was small, and the researchers did not have enough robust data to form valid hypotheses.

Qualitative feedback from the FGDs and key informant interviews was analysed thematically. Interview findings were organized in subcategories in line with the survey objectives and interpreted accordingly.

2.5 Limitations to the research and challenges encountered

- The population of Basotho living and working in the United Kingdom is relatively small compared to other African diaspora. Although the terms of reference (TOR) for the study required a sample of 100 participants, the total number of Basotho in the United Kingdom was established at about 300, with 50 to 80 health-care professionals. From this small target population, a total of 31 individuals took part in the survey, which represented a significant proportion of 40 to 60 per cent of the target population.

- As much as the study attempts to understand the depth of challenges facing the Lesotho health sector, findings and conclusions are only based on views generated from a small non-representative sample that participated in the study.

- Obtaining clear data from the ONS proved impossible as the diaspora population from Lesotho is so small that the ONS does not have disaggregated data on them. Other organizations that were contacted (some through Freedom of Information Requests) were either unable to provide data or had no information on the Basotho diaspora. This meant that the research had to be based on estimates provided by the LHC, the Basotho-UK and the UK NMC.

- The study period was relatively short with respect to the time-consuming process of identifying and engaging cooperation from potential respondents. However, the research team was persistent and persuasive.

- It took some convincing to get the potential respondents on board because of issues of mistrust. Many people were sceptical if the study would yield any results based on the track record of the Government of Lesotho carrying out numerous studies that are then left to gather dust on shelves. This resulted in a very slow uptake of responses to the survey in the beginning.

- Initially, it was a challenge to identify and get the FGDs together, as well as to identify key informants due to the slow uptake on the survey. This caused considerable delay in data collection. A Basotho-UK Committee member was particularly helpful in assisting with the identification and arrangement of two FGDs.

- The majority of respondents are nurses, with only two doctors and one dentist, psychological therapist and allied health worker respectively. There were no respondents for optometry, pharmacology, nutrition/diet and administration/policy. This situation prevails despite there being more than the quoted numbers, but it was difficult trying to reach professionals other than nurses.

- The TOR set out a target of three FGDs, each comprising at least nine participants. Convening focus groups proved to be difficult for various reasons including: (a) the relatively small population of Basotho diaspora health workers in the United Kingdom in general; (b) the nature of shift work that nurses tend to do (including night and weekend duty); (c) some participants do agency work to supplement their income and therefore have complex schedules; and (d) and the target groups for FGDs being spread out in various parts of the United Kingdom with small clusters where they exist.

CHAPTER 3 – Field research

The survey was carried out between March and June 2014. This section presents the findings of the survey questionnaire (Annex II). The number of responses to the survey questionnaire was 31.[50]

3.1 Questionnaire responses

The figures in this section have been generated from the survey questionnaire on Survey Monkey, with a few exceptions where figures were imported from elsewhere for the purpose of analysis. It should be noted that not all individuals responded to all of the questions in the survey. As such, the analysis below may refer to a total number of respondents below 31.

3.1.1 Demographic characteristics of respondents

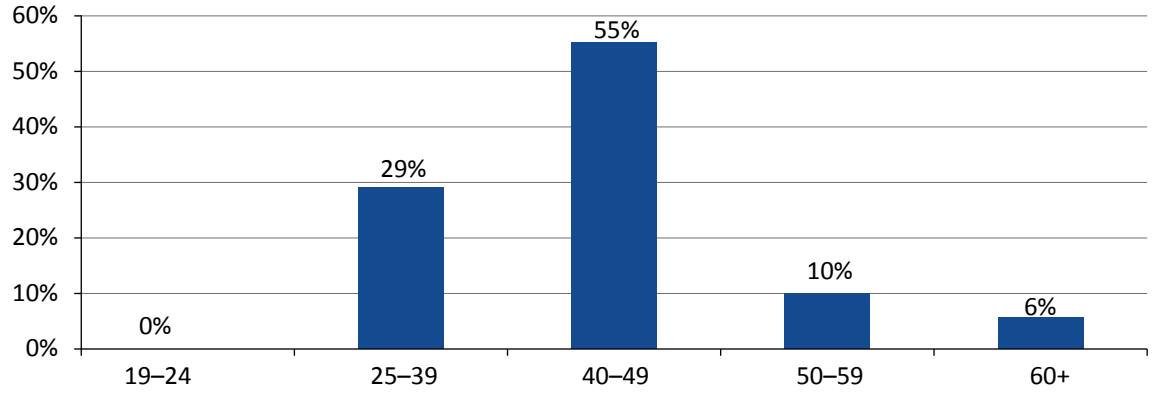
Gender

Out of 29 responses, 23 respondents (79.3%) were female and 6 respondents (20.7%) were male health-care professionals.

Age profile

Based on a sample of 30 respondents, the figure below indicates that most Basotho health-care professionals (18) in the United Kingdom fall within the age group of 40–49 followed by 9 respondents between 25–39 years, 3 in the 50–59 age group and only 1 in the 60+ age group. The absence of those aged below age 25 could be an indication of two things: (a) the length of time it takes to qualify and gain stability in the job market; and (b) a large majority of health-care professionals acquire training and initial experience in Lesotho before migrating to the United Kingdom. The relatively low number of respondents in age groups above 50 may be a reflection of Basotho health professionals tending to return/retire to their country of origin after working in the United Kingdom for a certain period.

Figure 2: Age of respondents



Place of birth

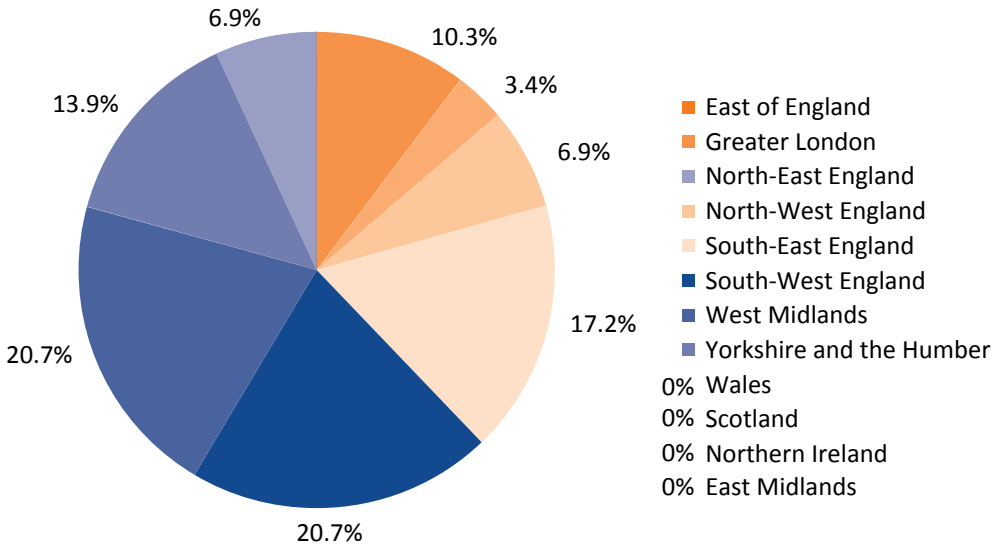
The majority of respondents (27) indicated they were born in Lesotho, with only 1 person indicating South Africa as the birthplace. This may mean that the majority, if not all, of the participants have strong family ties and possibly economic and other commitments in Lesotho and are therefore likely to be willing to contribute to the development of Lesotho's health sector. This is also reinforced by the result that most respondents specified their nationality as Lesotho (25 respondents), compared to 4 who listed themselves as British and 2 as South African.

50 Although there were 31 respondents to the questionnaire, one of the respondents answered only a single question, effectively meaning 30 mostly completed questionnaires.

Place of residence in the United Kingdom

Figure 3 sets out regional clusters of Basotho diaspora health professionals throughout the United Kingdom, based on the survey sample. It reflects an even spread in various parts of the United Kingdom. None of the respondents reside in Scotland, the East Midlands, East of England or Northern Ireland. That is not to say there are no Basotho health professionals in those parts of the United Kingdom as this was a small sample of the total number who live and work in the country.

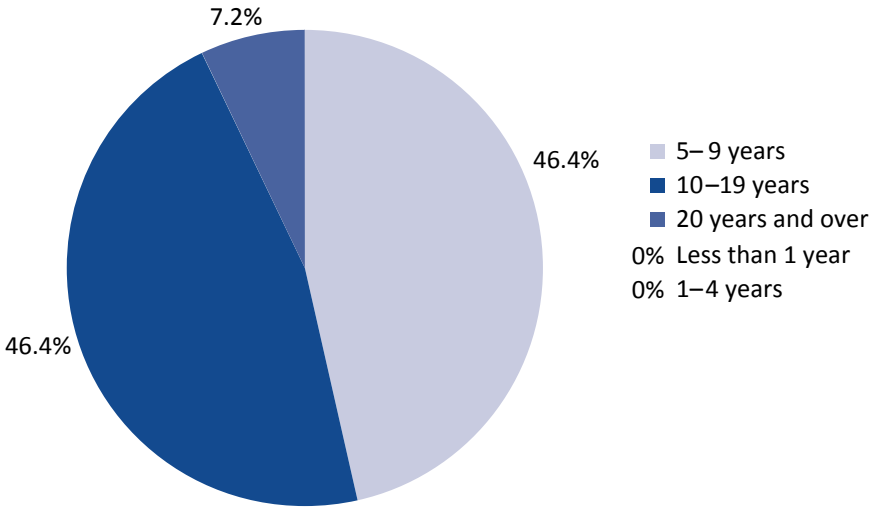
Figure 3: Residency in the United Kingdom



Length of stay in the United Kingdom

Figure 4 shows that 13 respondents have lived in the United Kingdom for 10–19 years and 5–9 years, as compared to 2 who indicated that they had been in the United Kingdom for over 20 years. The low number of those who have spent 20 years and over in the United Kingdom is perhaps another indication that a number of diaspora health professionals are likely to return to Lesotho close to, or upon retirement, as supported by opinions voiced in the FGDs and key informant interviews.

Figure 4: Length of residence in the United Kingdom



This indicates that most migration of Basotho diaspora health-care professionals happened in the distant rather than recent past, with the peak period being five to nine years ago and most of the rest having migrated even earlier. None of the respondents had been in the United Kingdom for less than four years. It is possible that this group may have been self-selected out of the survey and yielded

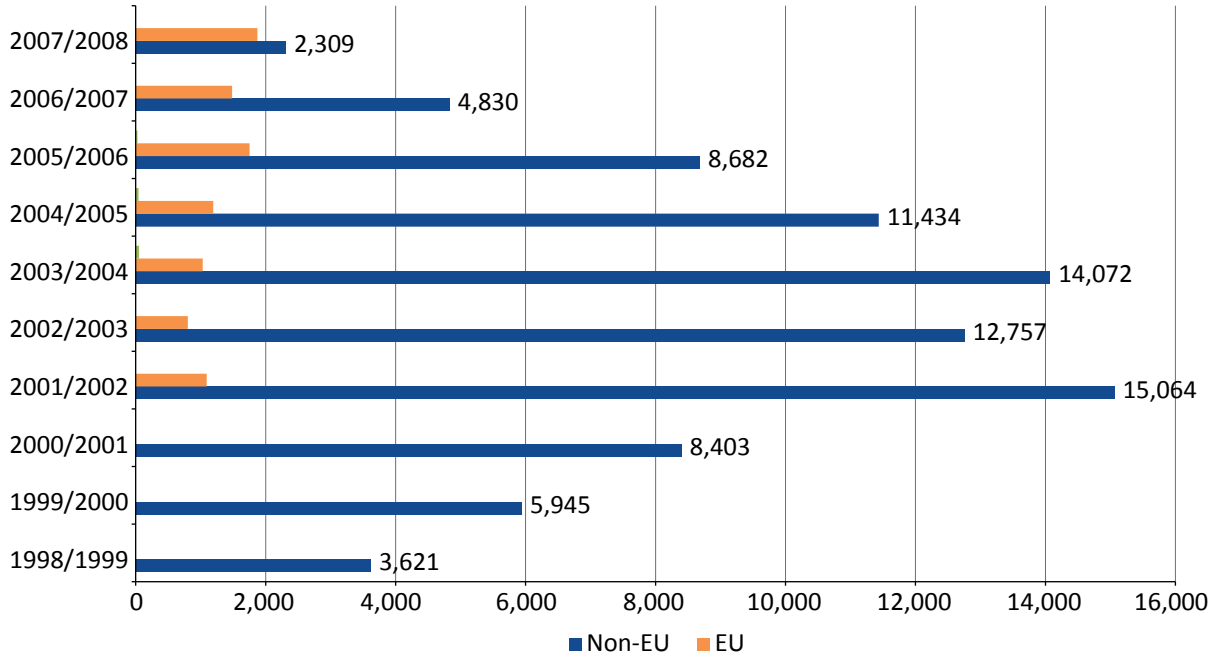
the least established individuals. Local factors may also play a role in making it more attractive for them to stay in Lesotho. A study of nurse migration in Malawi has shown no improvement in nurse retention with a fall in registrations in the United Kingdom, but that nurses leave the profession, enter administration or find other ways to migrate. The ones who stay preferentially choose to work for non-governmental organizations (NGO).[51] The researchers believe the same conditions and therefore choices prevail in Lesotho where the route into South Africa remains relatively easier to negotiate and the number of NGOs has grown, with at least 89 involved in health and social development.[52]

Finally, there is evidence that there has been a decline in inflow of nurses to the United Kingdom from other countries (particularly non-EU countries). According to Buchan (2012:13), this change has been partly the result of reduced demand in the United Kingdom, but also reflects a change in policy, such that while nurses from other EU countries continue to have free access to the United Kingdom under EU Directives, those from other countries have experienced difficulty and costs in attempting to travel to work in the United Kingdom.[53] Buchan (2012:13) further states that:

> A series of policy changes has made it much more difficult for non-EU nurses to enter the UK. Firstly, in 2005 the NMC instigated a much tougher (and costlier) programme for overseas nurses intending to practise in the UK, the Overseas Nurses Programme (ONP). Secondly, in 2006 the main entry clinical grades in the NHS were removed from the Home Office shortage occupation list. Thirdly, in 2007 the NMC then also raised the English language test requirements. Fourthly, in 2008 the UK immigration policy changed, with the introduction of a points-based work permit system, making international recruitment a more difficult option for employers. More recently, there has been further toughening of immigration policy. In May 2010, the UK government announced their intention to review the immigration system to ensure that net migration reduced between 2010 and 2015 to the levels previously seen in the 1990's. New immigration rules were brought into force in April 2012 in relation to the approach to granting work permits to new entrants, and approving resident status for non-EU nurses currently working in the UK on time limited work permits.

Figure 5 below illustrates the impact of these changes on overall nurse migration to the United Kingdom.

Figure 5: New registrations with the UK NMC, 1998–2008



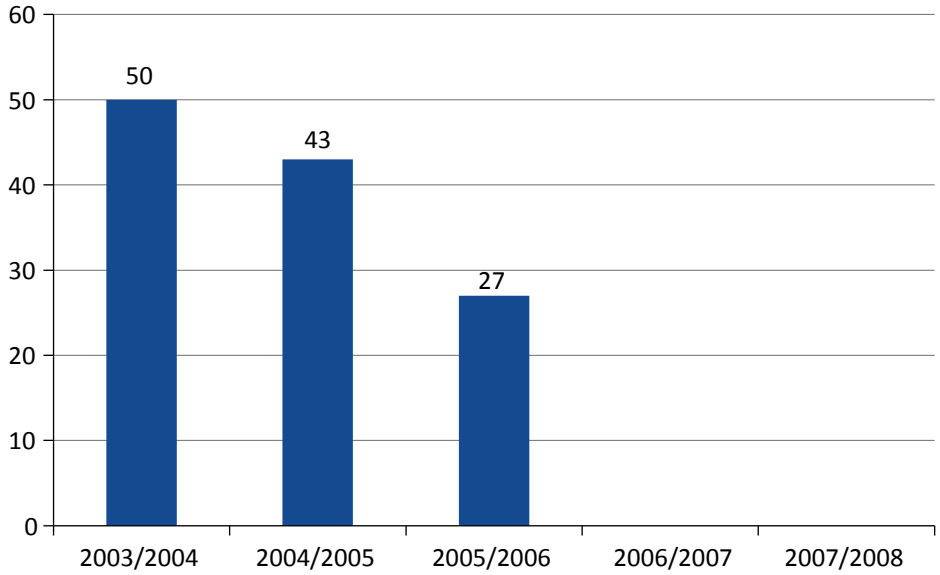
51 L. Mangham, *Addressing the human resource crisis in Malawi's health sector: Employment preferences of public sector registered nurses*, ESAU Working Paper 18 (Overseas Development Institute, London, 2007); p. 13.

52 Health and Social Development Commission Members, Lesotho Council of Non-governmental Organisations. Available from www.lcn.org.ls/member/HSDC.pdf

53 J. Buchan, and I. Seccombe I, "Overstretched. Under-resourced". *RCN Labour Market Review* (Royal College of Nursing Labour Market Review, Queen Margaret University, Oct. 2012).

Figure 6 below shows the figures for Basotho new registrations with the UK NMC for the years where numbers are available. All contributing countries are listed for 2007–2008 and Lesotho contributed none. These findings are consistent with the findings of the length of residence in the United Kingdom. Analysis of related studies on migration patterns to Australia, South Africa and the United States may reveal whether migration has instead shifted to these countries.

Figure 6: Basotho new registration with the UK NMC, 2003–2008



3.1.2 Educational and professional background

Education, training and work experience

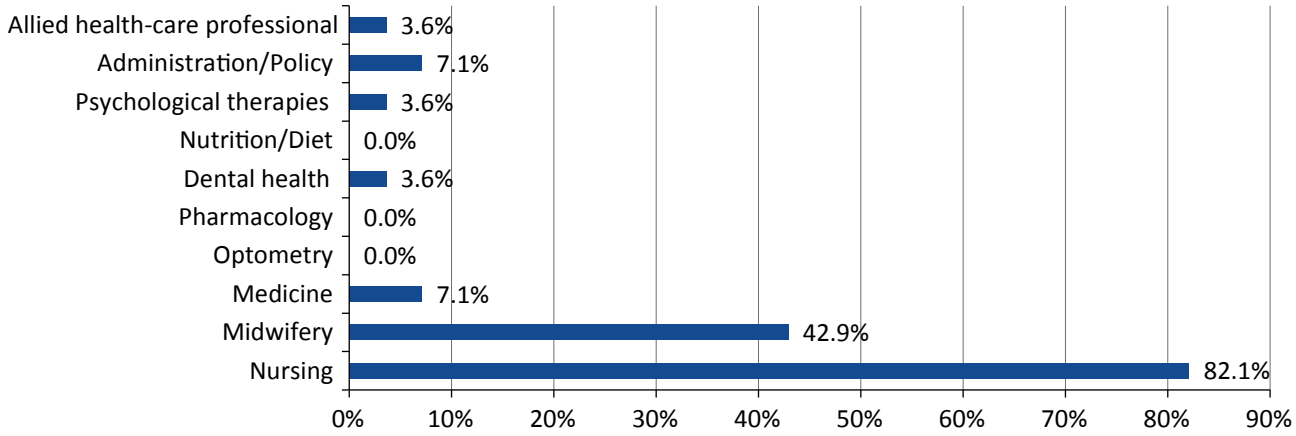
Fifteen respondents listed their highest level of educational attainment at diploma level, while eleven have a bachelor's degree, and two have a master's degree.

When asked where they had attained their education, the majority responded Lesotho (14), followed by the United Kingdom (9) and South Africa (2). Two respondents indicated they had attained their health education in a different country apart from the ones that are mentioned. One individual did not respond to this follow-up question.

Professional qualifications

As reflected in Figure 7, most respondents trained as nurses (23), with some of them also having trained as midwives (12). Two respondents indicated they were doctors, while there was a dentist, a psychological therapist and an allied health worker. There were no respondents for optometry, pharmacology, nutrition/diet and administration/policy (but that does not necessarily mean there are no Basotho diaspora in those fields in the United Kingdom; this only reflects the respondents to the survey). This may be a result of the historical concerted recruitment drive for nurses from Southern Africa to work in the United Kingdom. The large number of nurses and midwives represented in these figures is supported by the figure actually registered with the NMC in the United Kingdom, which stated that their records have 79 registered nurses from Lesotho. This result indicates that the nursing cadre in Lesotho would benefit the most from diaspora engagement.

Figure 7: Professional field of the respondents



Areas of specialization and additional training

Out of 24 who responded to the question, 20 respondents indicated that they had undergone further training in a medical specialty field (although many of them did not specify their field of specialization).

All respondents indicated they had received health-related training/professional qualification over and above their basic qualification. Of those who responded to this question, eight indicated they had received additional training in the United Kingdom, with only two stating they had received additional training in Lesotho. This indicates that Basotho in the diaspora benefit from training opportunities in the United Kingdom and would therefore have more to offer in terms of skills sharing opportunities/ programmes/strategies. There was no medical school at the time the survey was carried out, and the doctors who responded to the survey had been trained abroad. Both doctors had also sub-specialized in different medical fields (ophthalmology and urology).

Work experience

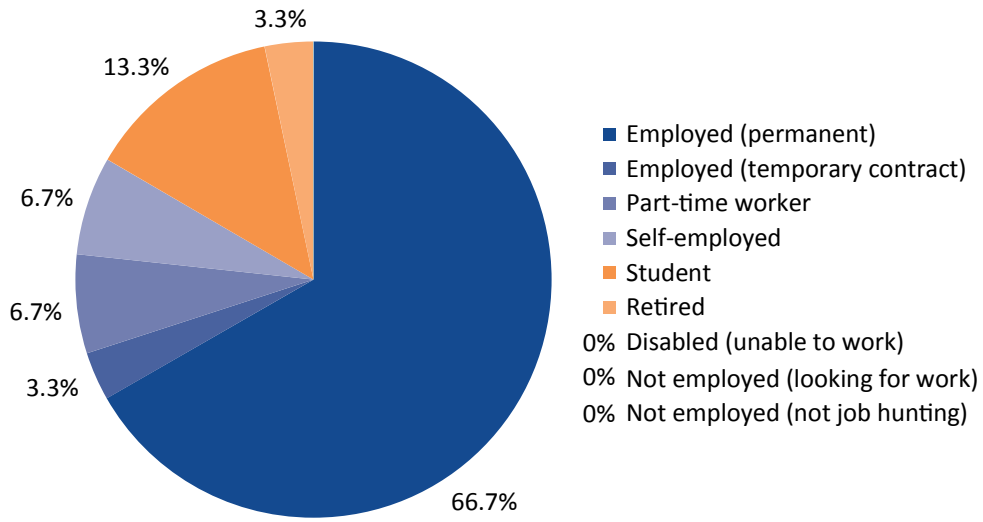
Out of the 30 respondents, 24 had some experience working in the health sector in Lesotho. Eight had over ten years of experience working in Lesotho, 6 had between five and nine years of experience, 9 had between one and four years of experience and 1 had less than one year of experience. Nurses had experience working in Lesotho and other professionals less so. This may be explained by the training resources in Lesotho where doctors and others have to obtain professional qualifications outside the country, and thus migrate as students with many of them not returning.

In addition, 10 respondents indicated that they had previous experience working in Lesotho in sectors other than the health sector, while 20 reflected the contrary. Since some health professionals have experience working in Lesotho (whether in or outside the health sector), it can be considered an advantage for any potential programmes on diaspora engagement in the development of Lesotho's health sector as an understanding of the country's work culture and other context-specific dynamics might help them settle down faster and get easily accepted by their peers.

Employment status

Figure 8 shows that most respondents are permanently employed in the United Kingdom (20); this is followed by students (4), those who are employed part-time (2) and self-employed (2) respectively, and one retiree. These figures are important in indicating the apparent need for programmes that would allow for the temporary return of diaspora health workers to Lesotho rather than those requiring permanent return, as members of the diaspora would probably not be willing to leave their permanent employment. This was apparent in the FGDs when most participants stated that they did not foresee returning to Lesotho for permanent work.

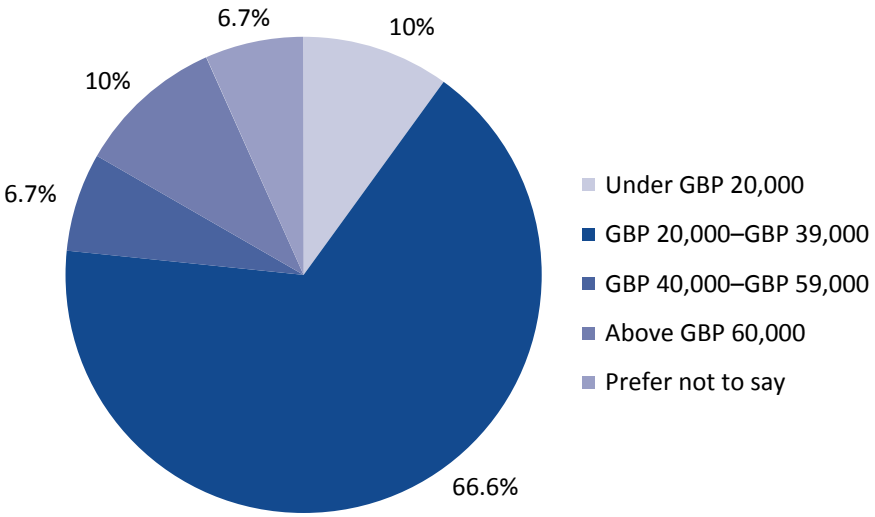
Figure 8: Employment status of respondents



Level of income

Respondents were asked to indicate their average annual income bracket. This question was included to help formulate benchmarks for remuneration levels or incentives to support individuals willing to offer their skills in Lesotho, apart from their regular earnings. The majority indicated a salary between GBP 20,000 and GBP 39,000 per year, constituting 66.6 per cent of those who disclosed their income bracket, as shown in Figure 9 below.

Figure 9: Average annual income of respondents



Exactly the same number of respondents (20) were working part time as were earning less than GBP 20,000. It is possible that most of this group overlapped. 4 were students and may form part of this group too. Of the respondents, 23 were female, and some of these had young children, which may

have an impact on their earnings. However, most of the respondents were around the average wage or higher.[54] This might reflect that most respondents had some form of specialization or additional skill and therefore had higher wages. It would be difficult for an economy such as Lesotho's to match these wage levels and thus encourage these professionals to work on a permanent basis. It is thus very important to work out strategies to leverage their advanced skills, engagement and willingness to contribute with shorter-term frameworks of participation.

3.1.3 Level of engagement with Lesotho

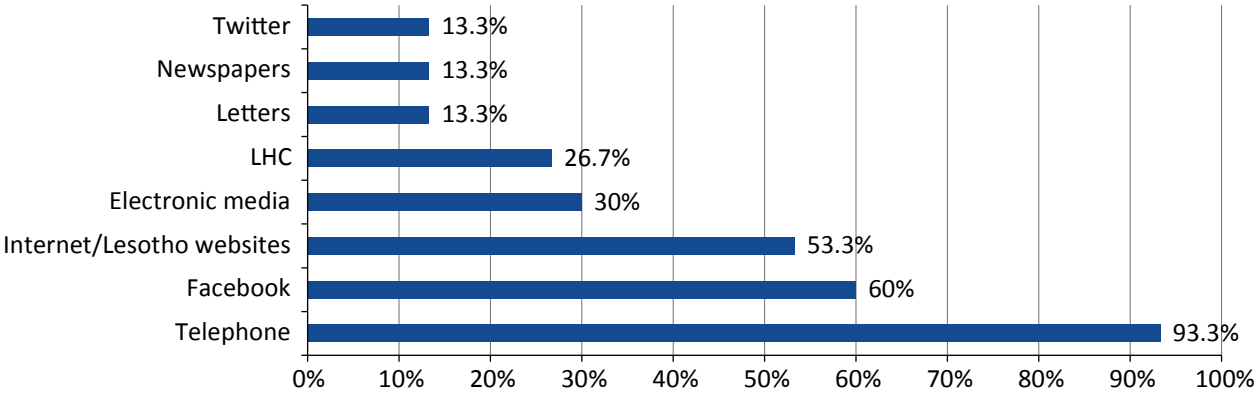
Level of connection to Lesotho

Of the 29 respondents, 26 indicated they felt connected to Lesotho a lot, with the narrative responses indicating strong links based on the following factors: (a) country of birth; (b) family (both immediate and extended) and friends in Lesotho; (c) property; (d) plans to retire in Lesotho; and (e) considering Lesotho as "home". The significance of such strong links is that they are more easily translated to a willingness to engage.

Communication

The most commonly used means of communication with people back in Lesotho were telephone (28 respondents), followed by Facebook (18 respondents), the Internet or Lesotho websites (16 respondents), electronic media (9 respondents), and the LHC (8 respondents). Letters, newspapers and Twitter came in last with 4 respondents each (see Figure 10 below). Respondents could choose one or more of the options.

Figure 10: Respondents' preferred modes of communication

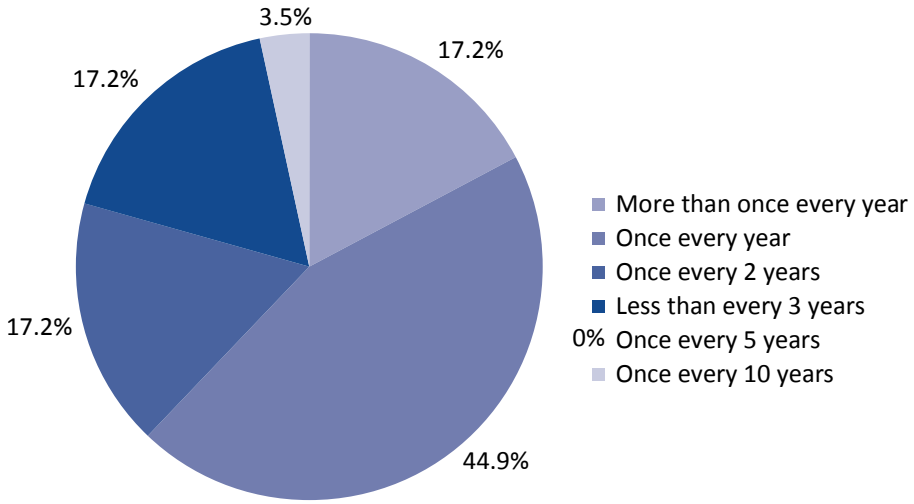


Return to Lesotho

All respondents specified that they had returned to Lesotho since migrating. This possibly illustrates the respondents' strong links with their country of origin, which could potentially translate to willingness to be involved in the development of Lesotho's health sector. In relation to the frequency of their visits to Lesotho (Figure 11), 13 respondents stated they return to Lesotho once every year and 5 stated they go more than once per year. Altogether, 18 respondents return to Lesotho at least once a year, a high level of engagement considering that all the respondents had been in the United Kingdom for at least 5 years, with some staying for over 20 years.

54 According to the United Kingdom's ONS, the average UK earnings in 2013 were GBP 26,880. (ONS, Annual Survey of Hours and Earnings, UK 2013 Provisional Results (2013), 12 December 2013. Available from www.ons.gov.uk/ons/rel/ashe/annual-survey-of-hours-and-earnings/2013-provisional-results/info-ashe-2013.html (accessed on 9 April 2015). For nurses, the figure was GBP 27,544, and for doctors, GBP 64,745 (ONS, Annual Survey of Hours and Earnings, 2013 Provisional Results (2013), 12 December 2013. Available from www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-328216. (accessed on 9 April 2015).

Figure 11: Frequency of return /visits to Lesotho



Average stay in Lesotho

On the average length of stay in Lesotho, 17 respondents indicated between four and six weeks, while 13 indicated between six months to a year. This information is crucial in determining the length of potential diaspora engagement programmes.

Intentions on permanent return to Lesotho

Concerning the respondents' future intention of returning to Lesotho on a permanent basis, 14 said they would, while 11 stated they were unsure, and 5 had no intention of going back permanently. Although many of them have been staying in the United Kingdom for a long time (see Figure 4), with some having taken UK citizenship, a significant proportion still intend to return on a permanent basis, while some are still undecided. This attests to the strength and durability of the links with Lesotho.

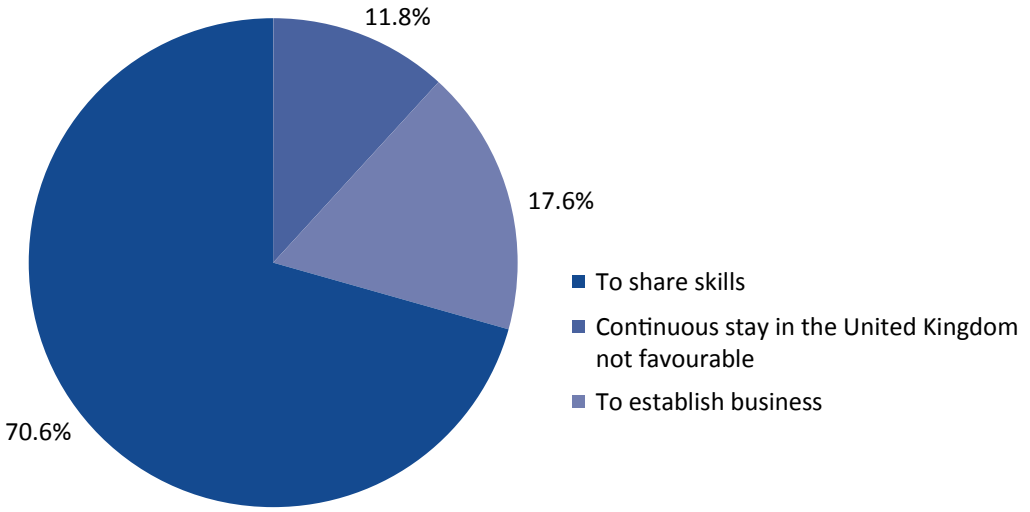
Willingness to contribute to the development of the Lesotho health sector

All respondents indicated their willingness to contribute to the development of the health sector in Lesotho. This could potentially translate into strong support for any schemes that would require diaspora professionals' involvement.

Potential reasons for wanting to return to Lesotho in the future

The questionnaire set out three general reasons for the respondents' future intention of returning to Lesotho, and the responses are reflected in Figure 12. Of the 17 who responded to this question, 12 would want to return to share their skills, 3 to establish a business, and 2 indicated they would return when continuous stay in the United Kingdom is no longer favourable.

Figure 12: Reasons for returning to Lesotho in the future



Varied narrative responses were given as to why respondents were unsure or unwilling to permanently return to Lesotho in the future. In summary, some of the reasons cited were: (a) maintaining the lifestyle in the United Kingdom; (b) better education and opportunities for their children; (c) political uncertainty in Lesotho; (d) issues of job security and progression; and (e) being married to non-Basotho national(s).

Possible areas of diaspora engagement

Figure 13: Types of support for diaspora engagement

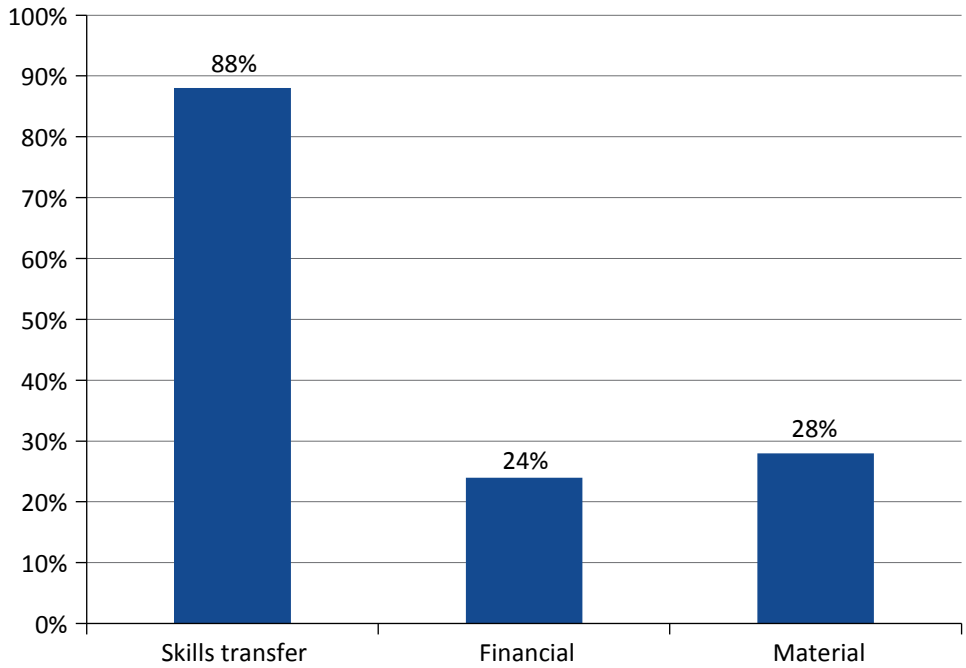
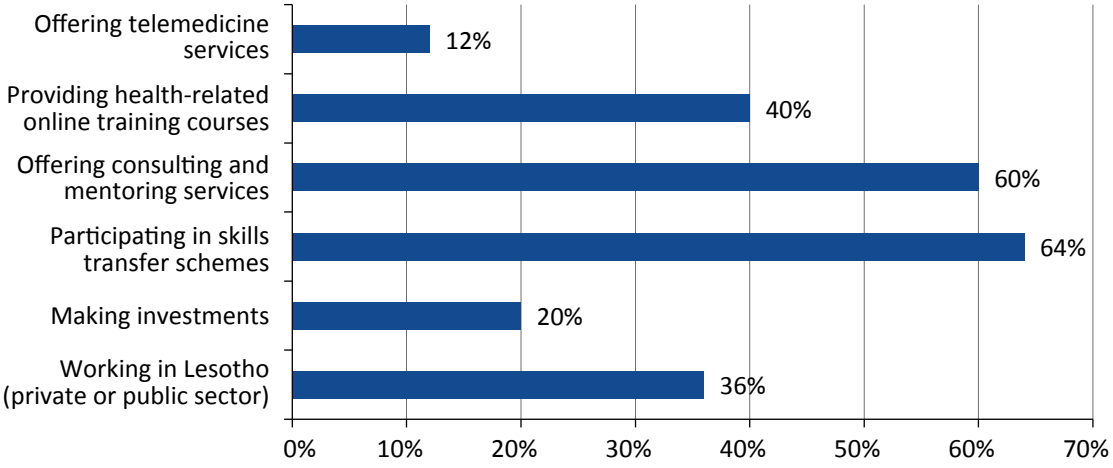


Figure 13 illustrates the possible areas of diaspora engagement. There are 22 respondents who indicated that they are interested in skills transfer, 6 in material contributions, while 7 would wish to contribute financially.

The following, in order of priority, are further ways in which the respondents are willing to engage: participating in skills transfer schemes (16 respondents), offering consulting and mentoring services (15 respondents), providing health-related online training courses (10 respondents), as well as working in the public or private sector in Lesotho (9 respondents). Some indicated they would be willing to

invest in the health sector (5 respondents), and a few said they could offer telemedicine services (3).[55] These are illustrated in Figure 14 below. Respondents could choose from more than one option.

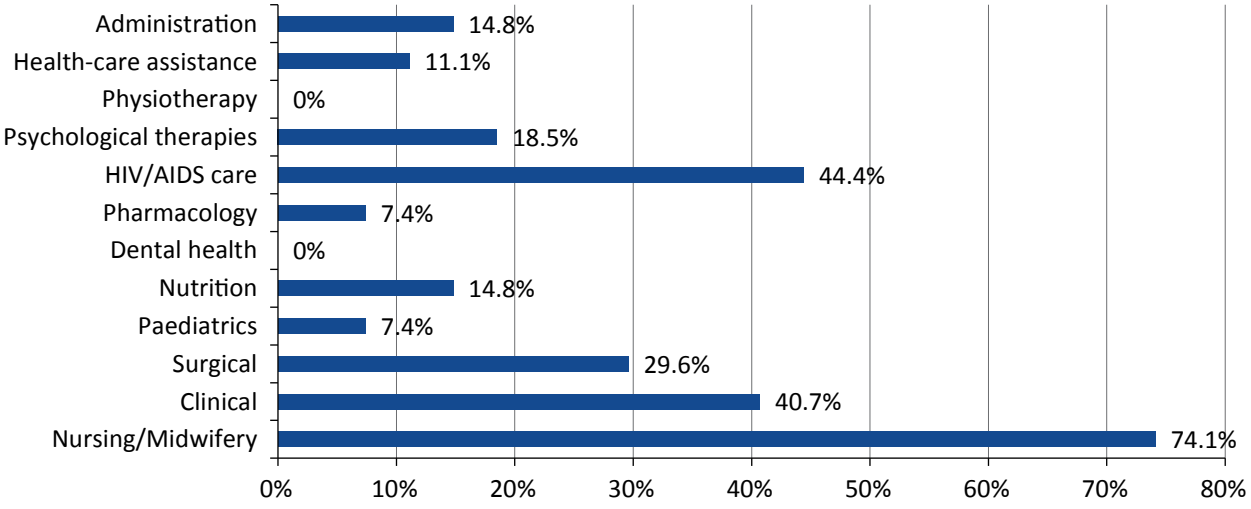
Figure 14: Areas of diaspora engagement



Areas of diaspora engagement specific to the health sector

Figure 15 sets out specific areas within the health-care sector where respondents would wish to contribute as follows. Respondents were free to choose more than one option.

Figure 15: Areas of potential diaspora engagement specific to the health sector



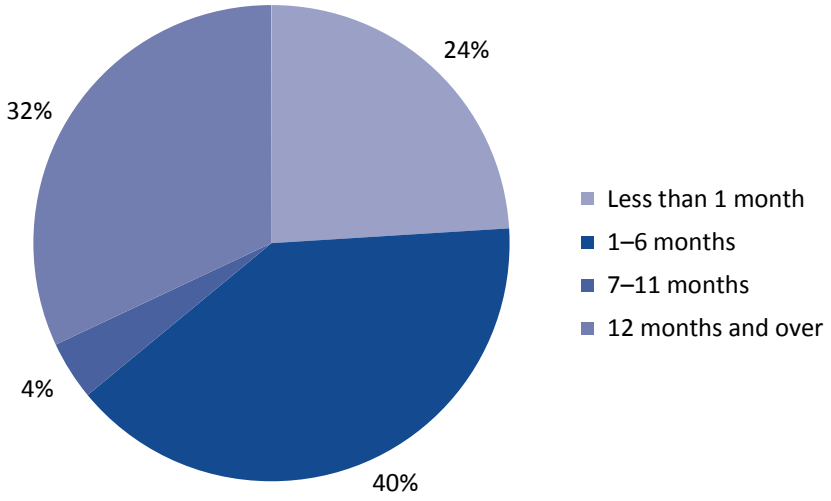
One of the crisis areas in Lesotho's health sector is HIV/AIDS, and the skills garnered working in a service with longer established systems for managing infectious disease would be very valuable. As such, almost half of the respondents would wish to contribute in this area in Lesotho. Although none of the respondents indicated working in administration, about four showed willingness to be involved in administration, implying they have identified the need and possess skills that could help plug that gap.

Length of potential placements

Ten respondents indicated willingness to go to Lesotho between 1 to 6 months, while eight are willing to go for 12 months or more. Six indicated they are willing to go for a month (see Figure 16). This information is vital in determining the types of schemes that are developed for diaspora engagement.

55 *Telemedicine* is the use of telecommunication and information technologies to provide clinical health care at a distance.

Figure 16: Length of potential placements



There was a 50/50 balance of respondents willing to go on a skills transfer scheme without their family accompanying them. This potentially allows for short-term diaspora engagement as they probably form a part of those who are not necessarily willing to go back on a long-term basis. This would allow for teaching and other schemes, for instance. The other half could potentially be involved in online mentoring schemes or similar schemes.

Dual citizenship

Respondents were asked to indicate, on a scale of 1 to 10 (with 1 being unlikely and 10 being very likely), whether they felt the availability of dual citizenship would increase the level of engagement in, or skills sharing by the diaspora in the health sector. This is to determine how the lack of dual citizenship would likely impinge on diaspora engagement decisions or not. The results were expected, based on the undertaken literature review, as well as the results of the FGDs and key informant interviews. Out of the 28 respondents, 21 picked 10 on the scale, and 6 was the lowest number chosen (picked by 1 respondent). This serves as an indication of how strongly the diaspora feel about the issue and suggests that by addressing this issue, the Government of Lesotho could see improved engagement of the diaspora members. This result may be because the vast majority of respondents are Lesotho citizens, as illustrated in section 3.1.1 and by the fact that out of 31 respondents, 25 indicated they were Lesotho nationals, while 4 stated their nationality as British and 2 as South African.

Experience of sharing information in Lesotho

Nine respondents indicated they had the opportunity to share their professional knowledge in Lesotho, through teaching and/or facilitating courses for colleagues in Lesotho (both doctors and nurses), and providing medical books to colleagues and students based in Lesotho. A thread ran through the narratives in the questionnaire responses indicating that generally, information sharing had been through chats and/or informal meetings with colleagues in Lesotho where they discuss how things are done in the United Kingdom and how to improve systems in Lesotho. Responses indicate that interventions had mostly been purely opportunistic, with minimal official involvement and through intervention on behalf of a family member. In terms of experiences on information sharing, the narrative in the questionnaire responses indicates a thirst for knowledge in Lesotho but overall poorly developed continual professional development. Some respondents said they had a positive experience. For instance, a respondent observed that there is a thirst for knowledge back in Lesotho and that engagement had not been a problem when it came to information sharing, perhaps despite minimal or no local facilitation. Others had somewhat negative experiences, with a respondent, for instance, implying that the health service in Lesotho is not patient centred. Similar threads in terms of experiences on information sharing ran through the FGDs, with more detailed examples given in sections 4.2, 4.3, 4.4 and 4.5 of this report.

The responses are encouraging as they show the respondents' willingness to engage in improving Lesotho's health sector, such that the development of formal strategies will enable their involvement in a more coherent way.

When asked whether they ever had the opportunity to participate in sharing their professional knowledge with fellow Basotho, nine respondents replied with an affirmative answer. In terms of period of information sharing with colleagues in Lesotho, 6 respondents indicated they had previously engaged in information sharing for less than a month, and 2 answered for a period of over 12 months. This may be an indication that short-term programmes would probably be more suited to engaging the diaspora in the United Kingdom.

Challenges to engagement

As pointed out earlier, all respondents indicated willingness to contribute to the development of the health sector in Lesotho. Respondents were also asked to indicate challenges that prevent (or could potentially prevent) them from contributing to the development of the health sector in Lesotho. Responses were in the form of narratives and included the following:

- Financial constraints and expense involved (expensive flights to Lesotho).
- Family commitments in the United Kingdom and children's education.
- Time constraints – time spent in Lesotho is usually taken up by family commitments and the like, so it is hard to commit time to engaging in other activities.
- Negative attitudes and perceptions of officials and colleagues in Lesotho towards members of the diaspora.
- Bureaucratic processes or red tape in Lesotho that makes the system inefficient.
- Lack of material resources locally.
- Lack of leadership and accountability within the health sector in Lesotho.
- Non-registration with professional bodies in Lesotho (such as the Medical Council or the NMC) could hinder people from working when they go on visits.
- Lack of personal and continual professional development in Lesotho.

The responses mentioned were also reflected in the FGDs and the key informant interviews and given in more detail, as set out in sections 4.8 and 5.4 of this report.

Possible solutions to challenges

Among possible solutions to the challenges to engagement suggested by the respondents, one was the development of a formal skills sharing programme for the diaspora that is effective and sustainable. The aim of this would be to:

- Enable diaspora members to structure leave prospectively (thus taking care of time constraint issues), and may make it easier for employers to recognize the time taken as professional leave.
- Make it possible to recruit members who are interested in such programmes and also facilitate equipment transfer with proper needs assessment and less red tape.

- Facilitate exchange programmes as acquisition of specialist skills may require some training to be undertaken in the United Kingdom (for instance, under the dual sponsorship scheme of the medical royal colleges).[56] It is easier to obtain sponsorship for a formal programme than for individual endeavours.

- Facilitate better acceptance by local staff of the input of returnees by formalizing roles. The local staff would hopefully define needs and work together with the diaspora members to help address such needs. Participants in FGDs thought local staff felt threatened by their efforts, leading to the negative attitudes described in the previous section.

Further possible solutions include:

- Improve working conditions and remuneration (to attract health professionals back to Lesotho on a more long-term or permanent basis, as well as retain those health professionals who are still in Lesotho and have not yet left).

- Formalize volunteering in the health sector through development of volunteering programmes and training related thereto.

- Develop and implement continual professional development strategies.

- Effectively address diaspora registration with professional bodies in Lesotho.

- Remove red tape to enable transfer of resources and equipment to Lesotho.

- Mitigate travel costs as flights are the biggest expense for diaspora members.

- Address dual citizenship issues to get more people involved in engaging and contributing to the development of the health sector and of Lesotho in general.

- Effectively address the issue of lack of leadership and accountability within the health sector as a whole in Lesotho.

- Regulate health-care facilities with a view to safeguarding against provision of poor health-care delivery.

Motivations or incentives for involvement

The following were cited as potential motivations or incentives for returning on a skills transfer scheme to Lesotho:

- Mitigation of travel and other costs.

- Logistical support for diaspora members in relation to transport to and accommodation in remote areas (where the need arises).

- Improvement of electronic media infrastructure in the country as a whole (such as access to telecommunications, internet connection and others).

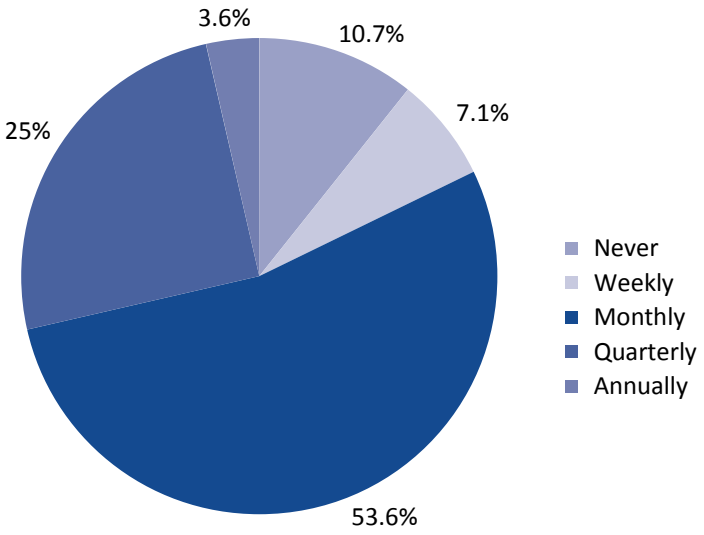
- General improvement of working conditions and remuneration (as a motivation for long-term or permanent return to Lesotho).

56 Dual sponsorship schemes are run by different medical colleges in the United Kingdom designed to provide an opportunity for international medical graduates to undertake targeted training in different specializations for a limited period of time.

Remittances

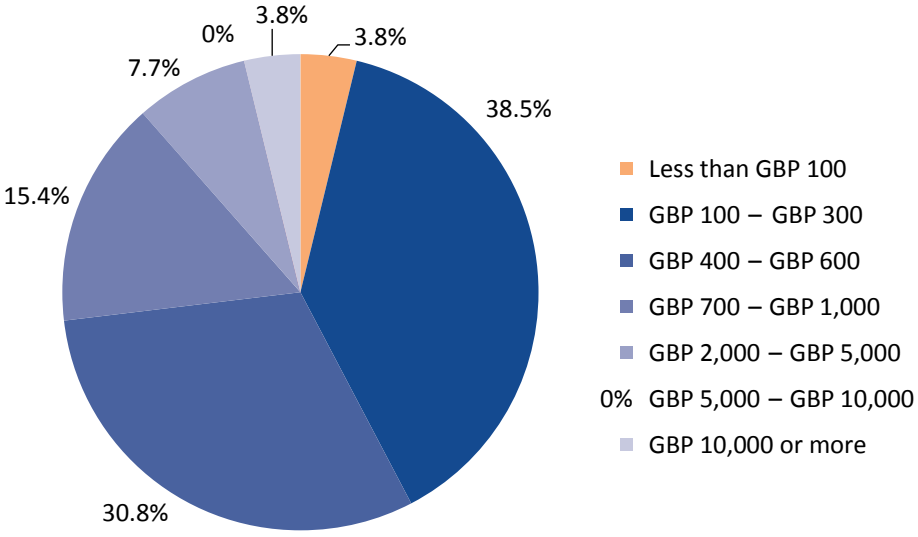
Respondents were asked whether they send remittances to family in Lesotho and how often to determine the financial and other links to Lesotho. There are 27 respondents who answered they had sent remittances home, with 15 doing so on a monthly basis, 2 on a weekly basis, about 7 quarterly and 1 annually (see Figure 17). These figures bear witness to the strong links that Basotho diaspora have to Lesotho.

Figure 17: Frequency of remittances



As illustrated in Figure 18, ten respondents indicated they remitted between GBP 100 and GBP 300 per transaction, followed by eight respondents who remitted between GBP 400 and GBP 600 on average, per transaction.

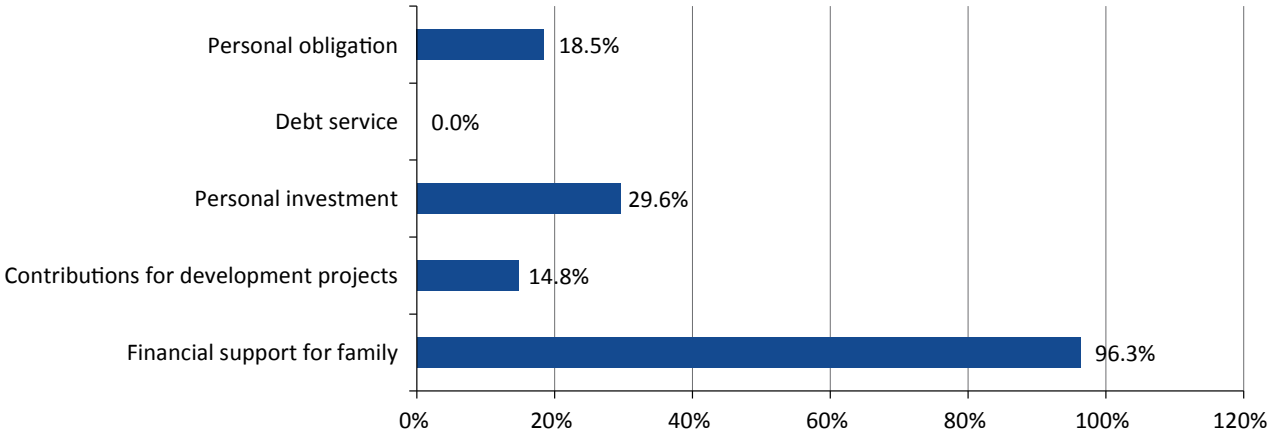
Figure 18: Amount of remittance



Reasons for remittance

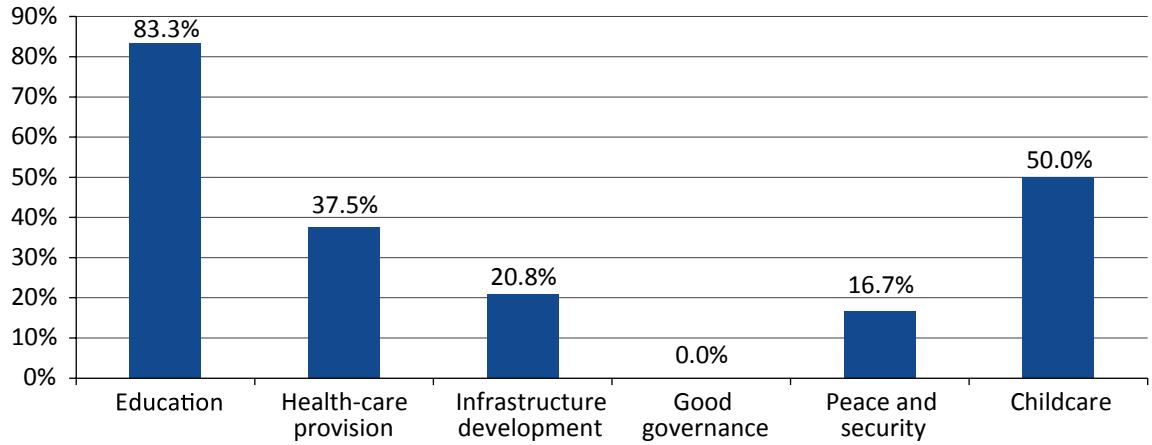
Respondents could choose one or more answers as reasons for remittance. Twenty-six respondents stipulated that they send remittances home as financial support for family. Eight indicated that they send money for personal investment. Both these factors likely signify that a large majority of the diaspora have strong family ties in Lesotho, which can be a motivating factor for engagement in potential skills sharing programmes. In addition, 4 respondents stated they remit money and/or goods as contributions for development projects. This indicates willingness of some diaspora members to engage in the development of their country of origin (see Figure 19).

Figure 19: Motivations for remittance



When asked what areas of development the remittances contributed to (where they could choose more than one answer), 20 respondents picked education, 12 answered childcare, 9 indicated health-care provisions, 5 selected infrastructure development and 4 said peace and security, as illustrated in Figure 20 below.

Figure 20: Areas for remittance contribution

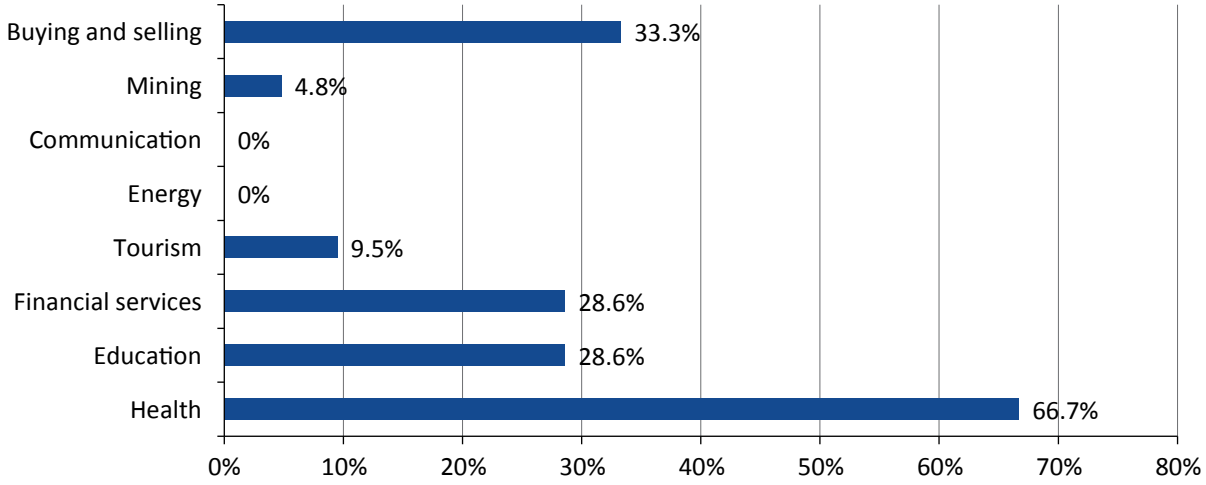


When asked whether the respondents think or believe the remitted money and goods contribute to Lesotho's development, 25 out of 27 replied in the affirmative.

Property or investment links

Out of the 29 respondents, 16 own some form of property in Lesotho and 10 indicated they have private investments in Lesotho. Furthermore, 24 respondents indicated that they are interested in making investments in Lesotho. These points could be construed as strong indicators of robust links to the country. It is worth noting that 14 respondents are interested in investing in health services and 6 each in education and financial services, as illustrated in Figure 21 below.

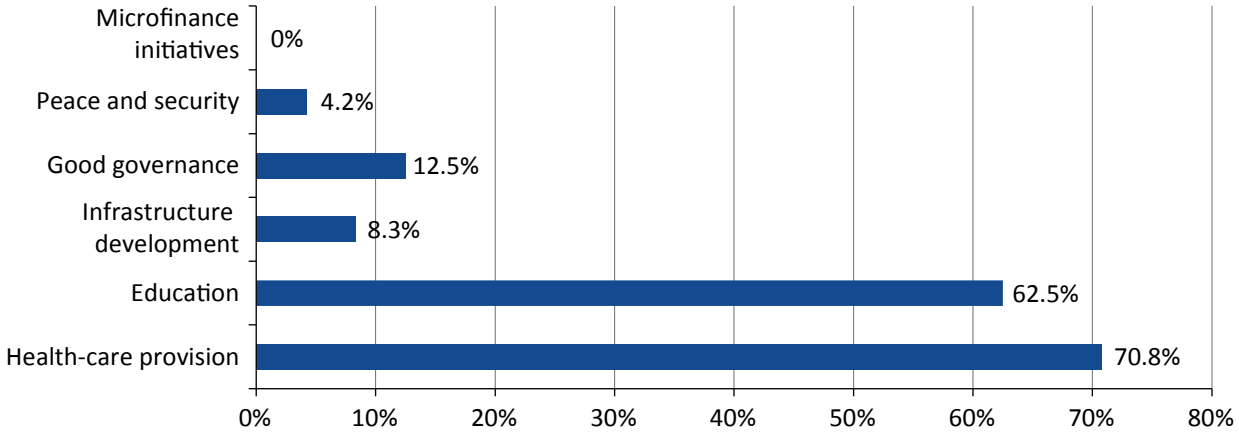
Figure 21: Areas of interest for respondents' potential private investment



Note: Respondents were able to choose more than one answer.

A similar thread prevails in relation to respondents' interests in supporting development projects, with the health sector receiving the highest vote (17 respondents), followed by the education sector (15), as illustrated in Figure 22 below.

Figure 22: Areas of interest for respondents' potential development projects



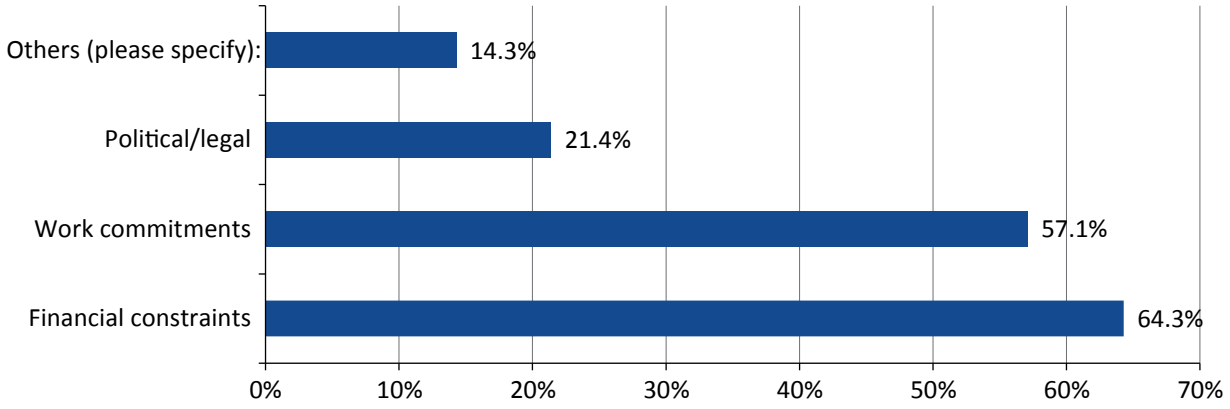
Note: Respondents were able to choose more than one answer.

Barriers to engagement

Half of the respondents gave an affirmative answer to the question whether there are restrictions that could hinder their contribution to the development in Lesotho. 4 respondents indicated there were no barriers, while 10 were unsure.

Figure 23 below sets out possible barriers to engagement. Financial constraints (9 respondents) and work commitments (8 respondents) were the highest barriers identified. One respondent singled out the lack of dual citizenship in Lesotho as the main barrier, under the "Others" category.

Figure 23: Types of barriers that may hinder contribution to Lesotho's development



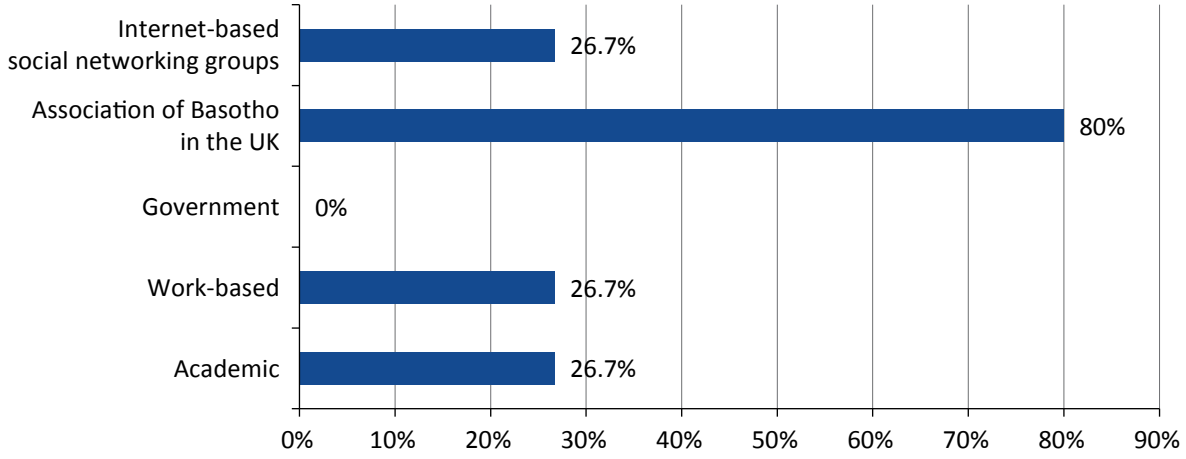
3.1.4 Diaspora networks

The issue of existing diaspora health or other organizations was raised to determine potential of facilitating future mobilization and outreach for particular activities. 14 respondents indicated they were not affiliated with any formal or informal diaspora network or association while 13 answered otherwise.

Membership of diaspora organizations

As illustrated in Figure 24, 12 out of 15 respondents indicated they were members of Basotho-UK. Membership to academic, work-based and Internet-based social networking groups (with the "Others" category indicating membership of a Lesotho-based group) were chosen, with 4 respondents each. Respondents were free to choose more than one answer. This result may indicate that the Basotho-UK forum is the main link for reaching out to diaspora health professionals for any future engagements.

Figure 24: Membership in diaspora organizations



Out of the 28 respondents, 27 indicated that they did not know of any Basotho health professional organizations in the United Kingdom. The one participant who responded in the affirmative seems to have misunderstood the question as the Basotho-UK forum was identified, where membership is not restricted to health workers but includes all Basotho diaspora in the United Kingdom.

Information sharing among diaspora members

E-mails (13 respondents), meetings (9) and word of mouth (9) were respectively cited as the most popular means of information sharing. Other forms include social media networks, such as Facebook (7) and Twitter (1). Respondents were free to choose more than one answer.

Recommendations emerging from the survey are given in Chapter 7.

CHAPTER 4 – Focus group discussions

4.1 Focus group discussions

Table 1: Profile of FGD participants

Profession	Specialty	Gender
Nurse	Occupational safety and health and risk management	F
Nurse/Midwife	Maternal and child health	F
Nurse	Infection control and management	F and M
Nurse	Theatre and Intensive Therapy Unit (ITU)	F
Nurse	Care of the elderly and stroke	F
Nurse	Manual handling	F
Nurse – Trainee	Health-care assistant	F
Nurse	General nurse	M
Nurse	Respiratory/Escalation wards	F
Nurse	Dementia and mental health	F
Nurse	Cardiology	F
Nurse	Tissue viability	F
Doctor/Surgeon	Ophthalmology	M
Public health professional	Research/master of public health study	F

Three FGDs were conducted and moderated. Participants in all the focus groups were engaging and showed keen interest in the subject matter. They came up with interesting recommendations, although there was scepticism and suspicion, especially with regards to whether anything would come of this study.

4.2 Migration patterns of health-care professionals from Lesotho to the United Kingdom

The FGDs revealed the following results. Basotho health-care professionals have been migrating to the United Kingdom over a long period, but the trend seems to have increased in the early 2000s when there was a drive to recruit health professionals from Southern Africa in the United Kingdom and Ireland. The increased migration was mostly nurses, a lot of whom were recruited to the United Kingdom by UK-based recruitment agencies for nursing and old-age homes. The majority of nurses will have started work in the United Kingdom in care homes, with some subsequently moving to clinical jobs in hospitals or community settings. Although some remain in homes, many are found in hospitals, community clinics and public service sector. A few work for private clinics or establishments. A number of nurses trained in Lesotho and had some experience working there for a period (mostly in the public sector but some in the private sector) before migrating to the United Kingdom. Some nurses trained in Lesotho, migrated to South Africa, and then migrated further to the United Kingdom (some such nurses consider themselves Basotho even though they travelled to the United Kingdom on South African passports as they have family and roots in Lesotho).

Participants pointed out that older colleagues tend to retire and move back to Lesotho rather than stay in the United Kingdom, mainly because most of them originally migrated with the objective of working for a number of years, and then relocating back to Lesotho. Most said they would retire to Lesotho. It transpired that older generation nurses tend to come on their own without their families, which means that they tend to go back home to Lesotho to their spouses and children. There has been a trend recently of reverse migration to Lesotho, which was attributed to one or more of the following:

- Personal commitments, such as family bereavement or long-term illness of a family member requiring permanent return of a diaspora member.

- Some health-care professionals come to the United Kingdom without their families and therefore cannot stay away indefinitely.
- A recent recruitment drive for health-care professionals for the newly established referral hospital in Maseru, the capital of Lesotho.
- Some professionals move to the United Kingdom with the specific intention of staying for a set amount of time, after which they return to Lesotho.
- Some nurses have gone back following retirement, having been in the United Kingdom over a number of years (mainly over 15 years).

The participants noted that migration of nurses between Lesotho and the United Kingdom has tended to be cyclical in some instances, where people have gone back to Lesotho through the recruitment drive mentioned above, but some have come back to the United Kingdom because they have found the situation at home not what they had expected for various reasons. These reasons include incentives promised by the recruiters not materializing, unsatisfactory working conditions, negative attitudes towards returning nurses by those remaining in Lesotho, the perception that their children's education would suffer and so forth. Many of the participants said they would eventually go back to Lesotho on a permanent basis, even if it meant for retirement, as "home is home," as one participant stated.

Virtually all respondents said they are willing to go back and engage in the development of the health sector in Lesotho. Nearly all are willing to go back on a temporary basis. None of the participants vocalized unwillingness to ever return to Lesotho. A few are willing to go back on a permanent basis, conditions permitting, but most on a short-term temporary basis, with the objective of eventually retiring to Lesotho and continue contributing in different ways. A few said they are willing to go back upon retirement, but are not willing to work in the health sector as long as conditions remained as they are.

The health-care professionals interviewed from Lesotho are found mostly in acute and primary health-care sectors, with very few in neonatal/paediatric care and others. This is believed to be a result of the basic nursing training in Lesotho that focuses on adult health care. A number of FGD participants made the point that although nurses in Lesotho train to a high standard as midwives, they rarely practice as midwives in the United Kingdom as they have to complete an adaptation course before they can practice here due to the different training systems.

4.3 General experience of health professionals from Lesotho in the United Kingdom

Participants in all FGDs agreed that the health sectors in Lesotho and the United Kingdom were on different levels and therefore incomparable. The general consensus was of positive living and working experiences in the United Kingdom. Participants agreed that the ethos of patient-centred care, along with the support, education, training and development opportunities for health professionals in the United Kingdom, played a big part in their positive experience. "As health-care workers in the UK we are generally treated in a way that makes us feel valued, empowered and supported and this results in improved patient safety, experience and outcomes," stated one participant, to the agreement of others.

4.3.1 Positive experiences in the United Kingdom

It was felt strongly that the high standards of excellence and professionalism in the United Kingdom's health sector were the antithesis of the situation in Lesotho where there is low level of professionalism and commitment, lack of investment in staff, poor infrastructure and lack of leadership and accountability from the top down. A number of anecdotes were given, demonstrating similar examples

on different issues. Some say leaving Lesotho was not only about low levels of pay, but because they were disheartened by the unsafe and appalling conditions they worked under due to lack of basic equipment and infrastructure, coupled with a perceived "no-care" attitude of those in power. Instances were given of demoralizing and unsafe conditions. In one instance, a participant stated:

> When working in the maternity ward at Queen Elizabeth Hospital II in Maseru we worked under appalling conditions in which there were no sheets in the labour ward with women giving birth on pillowcases.

Another participant pointed out:

> We often found ourselves having to administer oxygen without a gauge because it had been broken for months on end and very disturbingly having to handle HIV and/or AIDS patients without any gloves because of a lack of basic equipment in a lot of instances.

There was a general consensus of Lesotho's dire need for basic infrastructure and equipment to improve working conditions, inculcate a culture of safety and entrench continual training of health workers.

The attitude of health-care workers towards service users in Lesotho was repeatedly flagged as a major concern. The low level of professionalism in Lesotho seemed so much a part of the nursing culture that most respondents only became aware of it when they started working in the United Kingdom and realized how badly patients and their families are treated in Lesotho. Many stated that negative attitudes permeate even through the professional ranks where high-ranking officials (nurses and doctors) look down upon the ones in lower ranks.

> Moving to the UK has been an eye opener as I realised how unprofessionally we used to treat patients and lower ranking colleagues back home, with no consequences bearing upon us. In the UK patients come first and accountability is at the core.
>
> – Statement of one of the nurses, supported by similar anecdotes

There was general consensus for change in attitude towards service users in Lesotho and that concerted effort is needed to put patients at the heart of the service through awareness campaigns and the like. Lack of accountability and leadership was identified as a major problem in Lesotho, as opposed to the experience in the United Kingdom where leadership, professionalism and accountability are at the core. According to one of the respondents:

> Workers at different levels (including those in managerial positions) do whatever they like without fear of there being any consequences to their actions, as professional bodies such as the Nursing and Midwifery Council or the Medical Council in Lesotho repeatedly fail to act on cases or take steps to discipline those in the wrong. In addition, people in the civil service do not get disciplined at all and therefore tend to do things with impunity. Things are different here in the UK.

A participant in one of the groups captured the essence by stating that the mindset in Lesotho was so bad that conditions are not conducive for treating patients well. The lack of patient-centred care was identified as a major problem. An anecdote was shared of one nurse's mother contacting her in tears and relating the conditions where she had found a good friend of hers in the hospital when she went to see her. The friend, who had cancer, had been found by the nurse's mother unconscious and lying on a bed soaked with urine, where she clearly had not been washed or changed over a long period. There had also been different meals, one from the previous day and another from the morning, which had been left by her bedside; it seemed the nurses hadn't noticed that she had been unconscious and left her food there without checking to see if she is able to get up and feed herself. This is said to be just an example of what happens on a daily basis. The perplexing thing is that the training in Lesotho is considered to be superior to a number of places, since it is holistic rather than specialist.

4.3.2 Negative experiences in the United Kingdom

As a whole, negative experiences of working and living in the United Kingdom were fewer than the positive ones. Subtle cultural differences were brought up, which were said to have resulted in a somewhat negative experience. For example, greetings are at the core of Basotho culture, and walking past someone without greeting or acknowledging them is an affront. Some of the respondents found this rather disconcerting when they first arrived in the United Kingdom and therefore made them feel unwelcome and uneasy, until they realized it was just not part of the UK culture.

Upon first arriving in the United Kingdom, most nurses recruited from Lesotho and other Southern African countries were placed in nursing homes, rather than in hospitals or clinics. This resulted in them not using their skills, which became a great source of frustration. Most of the nurses said they felt undervalued and were not treated as professionals as they were not allowed to make clinical decisions with deference often given to non-clinical administration personnel and long-serving care assistants. One participant shared:

> Having left Lesotho at the level of Matron and finding one's competencies and abilities not recognised at all, but instead doing the work of the equivalent of an assistant health worker doing routine non-clinical work and taking orders from unqualified personnel was completely demoralising. It also worried me that I might lose my skills.

Some participants said they very quickly moved to different jobs that would allow them to practice their professions, while others were bound by the terms of their contracts with the recruitment agencies to serve a set minimum period before they could move on, sometimes to their detriment. This resulted in losing some of their skills from non-use over prolonged periods.

Although it was generally agreed that the level of specialization within the nursing cadre in the United Kingdom was a positive aspect of the system, it was still identified with certain negative consequences. There was general consensus that nursing training in Lesotho is more holistic and intense than that in the United Kingdom, which is specialist from the onset. The basic requirements for training in Lesotho are strict and rigid, with the minimum requirement of a General Certificate of Secondary Education equivalent and no alternative entry to nursing. It was argued that as a result, Lesotho-trained nurses are able to deal with a myriad of situations and tend to be more efficient in dealing with patients holistically. The general feeling was that the skills of nurses from Lesotho were under-utilized as a result. On several occasions, there were indications that nurses in the United Kingdom lack what in Lesotho would be considered basic nursing skills, such as inserting a catheter or a cannula, among other things. In many ways, they felt this hampers the delivery of timely and efficient care, where a specialist nurse from a different unit would have to do one thing and then another deals with something else, whereas nurses trained in Lesotho were trained to handle basic patient care by themselves. One of the respondents captured a concern of deskilling repeatedly highlighted by many, thus:

> The downside of the system of specialisation in the UK is that we lose our basic skills, which if one were to return to Lesotho, could greatly impair one's effectiveness as the situation there demands multi-skilling due to staffing and other problems.

Another specialization concern was that virtually all the nurses in the FGDs who trained in Lesotho were qualified midwives, but none of them practiced midwifery in the United Kingdom because the UK NMC was no longer accepting Intention to Practice (ITP) notifications from midwives working outside the United Kingdom. From 2005 to 2006, the ITPs have to be signed off by supervisors or midwives in a local supervising authority, which are only located in the United Kingdom.[57]

A further negative aspect that was repeatedly flagged by numerous participants is the perceived subtle or hidden racism (or in one participant's words, "posh racism") and resulting discrimination. Instances

57 NMC, Statistical analysis of the register, April 2006 to March 2007 (London, 2007). Available from www.nmc.org.uk/globalassets/siteDocuments/Statistical-analysis-of-the-register/NMC-Statistical-analysis-of-the-register-202006-202007.pdf (accessed on 6 April 2015).

related include the recurring assumption of health service users that black nurses or doctors are members of the cleaning or support staff rather than professionals. It was also agreed that racism in the professional context (that is, exercised by colleagues) was subtle and very often difficult to prove, hence not something that could easily be dealt with through grievance procedures. One respondent shared:

> As black migrant workers, we certainly experience more than the fair share of disciplinary cases, more so than people of other races. Complaints are more likely to be taken on board by management if they are by white care workers rather than by black nurses.

Another respondent related that:

> When I worked in a care home, I felt my qualifications, expertise and experience counted for nothing at all, as deference would be given more to white health assistants and we would be relegated to doing the menial jobs.

An additional point illustrating the negative aspects of the UK system was the perception of the United Kingdom as a litigious society. This was said to often result in health-care workers being overly cautious in carrying out their duties, sometimes to the detriment of patient care. For example, health care is often delayed when a nurse waits for someone else to be present before carrying out a procedure so that he/she will have a potential witness in case of a future litigation or disciplinary action.

4.4 Conditions that make the United Kingdom an attractive destination for health-care professionals from Lesotho

The following conditions are the general features that participants felt make the United Kingdom an attractive destination for health-care professionals from Lesotho:

- Higher levels of pay;
- Greater opportunities for career progression;
- Better living and working conditions;
- Lack of corruption within the system;
- Availability of equipment and infrastructure;
- Recognition of family commitments (such as right to carer's leave);
- Ingrained high levels of professionalism and accountability; and
- The ethos of patient care that puts the patient and users of the service at the core.

The culture of openness and transparency was said to be a great attraction to the United Kingdom. Many negative factors in the Lesotho system were identified to illustrate the attractiveness of the UK system. These negative factors include:

- Lack of accountability at all levels;
- Lack of basic infrastructure and equipment;
- Lack of compassion to patients and family members or relatives;
- Lack of support and understanding from management (that is, rigidity of the system);

- Corruption at the core of the system, especially in terms of training and other developmental opportunities; and
- Lack of policies to guide health workers, or ignorance of such policies (where they exist) by health workers and service users and lack of implementation where such policies exist.

A respondent succinctly captured the sentiment of many in this regard by stating:

> We, as health professionals feel undervalued in Lesotho, working under dire conditions characterised by lack of equipment/infrastructure, lack of leadership, severe manpower shortages, and very little prospects of career progression, and poor salaries resulting in inability to better our children's education and improve our lives and those of our extended families in general.

Another respondent captured the feelings of others by stating that the pay in Lesotho does not accommodate family welfare and that nurses are not remunerated accordingly after the basic training.

The consensus was that, although it would be impossible for Lesotho to match salaries in the United Kingdom that may attract diaspora members to return to Lesotho (on a permanent basis), other push factors could be adequately addressed for the development of the Lesotho health sector through mentorship programmes and awareness campaigns on attitudinal changes. The need for management to address the general requirements in the health system of Lesotho was emphasized so that operations remain efficient and excellent health care is delivered.

4.5 Skills development opportunities for diaspora health workers in the United Kingdom

There was unanimous perception that excellent opportunities for professional development in the United Kingdom are available and that Basotho health-care professionals benefit a great deal from them. Policies and processes on training in the United Kingdom were highly commended, as there is systematic mandatory training, mentorship programmes and periodic refresher courses, which make a huge difference in providing effective and safe patient care. Participants also valued that funding for training and development in the United Kingdom is universally available to those who wish to further their skills, as well as systematic appraisal, which ensures that people stay on top of their training.

The general consensus was that there was a lack of policy and leadership on training and development in Lesotho. Respondents echoed the need for management that appreciates the importance of training and understands training needs in the general health sector. Thus, training would be done in a systematic and coherent manner and benefit the system, as well as the personnel involved in the health care. An anecdote in this instance was given as follows:

> In one instance, a Financial Controller in the Ministry of Health in Lesotho was enrolled on a course on Diarrhoea Disease Control at the expense of either a nurse or nurse clinician attending. This is just one of the things that contributed to poor staff morale as the course would have been of far greater benefit to the health system if it had been attended by a nurse or a nurse clinician, rather than a bureaucrat.

A general agreement identified that similar situations occur in different areas of health-care delivery. Emphasis was also put on the need for occupational safety and health, as well as training relating thereto to be put at the core of the system in Lesotho.

4.6 Motivations of health workers to contribute to the development of Lesotho's health sector

Basotho have very strong links to Lesotho as the majority, if not all, have family members back home that they support financially and otherwise. Most of the participants are willing to engage in the development of the health sector in Lesotho. Almost everyone is willing to go back on a temporary basis on skills sharing and investment programmes, while some said if the conditions were right, they are willing to go back on a more permanent basis. Some are willing to go back to Lesotho upon retirement in the United Kingdom so they can "give back" to their country of origin. Many indicated willingness to volunteer their services to contribute in the improvement of the Lesotho health sector.

Diaspora members indicated they were motivated by different factors to contribute to the development of the health sector in Lesotho. Most specifically, they identified the negative aspects of the state of the health sector in Lesotho as the motivating factors for engaging in the development of their country of origin. Many of the respondents had either experienced or observed a family member or friend being ill-treated or getting inadequate or inappropriate treatment. There is a thread of similarity running through the different stories, and for many of the participants, the motivation came from the realization that nurses from Lesotho are equally skilled, if not more, than their counterparts trained in the United Kingdom. This is seen as an endorsement of the education and training in Lesotho being at par with what prevails in the developed world.

For some, the motivation has been the positive experience working in the United Kingdom, where they feel they are treated as proper professionals. This motivation also makes them feel appreciated and enables them to treat patients as prime, and would want that to be translated into a force for good in Lesotho.

4.7 Diaspora initiatives for engaging with the health sector in Lesotho

There have been a number of diaspora initiatives to support the health sector in Lesotho undertaken by individuals, rather than as a collective. The majority of the participants indicated that they had and continue to contribute as individuals in a number of different ways, but mainly through information sharing and advice on different aspects of health care to support colleagues in Lesotho. In addition, other members engage by sending books and resources to colleagues and students in Lesotho. One respondent said she regularly sends copies of the *British National Formulary* to Lesotho, which has been useful to her colleagues at home. One participant who is a physician indicated that he has kept his registration with the Lesotho Medical and Dental Council, which enables him to volunteer and work with patients at the hospitals each time he visits Lesotho while on leave. He also engages in teaching junior doctors, nurses and other staff, in addition to helping with the equipment that is often lying around unused due to the inability of operating it. Another participant indicated that when on leave in Lesotho, she volunteers by working with nurses in different hospitals or clinics when she can. The following paraphrased narrative is an example of how a number of diaspora members have contributed in their own ways.

> I took a relative's very ill child to a hospital in the middle of the night and observed a doctor barely examining the child and prescribing medication without checking vital statistics such as the child's temperature and then immediately leaving the hospital. When the nurse went to administer the medication prescribed by the said doctor, I intervened and pointed out to the nurse the importance of checking the child's temperature and taking a proper history beforehand, in order to minimise the chances of the child reacting adversely to the prescribed medication. The on-duty nurse then pointed out that they give deference to the doctors and would have taken the temperature and other statistics if the doctor had so requested. The

> nurse responded that my comment had opened her eyes and that she would learn to be more proactive in the future as she realised the importance of following her basic training instead of the usual automatic deference to the doctors.

A number of participants indicated their frustration in their efforts to engage being thwarted by the lack of coherent policies and strategies for enabling such engagement. Many participants shared similar anecdotes related by one of the participants as thus:

> The hospital I work for regularly decommissions equipment which is still in a very good condition and offers it to personnel who might want to donate it to the health sector in their home countries, but I have unfortunately and most frustratingly been unable to donate and transport such equipment as it is impossible to establish the proper channels for getting such equipment to Lesotho and to the hospitals/clinics that could potentially greatly benefit from it. The red tape involved as well as the cost of transporting such equipment has been a real turn off, with the Lesotho High Commission unable to help in this respect.

Many of the health professionals are willing to go and apply their skills to support their colleagues in Lesotho. Participants felt that having strong organization and more enabling arrangements in place would result in greater willingness to participate in schemes intended for that purpose.

Many of the participants recounted negative instances of those remaining personnel who look snootily upon returning health professionals. A number of participants felt that their experience engaging in Lesotho could have been more positive if the leadership showed interest in diaspora involvement and had a more positive attitude towards them. Others felt their experience could have been enhanced if there were programmes in place that set out specific needs where their expertise was needed the most.

The participants indicated that they have discussed engagement in Lesotho's health sector as a collective so they can have a more effective and sustainable input, but have been unable to go past the discussion stage. These discussions took place in the Basotho-UK forum, as well as in individual social groupings.

4.8 Challenges or barriers to engagement by Basotho in the diaspora

A number of challenges and barriers, both existing and potential, were flagged as possible hindrances to diaspora contributions to the development of the health sector in Lesotho. These challenges are set out below:

- Negative attitudes of local staff towards members of the diaspora.
- Lack of leadership and ownership of programmes/strategies within the health sector.
- Lack of professionalism and accountability across the health sector, including in the MOH.
- Lack of conditions conducive for engagement, such as flexible contracts (for instance, annualized hours) that take into account family commitments.
- Lack of infrastructure and resources/equipment, very often resulting not from the lack of financial resources, but from lack of proper leadership and ownership where health professionals are not consulted on procurement of equipment, with decisions relating thereto being made by bureaucrats without any knowledge on the specific needs of professionals on the ground.
- Customs rules are considered a hindrance as people who are willing to donate resources, such as equipment, books and others are put off by: (a) lack of information on how to go about it; and (b) prohibitive costs of shipping and customs duty.

- Donated medical equipment does not reach the proper beneficiaries or destinations due to corrupted officials who embezzle or sell off donations for personal gain.

- The prohibitive cost of arrears due for nurses to pay for registration with the LNC for periods away from Lesotho.

- Lack of dual citizenship in a country that: (a) historically has the export of labour as its major resource; and (b) is economically dependent on its sole immediate neighbour, South Africa. The following perceptions are provided: (a) relinquishing citizenship results in people not investing in Lesotho; (b) Lesotho citizens who take up another nationality are effectively precluded from investment and other matters in Lesotho; (c) dual citizenship encourages more involvement and investment, as people feel they have a stake in the development of the health and other sectors as citizens of the country; and (d) lack of dual citizenship continues to result in people choosing not to be involved in development and other initiatives in Lesotho. As stated by a participant (capturing the sentiments of others):

  > We are made to feel as if we do not belong to what we consider to be our home country and feel aggrieved that we are being denied the most basic right of being recognised as Basotho. If my country does not want me and does not care about recognising me, why would I be motivated to invest in the country? If I am denied rights to property ownership and the like, I certainly will not be motivated to contribute or engage in any way to the development of the country.

Recommendations from the FGDs are set out in Chapter 7.

CHAPTER 5 – Key informant interviews

Key informant interviews were conducted with six individuals of Lesotho origin. Their profiles, as well as level of involvement in health sector issues, are set out below. The key informant interviews were conducted through phone, Skype and FaceTime.

Profile of interviewees:

Key Informant 1

- Based in Lesotho, migration expert who has worked extensively on research on migration in the Southern African region for over a period of years
- Research profile includes research on brain drain in Lesotho, which includes the health sector

Key Informant 2

- Member of the Basotho-UK Committee and worked with the Basotho diaspora on various projects that aim to increase levels of engagement of the diaspora with Lesotho
- Interacts with health professionals through a seat on the Basotho-UK Committee and has acted as a liaison between Basotho diaspora members and the Government of Lesotho through the LHC

Key Informant 3

- Consultant physician and medical practitioner in the United Kingdom for over 18 years
- Came to the United Kingdom to study medicine and then went on to work in the NHS and also specialized in the United Kingdom
- Currently settled in the United Kingdom but still has family links and property in Lesotho

Key Informant 4

- Mental health nurse currently based in Lesotho, but formerly worked in the United Kingdom's health sector
- Former member of Basotho-UK
- Has set up a clinic in Lesotho with some fellow returnee colleagues

Key Informant 5

- Occupational health nurse and a member of Basotho-UK
- Has worked in the United Kingdom for over 10 years and has particular interest in diaspora issues

Key Informant 6

- Nurse working in the health sector in the United Kingdom for over 20 years
- Migrated to the United Kingdom for family reasons
- Has met and worked with a number of Basotho diaspora health-care professionals over the years.

5.1 Interview outcomes

All the key informants perceived that there were hardly any statistics on Basotho diaspora health-care professionals and their migratory patterns. Since this study is the first of its kind on Basotho diaspora in the United Kingdom, there are no available statistics on the phenomenon. All informants stated that, in general, Basotho in the diaspora are enthusiastic about their home country and believe that home is where the heart is ("hae ke hae"). Most of the diaspora members continue to engage in development initiatives in Lesotho, with many of them owning property, and getting involved in other development initiatives, such as building churches and schools. The general perception is that they are interested in contributing to the development of the health sector in Lesotho. There is also a common notion that volunteering would be successful as most diaspora members spend their holidays in Lesotho, with some of them already volunteering in different places. Although the key informants were not aware of collective initiatives of the diaspora to contribute to Lesotho's health sector, examples of cumulative and individual contributions have been known to exist in different sectors. One key informant pointed out that the Basotho-UK have raised funds to sponsor the education of some Lesotho children and that another group collects and sends over second-hand clothing for orphans in Lesotho. Another thread running through the interviews was a belief that the diaspora would more likely be willing to return on a temporary rather than a permanent basis, although some (especially those close to retirement age) would be willing to return on a more permanent basis.

5.2 Migratory patterns

Migratory patterns of Basotho health-care professionals were recognized as follows:

- Some people come to the United Kingdom to study and then stay on to get work experience after they finish their studies and eventually settle in the country.
- Migration to the United Kingdom seems to be two-pronged: those who come directly from Lesotho and those who migrate to South Africa, work there for a while, and then migrate further to the United Kingdom and other countries.
- Health professionals, especially in the nursing cadre, have come through UK-based recruitment agencies contracting in Lesotho and South Africa (mainly in the early 2000s). The flow of health-care professionals recruited in the United Kingdom from Lesotho slowed down after the implementation of the UK Code of Practice for the International Recruitment of Health-care Professionals, which proscribes recruitment of health workers from developing countries, including Lesotho.[58]
- Lately, some health professionals have come to the United Kingdom through recommendation from those who have already moved or settled in the country.
- Migration tends to be for the duration of individuals' working lives with the intention of eventually returning to Lesotho.
- A few professionals have gone back following a recruitment drive for a recently opened referral hospital in Lesotho.
- There seems to be a trend of health professionals migrating back to Lesotho when they retire from their positions in the United Kingdom.
- Basotho diaspora tend to visit Lesotho periodically, with some actually going back to work for a while but coming back to the United Kingdom later.
- Many older professionals tend to move to the United Kingdom without their families, but the trend with the younger professionals is to move to the United Kingdom with their immediate families.

58 Department of Health, Code of Practice for the international recruitment of healthcare professionals (London, 2004).

- Some professionals who migrate to South Africa then to the United Kingdom have acquired South African citizenship and travel to the United Kingdom on South African passports. A crucial factor in this regard, however, is that they tend to still have ties to Lesotho, with some still supporting families or owning some property in Lesotho.

- Those who do not return to Lesotho upon retirement continue supporting family members back home and invariably become involved in development projects.

5.3 Areas of interest

In terms of identifying the areas that are of interest, the participants would like to contribute in PHC and clinical practice, especially in paediatrics, HIV/AIDS and mental health. There was also consensus that diaspora professionals are willing to engage in temporary or permanent skills sharing or training schemes and information sharing in different sectors of health care in Lesotho. In addition, there was a general consensus that the majority of diaspora members are willing to contribute through temporary placements for a number of reasons, such as the following:

- Lack of career progression and/or training opportunities in Lesotho;

- Incomparable wage levels, as well as living and working conditions between the United Kingdom and Lesotho;

- Indefinite leave to stay status or naturalization acquired through years of living in the United Kingdom; and

- Family reasons or commitments as many have migrated with their families and would want their children to benefit from facilities and opportunities that are unavailable in Lesotho.

Some informants felt that, due to salary differentiation and disparity in working conditions between Lesotho and United Kingdom, diaspora professionals who plan to return to Lesotho permanently are most likely to be involved in health care as a business (setting up clinics and the like), instead of working in the public sector, which is the leading employer in Lesotho's health sector. The informants believe that skills and experience acquired in the United Kingdom would enable them to do this. An example worth citing is some diaspora nurses who have done so in recent years.

A few informants indicated the retirement age in Lesotho as a factor that would probably bar health professionals from permanently returning to the country and directly engaging in the public sector. This disadvantage might mean that Lesotho loses out on all the expertise of people who are still highly active and able to deliver, but are barred from contributing meaningfully because of their age. One professional who had returned to Lesotho close to the stipulated retirement age said she had been denied a position at a new referral hospital due to her age, despite her competencies, ability and willingness to contribute skills she had acquired during her long stay in the United Kingdom.

5.4 Challenges or disincentives to engagement

The following were identified as existing or potential barriers to the diaspora's engagement in development schemes in Lesotho:

- Red tape or bureaucracy and partisan politics.

- Lack of infrastructure/equipment/tools of the trade in Lesotho.

- Negative attitudes and/or indifference of officials and service users in Lesotho towards diaspora professionals.

- Lack of leadership and strategic thinking on the side of Lesotho that greatly hampers a number of important projects, including diaspora engagement.

- Cost of volunteering, particularly the cost of travel between the United Kingdom and Lesotho. Respondents suggested that mitigation of costs could be done in various ways, such as the Government of Lesotho or private company sponsorship covering the costs, or negotiating deals with airlines to South Africa and Lesotho. Arrangements for shouldering accommodation costs can be made in case diaspora professionals are placed in an area in Lesotho where they have no family or friends to stay with.

- The respondents felt strongly that the lack of dual citizenship is a hindrance to the development of Lesotho, as the diaspora have no incentive to invest in the country if they cannot claim such investments when they are no longer considered citizens once they take up nationality elsewhere. A few felt that despite the geographic position of Lesotho as a complete enclave of another country, it being economically dependent on its neighbour, as well as reliance on remittances, being unable to have dual citizenship is a ludicrous situation.

Recommendations emerging from the key informant interviews are set out in Chapter 7.

CHAPTER 6 – Case studies

For this report, two case studies were carried out. First is a diaspora member who, although willing to contribute to the development of the health sector through short-term engagement programmes (voluntary or otherwise), was unwilling to permanently return and work in Lesotho. The second is a returnee nurse who, together with fellow returnee colleagues, has set up a clinic in Lesotho. The case studies give a more in-depth exploration of some of the migration issues involving Basotho health-care professionals.

6.1 Case study 1

The migratory trajectory of one nurse is briefly outlined below as it demonstrates the premise for her unwillingness to return (also typical of some professionals in a similar position).

The first case study was of a female nurse who had trained and briefly worked in Lesotho before migrating to South Africa where she worked for about 15 years in a hospital before migrating to the United Kingdom over 10 years ago. She felt that the training she received in Lesotho was of high standard, with the advantage that it was "old school" as it was holistic (starting with making patients' beds, washing and cleaning patients and caring for them in a holistic manner). The move to South Africa was prompted mainly by better remuneration, as she was able to provide more adequate support for her family. She found the working conditions in South Africa somewhat better than in Lesotho, but felt that conditions had deteriorated during her stay there. She was attracted to the United Kingdom through a recruitment drive for nurses from various countries (including South Africa) by the NHS. Better pay and working conditions were major attractions, especially having seen how many of her colleagues who had moved to the United Kingdom before her had thrived. Similar to other Basotho nurses in the United Kingdom diaspora, her overall experience of working and living in the United Kingdom has been a positive one, with the patient-centred ethos forming the basis of a system that demands accountability and therefore generates a professional and efficient system. The nurse also mentioned potential barriers to diaspora engagement with Lesotho similar to those raised in the FGD and key informant interviews.

Like professionals in the diaspora in general, she goes to Lesotho on regular holidays and notices a stark difference between health-care provision in Lesotho and the United Kingdom. She feels the situation in Lesotho is untenable, starting with the attitudes of service providers to their work and towards their patients. The lack of professionalism and poor work ethic are sources of great concern to her. She cited an example when she took a relative to a clinic for medical attention, and her relative was then transferred to the main referral hospital by ambulance, along with a few other patients. The local nurse accompanying the patients sat in the front with the driver and refused to sit at the back with the patients. The case study nurse pointed out the importance of the nurse going in the back with the patients by relating a tragic incident where, in similar circumstances, a patient became delusional while in transit, opened the ambulance door, and fell out of the ambulance with fatal consequences. The local nurse brushed the lesson aside, insisting she had assessed all the patients in the ambulance beforehand and that she knew what she was doing. The case study nurse added:

> Such deeply ingrained attitudes make it difficult for one to want to return to work in Lesotho, especially when one knows there is no accountability where fatalities occur or things go seriously wrong.

Similar to the sentiments raised in the FGDs, the nurse felt that lack of patient-centred care and professionalism/accountability, as well as the negative attitudes of professionals, was so ingrained that conditions are not conducive for treating patients well. She added that poor leadership, as well as lack of clear policies on continual professional development, are other great disincentives to returning to Lesotho to work on a permanent basis.

The nurse further stated that level of pay was a strong disincentive to permanently returning to work in Lesotho, as she feels she would be unable to maintain the standard of living she is used to in the United Kingdom and incapable of fulfilling her family commitments and support. The nurse – as is the case with numerous diaspora health-care professionals – financially and materially supports not only her mother, but also other members of her extended family who live in Lesotho. She added that there seems to be no prospect that wage levels in the health sector would improve any time soon, which discourages professionals from relocating to Lesotho for work. She also referred to the recent recruitment drive that was intended to attract Basotho diaspora nurses in the United Kingdom back to the new referral hospital in Lesotho on the promise of generous pay packages, which, according to her returnee friends, have not materialized.

The absence of access to dual citizenship for Basotho was also identified as a major disincentive to diaspora engagement. The nurse felt a change in the law to facilitate dual citizenship would greatly enhance the prospect of more professional diaspora engagement.

6.2 Case study 2

The second case study was of a female Mosotho nurse who had trained in Lesotho and had lived and worked in the United Kingdom for over 10 years, moved back to Lesotho when she retired, and set up a clinic with fellow returnee nurses who had also been in the United Kingdom at the same time as her. Her story explains the typical migration patterns and also gives insight into the challenges that Lesotho returnees face while trying to reintegrate and/or continue working post retirement (given that the retirement age is so low in Lesotho). The account also has some pertinent suggestions on what would attract professionals in the diaspora to engage in development in Lesotho.

The nurse was recruited by a UK-based nursing agency and placed in an old-age home upon arrival in the United Kingdom. She found the experience in the care home negative and unpleasant as, not only was she not using her nursing skills, but also her status as a matron (in a big hospital in Lesotho) was uncredited. She worked in the care home for two months and then moved on to a hospital job, where she was much happier as she felt she was no longer at risk of losing her nursing skills. She noted that this was a typical migration path for nurses from Lesotho. The nurse further noted that older and more experienced nurses often migrate to the United Kingdom without their families, and therefore tend to return to Lesotho rather than stay on indefinitely. Some leave Lesotho with the objective of working for a specific number of years, after which they return to Lesotho, while others return upon retirement. She pointed out that the situation tends to be different with the younger nurses, who tend to migrate with their families or start families after moving to the United Kingdom, as they often have greater incentive to remain in the country on a more permanent basis.

The positive and negative aspects of living and working in the United Kingdom cited by the nurse were similar to those highlighted in the FGDs. The nurse also alluded to potential barriers to diaspora engagement with Lesotho similar to those raised in the FGDs and key informant interviews. Of particular note, she highlighted the issue of an early retirement age in Lesotho (age 55), which she felt could lead to many skilled diaspora professionals being precluded from participating in the development of their country of origin once they reach the retirement age, despite still being fully capable and willing to contribute. A change of policy that permits professionals who are beyond retirement age but still able to work may serve as an incentive for many diaspora professionals to engage. Another issue raised by the nurse was the strict requirement of the Lesotho NMC for nurses to pay registration fees for periods spent outside the country, as such arrears tend to be prohibitive and may work as a disincentive to engagement. She felt that an exemption or review of such policy would incentivize some diaspora professionals to engage in the development of the health sector in various ways.

6.2.1 Experience upon return to Lesotho

The nurse stated that representatives of the recently established referral hospital in Lesotho held a recruitment drive in the United Kingdom, where a number of health professionals (mainly nurses) applied for positions and returned to work at the hospital. Although she had applied, she and others were turned down because of their age, despite being qualified and having more experience than some of those who were successfully hired. Since they had decided to return to Lesotho permanently, they left the United Kingdom with the aim of setting up a health clinic. Setting up the clinic was complicated and lengthy, and the cost of paying the nursing registration arrears covering the period of years they were based in the United Kingdom was huge, which added greatly to the overall cost.

The nurse indicated that the registration process was a huge challenge. Not only was it extremely slow, but it was also totally disjointed, such that one department had no idea what the other was doing. Attitudes to service provision were considered poor. She felt that too many government departments were involved in the process, resulting in an non-cohesive system. There is no committee tasked with processing applications for setting up clinics (among other things), which results in grave delays. The whole process took over six months before it was possible to actually set up and start delivering services.

Another challenge that she encountered was procurement of equipment. Acquiring loans from the bank and elsewhere was challenging, with no assistance proffered from any quarters. Having worked outside the country for long periods meant a lack of credit history in Lesotho and very little assistance from any quarter. This also further prolonged the clinic set-up.

When the clinic was eventually set up, there were still other problems. Uptake on the use of the clinic was slow to begin with, as there was some level of scepticism on the authenticity of the set-up. The nurse pointed out that this was probably due to past experiences where sham clinics had apparently been set up because of an inefficient regulatory system. Another reason was prevailing negative attitudes towards health-care professionals from outside the country. Gaining the trust of the public took some doing.

According to the nurse, since they set up the clinic, there have been other clinics (both bogus and legitimate) established in the same area, resulting in slow uptake for their clinic's services. This is the outcome of a deficient planning and regulatory system, where a cluster of clinics saturate one area while there is an apparent lack in others.

Recommendations emerging from the case studies are included in Chapter 7.

CHAPTER 7 – Observations and recommendations

7.1 Observations and recommendations

This chapter sets out observations and recommendations emerging from the study.

1. There is strong willingness among Basotho diaspora health professionals to contribute to Lesotho's health sector. A few diaspora members have been carrying out personal initiatives in Lesotho and intend to contribute further as a collective under the auspices of the Basotho-UK forum. Strengthening support for this group would greatly benefit the conveyance of individual efforts into a more effective joint intervention.

2. The majority of diaspora health professionals of Lesotho origin based in the United Kingdom are nurses. The main interests of this group are in teaching, mentoring and volunteer clinical work. The few doctors who responded to the survey and/or participated in the discussions/ interviews are as willing to engage with their country of origin, as are the nurses. These doctors are interested in teaching and volunteer clinical work as engagement initiatives.

3. Diaspora health professionals are spread around the United Kingdom, with small clusters in different areas, such as Basingstoke, Birmingham and London. Affiliation with the Basotho-UK group makes it easier to reach diaspora members wherever they are in the country.

4. Most respondents prefer to participate in short-term activities, voluntary or otherwise, as many of them are employed full time in the United Kingdom. The majority of respondents also have young families living with them. Short-term engagement programmes of two weeks to three months in Lesotho are recommended to harness the skills base within the Basotho diaspora.

5. The respondents would like to see priority given to establishing formal arrangements to enable diaspora engagement with fairness, transparency and elimination of red tape as cornerstones of the process.

6. Clear strategies and policies with specific programmes for engaging diaspora health professionals should be developed to highlight contributions in areas of greatest need in the most constructive manner. Such policies/programmes can also provide the proper framework for initiating participation of those health professionals who would like to contribute but have no idea how to.

7. The starting point for harnessing the skills and experiences of diaspora health-care professionals should be to set up a register of professionals living and working in the United Kingdom, identifying their skills and competencies, as well as areas of interest, through the Basotho-UK forum (or a similar platform).

8. Engagement programmes should also include returnees based in Lesotho or those who wish to return upon retirement. Reviewing the current status on Lesotho's retirement age would allow for the skills base within the diaspora to be utilized.

9. Skills sharing through teaching and mentoring would require facilitating "train-the-trainer" courses that provide diaspora members with knowledge and skills in teaching and mentoring colleagues, as not all professionals who are experts in their respective fields are necessarily good trainers. Such courses would promote effective engagement in Lesotho's skills sharing programmes.

10. Facilitating short and/or long-term sabbaticals addresses the issue of diaspora professionals having to use up their annual leave for volunteering or engaging in skills sharing programmes. Details of such effort need to be worked out between the Government of Lesotho (and its agencies), the NHS, various hospital trusts, professional bodies and others to make it easier for diaspora professionals to participate.

11. Respondents have identified attitudes as a problem in delivering health-care services in Lesotho. The experiences of the diaspora can help in developing patient-centred care and inculcating a culture of professionalism and accountability.

12. Respondents identified negative attitudes towards diaspora members as a disincentive to engagement. The stakeholders in Lesotho should play an active part in promoting the role and benefits of diaspora engagement in local activities to help prevent misunderstandings.

13. Respondents aspire for the possibility of dual citizenship to prevent them from having to choose between Lesotho and the United Kingdom. There is evidence in the literature that dual citizens remit and engage more with their countries of origin. It was noted that some countries within the Southern Africa Development Community have already moved towards this endeavour.

14. A registration mechanism in Lesotho that is timely, consistent, transparent, signposted and free of red tape should be established to enable the speedy processing of applications for health related businesses and thus encourage those professional diaspora who are inclined to contribute.

15. Clear protocols for handling and transferring medical equipment for use in charitable projects should be established.

16. Respondents regard the cost of travel from the United Kingdom to Lesotho as a major inhibiting factor for engagement of the diaspora. Strategies for mitigation of travel and subsistence costs in defined programmes should be developed.

17. Returning diaspora members who are willing to engage in the development of the health sector should be entitled to formal arrangements with professional bodies in Lesotho (such as medical and the nursing councils) to recognize that professionals constantly move abroad. Mechanisms to mitigate against punitive arrears should be developed as part of these arrangements.

18. Respondents felt that health professionals have diverse investments and possess different skills and interests outside the medical arena that could be applied universally. The findings of this study should be extended to consider how health professionals could increase their engagement in sectors beyond health, thus contributing more widely to the development of the country.

19. It is important to identify and learn from programmes for diaspora engagement in other parts of the world. Best practice from such programmes could be adapted and incorporated into a programme for Lesotho, thus avoiding pitfalls.

7.2 Conclusion

The study's objectives were to map the sociodemographic characteristics of Basotho health-care professionals working and living in the United Kingdom, and further, to record their migratory trajectories and their interest in contributing to the development of the health sector in Lesotho. The study also sought to identify barriers hindering the Basotho diaspora in the United Kingdom from engaging in skills transfer, investment and other development related activities. This was with the ultimate aim of facilitating the Government of Lesotho's strategy to mobilize diaspora resources for the development of the health sector in Lesotho. The study involved a survey of 31 respondents, supplemented by three FGDs, six key informant interviews and two case studies.

Most of the Basotho health-care professionals in the United Kingdom are female nurses. The majority of respondents are working full time and earning above the UK median wage. The respondents had mostly attained qualifications beyond the basic level of training. There is no specific Basotho diaspora health-care network in the United Kingdom, and the diaspora interact through the Basotho-UK forum.

The high proportion of those who remit finances to Lesotho is testament to the close personal links maintained by diaspora members. There is also a high level of professional engagement with Lesotho among the Basotho diaspora, such as ad hoc volunteerism and skills sharing. The barriers and challenges include cost, attitudes, working conditions, lack of structured programmes, and a deficient legal framework for engagement. Implementation of the recommendations set out in this document is expected to aid in harnessing the skills of an engaged, motivated and highly qualified group of professionals for the development of Lesotho's health sector.

Bibliography

Ambrose, D.
2005 Lesotho health sector in crisis. *Summary of Events in Lesotho*, 12(1) (First Quarter), 2005.

Buchan, J. and I. Seccombe
2012 Overstretched. Under-resourced. *Royal College of Nursing (RCN) Labour Market Review*. Queen Margaret University.

Cobbe, J.
2012 Lesotho: From Labour Reserve to Depopulating Periphery. Online iournal of the Migration Policy Institute, 2 May 2012. Available from www.migrationpolicy.org/article/lesotho-labor-reserve-depopulating-periphery.

Crush, J. et al.
2010 Migration, remittances and development in Lesotho. *SAMP Migration Policy Series* 52. Institute for Democracy in Africa, Cape Town and Queen's University, Canada.

Gayfer, J., M. Flint and A. Fourie
2005 Evaluation of DFID's Country Programmes: Country Study Lesotho 2000–2004, Evaluation report EV657. Department for International Development, United Kingdom.

Government of Lesotho, Ministry of Finance and Development Planning
2012 National Strategic Development Plan 2012/13–2016/17: Growth and Development Strategic Framework. Available from www.imf.org/external/pubs/ft/scr/2012/cr12102.pdf.

Government of Lesotho, Ministry of Health
2013 Health Sector Strategic Plan 2012/13–2016/17. Available from www.nationalplanningcycles.org/sites/default/files/country_docs/Lesotho/19_04_2013_lesotho_hssp.pdf.

Government of the United Kingdom, Department of Health
2004 Code of Practice for the international recruitment of healthcare professionals. London.

Groenhout, R.
2012 The "brain drain" problem: Migrating medical professionals and global health care. *International Journal of Feminist Approaches to Bioethics*, 5(1):9.

The Heritage Foundation
2014 Index of Economic Freedom. Available from www.heritage.org/index/country/lesotho. (accessed on June 2014).

Index Mundi
2013 Lesotho Country Profile 2013. Available from www.indexmundi.com/lesotho/ (Source: CIA World Factbook) (accessed on April 2014).

International Organization for Migration (IOM)
2012 Diaspora Engagement Projects in the Health Sector in Africa. Department of Migration Management, Migration Health Division. Available from diaspora.iom.int/sites/default/files/infosheet/dehpo.pdf.

Kingdom of Lesotho
1993 The Constitution of Lesotho.

Lesotho-Boston Health Alliance (LeBoHA)
2014 Stemming and reversing the out-migration of human resources for health in Lesotho. Glob Health Workforce Alliance, World Health Organization (WHO). Available from www.who.int/workforcealliance/forum/2011/hrhawardscs33/en/.

Lesotho Council of Non-governmental Organisations
2014 Health and Social Development Commission Members. Lesotho Council of Non-Governmental Organisations. Available from www.lcn.org.ls/member/HSDC.pdf.

Mangham, L.
2007 Addressing the human resource crisis in Malawi's health sector: 2007 Employment preferences of public sector registered nurses, ESAU Working Paper 18. Economic and Statistical Analysis Unit, Overseas Development Institute, London.

Misau, Y. A., N. Al-Sadat and A. B. Gerei
2010 Brain-drain and healthcare delivery in developing countries. *Journal of Public Health in Africa*, 1(1).

Mwase, T. et al.
2010 Lesotho Health Systems Assessment 2010. Health Systems 20/20, Abt Associates Inc., Bethesda, MD.

Naicker, S. et al.
2009 Shortage of healthcare workers in developing countries – Africa, *Ethnicity and Disease*, 19:60–64.

Nursing and Midwifery Council (NMC), United Kingdom
(n.d.) NMC Statistical analysis of the register, April 2006 to March 2007. Nursing and Midwifery Council, London, UK.
2002 Statistical analysis of the register 1 April 2001 to 31 March 2002. Available from www.nmc.org.uk/globalassets/siteDocuments/Statistical-analysis-of-the-register/NMC-Statistical-analysis-of-the-register-2001-2002.pdf (accessed on 9 April 2015).
2004 Statistical analysis of the register of 1 April 2002 to 31 March 2003. Available from www.nmc.org.uk/globalassets/siteDocuments/Statistical-analysis-of-the-register/NMC-Statistical-analysis-of-the-register-2002-2003.pdf (accessed on 9 April 2015).

Office for National Statistics (ONS)
2013a Annual survey of hours and earnings, 2013 provisional results release. Available from www.ons.gov.uk/ons/rel/ashe/annual-survey-of-hours-and-earnings/2013-provisional-results/info-ashe-2013.html.
2013b Annual survey of hours and earnings, 2013 provisional results release. Available from www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-328216.

Plaza, S. and D. Ratha (eds.)
2011 *Diaspora for Development in Africa*. World Bank, Washington, D.C. Available from siteresources.worldbank.org/EXTDECPROSPECTS/Resources/476882-1157133580628/DfD_FullReport.pdf.

Poppe, A. et al.
2014 Why sub-Saharan African health workers migrate to European countries that do not actively recruit: a qualitative study post-migration. *Glob Health Action* 7: 24071. Available from dx.doi.org/10.3402/gha.v7.24071.

Seipobi, E. M. et al.
1993 Attrition and the Health Sector, A Summary of a Study on Factors Leading to Attrition Among Nurses in the MOHSW in Lesotho (September 1992–May 1993), Ministry of Health, Lesotho. Paper available from the Ministry of Health and Social Welfare in Lesotho, P.O. Box 514, Maseru 100, Lesotho.

World Bank

2013 Migration and Remittance Flows: Recent Trends and Outlook, 2013–2016, Migration and Development Brief 21, World Bank, Washington, D.C. Available from siteresources.worldbank.org/INTPROSPECTS/Resources/334934-1288990760745/MigrationandDevelopmentBrief21.pdf.

United Nations Development Programme (UNDP)

2014 Lesotho Millennium Development Goals (MDG) Report. 23 July 2014. UNDP. Available from www.ls.undp.org/content/lesotho/en/home/library/mdg/ (accessed on 9 April 2015).

Women and Law in Southern Africa (Lesotho)

n.d. Africa Discrimination and Citizenship Audit Lesotho Report Lesotho, Transformation Resource Centre. Available from the Transformation Resources Centre, P.O. Box 1388, Maseru, Lesotho.

World Health Organization (WHO)

2005 Health Action in Crises: Lesotho. WHO. Available from www.who.int/hac/crises/lso/background/Lesotho_aug05_rev.pdf.

2007 WHO Country Cooperation Strategy, Kingdom of Lesotho 2004–2007. WHO Regional Office for Africa. Available from www.afro.who.int/index.php?option=com_docman&task=doc_download&gid=1422.

2009 Lesotho Country Cooperation Strategy 2008–2013. WHO Regional Office for Africa. Available from www.afro.who.int/index.php?option=com_docman&task=doc_download&gid=3331.

2015 Country profile for Lesotho. Last updated January 2015. Available from www.who.int/countries/lso/en/ (accessed on 9 April 2015).

Annex I: Working definition of health professionals/workforce

Below are the nine broad WHO categories as amended for the purpose of this study:

Physicians

Includes generalist medical practitioners and specialist medical practitioners.

Nursing and midwifery personnel

Includes nursing professionals, midwifery professionals, nursing associate professionals and midwifery associate professionals.[1] Traditional midwives are not classified here, but as community/ traditional health workers (see below).

Dentistry personnel

Includes dentists, dental assistants, dental technicians and related occupations.

Pharmaceutical personnel

Includes pharmacists, pharmaceutical assistants, pharmaceutical technicians and related occupations.

Laboratory health workers

Includes laboratory scientists, laboratory assistants, laboratory technicians, radiographers and related occupations.

Environment and public health workers

Includes environmental and public health officers, environmental and public health technicians, sanitarians, hygienists, district health officers, public health inspectors, food sanitation and safety inspectors and related occupations.

Community and traditional health workers

Includes community health officers, community health education workers, family health workers, traditional and complementary medicine practitioners, traditional midwives and related occupations.

Other health workers

Includes a large range of other cadres of health service providers, such as medical assistants, dieticians, nutritionists, occupational therapists, medical imaging and therapeutic equipment technicians, optometrists, ophthalmic opticians, physiotherapists, personal care workers, speech pathologists and medical trainees.[2]

Health management and support workers Includes other categories of health systems personnel, such as managers of health and personal care services, health economists, health statisticians, health policy lawyers, medical records technicians, health information technicians, ambulance drivers, building maintenance staff, and other general management and support staff.[3]

Source: WHO, Technical Notes – Global Health Workforce Statistics database. Available from www.who.int/hrh/statistics/TechnicalNotes.pdf
NB: Professional health sector workers like non-clinical administrators are also considered due to their specialist knowledge and skills of working in the sector.

1 These include nursing aides.
2 Includes medical students who already informally work in the health service sector as trainees and interns.
3 "Ambulance drivers and building maintenance staff" shall be excluded in our mapping survey although they fall under the WHO broad definition.

Annex II: Survey questionnaire

Mapping of Basotho Health-care Professionals in the UK

The International Organization for Migration (IOM) has commissioned a survey to identify health professionals from Lesotho who presently work in the United Kingdom (UK). This questionnaire is intended to collect information on competencies and skills and areas of specialization amongst health professionals from Lesotho. This is to help study the push and pull factors in migration and to identify ways and circumstances in which individuals abroad would help contribute their skills/knowledge to the development of the health sector in Lesotho.

The African Foundation for Development (AFFORD) has been commissioned to carry out this survey on behalf of the IOM. All information collected will be kept in the strictest confidence, and used for research purposes only.

The Questionnaire will take roughly 20 minutes to complete.

I. BACKGROUND INFORMATION

1. Gender:

- ○ Male
- ○ Female

2. What age band do you fall into?

- ☐ 19-24
- ☐ 25-39
- ☐ 40-49
- ☐ 50-59
- ☐ 60+

3. In what country were you born?

- ○ Lesotho
- ○ South Africa
- ○ United Kingdom

Other (please specify)

4. What is your Nationality?

- ☐ Lesotho
- ☐ South Africa
- ☐ United Kingdom

Other (please specify)

5. What is your marital status?

- ○ Single
- ○ Married
- ○ In a committed relationship
- ○ Divorced
- ○ Widowed

6. Where do you currently reside in the UK?

- ○ East Midlands
- ○ East of England
- ○ Greater London
- ○ North-East England
- ○ North-West England
- ○ South-East England
- ○ South-West England
- ○ West Midlands
- ○ Yorkshire and the Humber
- ○ Wales
- ○ Scotland
- ○ Northern Ireland

7. For how long have you been resident in the UK?

- ○ Less than 1 year
- ○ 1-4 years
- ○ 5-9 years
- ○ 10-19 years
- ○ 20 years and over

II. QUALIFICATION AND EMPLOYMENT EXPERIENCE

8. What is the highest level of education you have attained?

- ○ Diploma
- ○ Bachelor
- ○ Masters
- ○ PhD

Other (please specify)

9. Where did you obtain your highest level professional health qualification?

10. In which of the following areas of the health sector have you trained?

- ☐ Nursing
- ☐ Midwifery
- ☐ Medicine
- ☐ Optometry
- ☐ Pharmacology
- ☐ Dental Health
- ☐ Nutrition/Diet
- ☐ Psychological Therapies
- ☐ Administration/Policy
- ☐ Allied Healthcare Professional

Other (please specify)

11. Have you specialized? If Yes, please specify.

- ○ Yes
- ○ No

12. If you have received any other health-related training/professional qualification other than those mentioned above, please give the title and specify the country:

Title:

Country of qualification:

13. What is your current employment status?

- ○ Not employed (looking for work)
- ○ Not employed (not job hunting)
- ○ Employed (permanent)
- ○ Employed (temporary contract)
- ○ Part-time worker
- ○ Self-employed
- ○ Student
- ○ Retired
- ○ Disabled (unable to work)

Other (please specify)

14. Do you have any medical work experience in Lesotho?

- ○ Yes
- ○ No

14 (a) If Yes, how long for?

14 (b) What was your job title?

15.Do you have any other (non-medical) work experience in Lesotho?

- ○ Yes
- ○ No

15 (a) If Yes, how long for?

15 (b) What was your job title?

16. Which of the following best describes your professional field within the health sector?

- [ ] Physician
- [ ] Surgical
- [ ] Nursing/Midwifery
- [ ] Optometry
- [ ] Dentistry
- [ ] Pharmaceutical
- [ ] Laboratory
- [ ] Health Management and Support
- [ ] Environment and Public Health
- [ ] Community Health

Other (please specify)

17. What is your current job title?

18. Which of the following approximates your average annual income?

- ( ) Under £20,000
- ( ) £20,000 - £39,000
- ( ) £40,000 - £59,000
- ( ) £60,000 plus
- ( ) Prefer not to say

III. ENGAGEMENT WITH LESOTHO

19. To what extent do you feel connected to Lesotho?

- ( ) Not at all
- ( ) Somewhat
- ( ) A lot

20. Please explain why.

21. How do you get information and stay in touch with people from Lesotho?

- [ ] Telephone
- [ ] Letters
- [ ] Facebook
- [ ] Electronic media
- [ ] Twitter
- [ ] Newspapers
- [ ] Internet/Lesotho websites
- [ ] Lesotho High Commission

Other (please specify)

22. Since you left Lesotho, have you returned to visit?

- ○ Yes
- ○ No

23. If No, what would you say is the reason(s) for this?

24. If Yes, how often do you visit?

- ○ More than once every year
- ○ Once every year
- ○ Once every 2 years
- ○ Less than every 3 years
- ○ Once every 5 years
- ○ Once every 10 years

Other (please specify)

25. On average, how long do you stay?

- ○ 1-3 weeks
- ○ 4-6 weeks
- ○ 1-2 months
- ○ 3-6 months
- ○ 6 months to 1 year

26. What were the main reasons for your visit? (Please tick more than one as appropriate)

- ☐ To visit family and friends
- ☐ To volunteer
- ☐ To share knowledge with colleagues in Lesotho
- ☐ To invest
- ☐ To work
- ☐ To study
- ☐ Charity work
- ☐ Politics/lobbying

Other (please specify)

27.(a) Do you intend to return to Lesotho on a permanent basis in the future?

- ○ Yes
- ○ No
- ○ Not Sure

27. (b) If NO or Not sure, please explain the reason(s) why.

28. Why do you want to return to Lesotho?

- ○ Continuous stay not favourable
- ○ To establish business
- ○ To share my skills

Other (please specify)

29. When you reflect on your last visit, would you say it was beneficial for the health sector in Lesotho? Please explain.

30. Have you ever had the opportunity to participate in sharing your professional knowledge with Basotho?

- ○ Yes
- ○ No

30.(a) If Yes, please elaborate and evaluate your experience.

31. If Yes, how long was this for?

- ○ Less than 1 month
- ○ 1-3 months
- ○ 4-7 months
- ○ 8-11 months
- ○ 12 months and over

32. Are you interested in contributing to the development of the health sector in Lesotho?

- ○ Yes
- ○ No

33. If No, please tell us the reason(s):

34. If you are interested but are unable to, please tell us the challenges preventing you or that could potentially prevent you from contributing to the development of the health sector in Lesotho.

35. Please tell us what you think would be possible solutions to the challenges.

36. If Yes, (to Q.32) in what ways would you like to be involved?

- [ ] Working in Lesotho (private or public sector)
- [ ] Making investments
- [ ] Participating in skills transfer schemes
- [ ] Offering consulting and mentoring services
- [ ] Providing health-related on-line training courses
- [ ] Offering telemedicine services

Other (please specify)

37. In which of the following health sector areas would you want to contribute?

- [ ] Nursing/Midwifery
- [ ] Clinical
- [ ] Surgical
- [ ] Paediatrics
- [ ] Nutrition
- [ ] Dental Health
- [ ] Pharmacology
- [ ] HIV/AIDS Care
- [ ] Psychological Therapies
- [ ] Physiotherapy
- [ ] Healthcare Assistance
- [ ] Administration

Other (please specify)

38. Would you be interested to return to give your skills/expertise to Lesotho permanently or temporarily?

- ( ) Interested in permanent service
- ( ) Interested in temporary service

39. If interested, what motivations/incentives would you need to determine your return on a skills transfer scheme to Lesotho?

40. If you are interested in a skills transfer scheme, how long would you like to go for?

- ( ) Less than 1 month
- ( ) 1-6 months
- ( ) 7-11 months
- ( ) 12 months and over

41. Would you be willing to work in Lesotho (on a skills transfer scheme) without your family accompanying you?

- ○ Yes
- ○ No

42. On a scale of 1 to 10, how much would the existence of a structured skills transfer programme make your participation/contribution more likely?

1 being very unlikely and 10 being very likely.

	1	2	3	4	5	6	7	8	9	10
scale	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

IV. REMITTANCES AND DONATIONS

43. Since being in the UK, have you ever sent remittences (money/goods) to family members or friends in Lesotho?

- ○ Yes
- ○ No

44. How often do you send money or goods to Lesotho? If Never, please skip to Q49

- ○ Never
- ○ Weekly
- ○ Monthly
- ○ Quarterly
- ○ Annually

Other (please specify)

45. How much (money/goods) do you send home on average per transaction?

- ○ Less than £100
- ○ £100 - £300
- ○ £400 - £600
- ○ £700 - £1,000
- ○ £2,000 - £5,000
- ○ £5,000 - £10,000
- ○ £10,000 or more

46. Why do you send remittances (money or goods) home?

- ☐ Financial support for family
- ☐ Contributions for development projects
- ☐ Personal investment
- ☐ Debt service
- ☐ Personal obligation

Other (please specify)

47. Do you believe/think the money or goods you remit contribute to development back home?

- ○ Yes
- ○ No

48. If Yes, in what area of development do the goods or money contribute?

- [ ] Education
- [ ] Healthcare provision
- [ ] Infrastructure development
- [ ] Good governance
- [ ] Peace and security
- [ ] Childcare

Other (please specify)

V. NATIONAL DEVELOPMENT

49. Do you have any property in Lesotho?

- ( ) Yes
- ( ) No

50. Do you have any private investments in Lesotho

- ( ) Yes
- ( ) No

51. Are you interested in making investments in Lesotho?

- ( ) Yes
- ( ) No

52. If Yes, what type of investments are you interested in?

- [ ] Health
- [ ] Education
- [ ] Financial services
- [ ] Tourism
- [ ] Energy
- [ ] Communication
- [ ] Mining
- [ ] Buying and selling

Other (please specify)

53. Are you currently interested in contributing or donating to development projects in Lesotho?

- ( ) Yes
- ( ) No

54. Which development projects are you interested in supporting?

- [ ] Healthcare provision
- [ ] Education
- [ ] Infrastructure development
- [ ] Good governance
- [ ] Peace and security
- [ ] Micro-finance initiatives

Other (please specify)

55. What kinds of support would you be interested in contributing?

- [ ] Skills transfer
- [ ] Financial
- [ ] Material

Other (please specify)

56. What part of Lesotho would you be interested in developing?

All districts (please state yes, if applicable)

Specific district(s) (please specify)

57. On a scale of 1 to 10, would you say that the availability of dual citizenship would increase the level of engagement in, or skills sharing by, the Diaspora in the health sector in Lesotho?

1 being very unlikely and 10 being very likely

	1	2	3	4	5	6	7	8	9	10
scale	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

58. Are there any barriers or restrictions that exist that could stop you from contributing to national development?

- ○ Yes
- ○ No
- ○ Not Sure

59. If Yes, what are the barriers? (Please elaborate).

Financial constraints:

Work commitments:

Political/legal:

Other (please specify):

VI. DIASPORA NETWORKS

60. Do you belong to any diaspora network/association (formal or informal)?

- ○ Yes
- ○ No

61. If Yes, please tick as applicable:

- ☐ Academic
- ☐ Work-based
- ☐ Government
- ☐ Association of Basotho in the UK
- ☐ Internet-based social networking groups

Other (please specify)

62. Please state the name and objective of the association/network/group:

63. How is information shared among members of the diaspora?

- ☐ Meetings
- ☐ E-mails
- ☐ Websites
- ☐ Twitter
- ☐ Facebook
- ☐ Newsletters
- ☐ Word of mouth

Other (please specify)

64. Is there a contact person/focal point for your diaspora network/association?

- ○ Yes
- ○ No

65. If Yes, please indicate contact details below:

Name:

Address:

Email:

Telephone:

66. Do you know any Basotho health professional organization(s) in the UK?

- ○ Yes
- ○ No

67. If Yes, please state its name and objective:

68. Would you be interested in receiving additional information about projects for Lesotho diaspora in future?

- Yes
- No

69. Do you know other Basotho health professionals who may be interested in being part of this project?

- Yes
- No

70. If Yes, please forward the link for this survey to them (please copy and paste) and encourage them to respond.

71. Where do they live/work?

72. Would you be willing for us to contact you to provide additional information on the above questions?

Yes

No

Not sure

Please specify email address

73. If you have any general comments, insights, questions or suggestions you would like to make that have not been covered in this survey, please feel free to write these in the space below:

74. We would be grateful if you could provide us with your contact details.(Optional) (All information collected will be kept in the strictest confidence, and used for research purposes only).

Surname:

Name:

Address:

City/Town:

Email:

Telephone:

Please indicate if you would be interested in a focus group discussion to explore the issues in this survey in more detail.

○ Yes

Thank you for your participation.

If you have any questions or wish to contact us, please email us at:

keke@afford-uk.org

Annex III: Focus group discussion guide

Lesotho has significant health challenges in the form of HIV/AIDS, tuberculosis, diabetes, hypertension, which account for high morbidity and mortality rates. There is an acute shortage of expertise within the health sector with many unfilled posts. Many factors have been implicated in this, some local to do with training, pay, working conditions and infrastructure. Other factors are external and include more competitive opportunities for better pay and career development and advancement. Although Lesotho has in recent years, made an effort to improve the health sector, it is estimated that a sizeable proportion of Basotho health professionals live and work abroad.

The aim of this focus group, to find out the skills and competencies of Basotho health-care professionals in the UK and to establish ways in which they would be willing to contribute their skills for the development of the health sector and other sectors in Lesotho. The focus group is also intended to identify barriers that could hinder the health workers from engaging in skills transfer, investment and other related developments in Lesotho.

1. What has been your experience as health professionals from Lesotho living and working in the UK?

2. What conditions make the UK an attractive destination for health-care professionals from Lesotho?

3. (a) What kinds of opportunities exist for diaspora health-care workers to further develop their skills in the UK?
   (b) In your experience, do Basotho health-care workers benefit from such opportunities?

4. (a) In your view, in what sectors, and where would you most likely find the majority of Basotho health professionals working in the UK?
   (b) Has there been a trend of some of them going back to Lesotho? If so, what do you believe is behind the trend?

5. (a) Can we discuss ways in which individuals in the diaspora have been engaging or contributing back home in the health or any other sector?
   (b) If there were any, what was the experience like?
   (c) If there has been no such engagement/contribution, why?

6. (a) Similarly, can we discuss any initiatives that have been pursued by members of your community (diaspora health professionals) that would potentially contribute to the development of the health sector in Lesotho?
   (b) If there were any, what was the experience like?
   (c) If there has been a desire for such initiatives but they have not been pursued, what obstacles have prevented engagement in such initiatives?

7. In what ways can we harness the best skills and experiences of Basotho health-care professionals living here in the UK for the benefit of the country of origin?

8. (a) Would such inputs/promotions/initiatives require a return to Lesotho?
   (b) Would you be interested in returning temporarily or permanently to Lesotho for this purpose?
   (c) What are the drives/motivations and incentives needed to encourage a wider participation by Basotho health professionals in that kind of scheme?

9. (a) In your view, what barriers exist that could hinder the Basotho living and working in the UK from engaging in skills transfer, investment and other development related activities in Lesotho?
   (b) What solutions could you suggest to address such barriers?

10. Can you enumerate areas within the health sector whose development you are most interested in?

11. According to you, what measures do you think can be implemented by political decision-makers (in Lesotho and in the UK) in order to maximise the input of the health-care professionals for the development of the health sector in Lesotho?

12. Are you aware of any Government of Lesotho initiatives aimed at engaging the Basotho diaspora in the development of the health sector or other sectors in Lesotho?

13. Are you aware of any UK Government initiatives aimed at assisting the Basotho diaspora in the development of the health sector in Lesotho?

14. Given the time you have spent in the UK, do you foresee any challenges if you were to return to work in Lesotho? If so, what are they?

15. How do you think you should prepare for them?

16. What else do you think should be done to encourage more diaspora health professional engagement for development in Lesotho? Is there anything you wish to add?

Annex IV: Key informant interview guide

Lesotho is experiencing acute human resource shortages within its health sector, arguably exacerbated by migration of health-care professionals to South Africa and abroad (including the United Kingdom). In a bid to address this, a mapping exercise is being undertaken to explore the challenges and opportunities for engaging Basotho Diaspora health-care professionals in both short and long term return placements. This project will aim to identify the location, skills, competencies and practices of these professionals, as well as their experiences of supporting training and human resource gaps and opportunities in the Lesotho health sector training institutions (including the newly established medical school).

We consider your extensive knowledge and experience of research/working with Basotho health professionals within the diaspora community invaluable to the outcome of this survey and we are interested in hearing your views.

Name:

Profession:

Place of Employment:

Position/Title:

Work Experience:

Contacts: Telephone/Email/Website

Brief Profile:

Questions

1. From your experience can you comment on the magnitude of Basotho health professionals working in the United Kingdom? Are you, for instance, aware of any on-going statistics regarding this phenomenon?

2. Drawing from your experience, is it possible that there has been a particular pattern in the way health professionals of Lesotho origin have been engaged with the health sector in the UK. What has this trend been like?

    - How do these professionals come into the country?
    - In which geographical location within the UK do they commonly live? Are there clusters of Basotho in certain areas?
    - Looking at the trend of their migration, would you say they are mostly temporary, permanent or cyclical (back and forth movements)?

3. Do you think these professionals are enthusiastic about contributing to the development of the health sector in Lesotho? Have there been any initiatives to that effect that you know of?

4. What are the core areas of interest that Basotho health professionals in the UK would like to contribute to the development in their country of origin? Would you say they are more interested in clinical work, health management or health as a business?

5. Do you think most of them would rather contribute to the development of their home country's health sector through temporary placements or would they prefer a permanent return? Why do you think so?

6. What likely factors/incentives do you thinks would motivate health professionals of Lesotho origin to return and help streamline the health sector in their country of origin?

7. Do you know any Basotho diaspora associations, networks or organizations here in the UK or elsewhere?

8. What is your overall thinking on the subject of diaspora health professionals supporting health sector development in their home country? What are the challenges?

9. Are you aware of any government (Lesotho or UK) initiatives/strategies to engage the Basotho diaspora in the development of the health sector in Lesotho?

10. Do you have access/knowledge of any relevant literature, contacts or links that you think might be useful to this study?

11. Is there anything we might have overlooked that you would like to add?

Thank you for your time.

International Organization for Migration (IOM)