

RETURN MIGRATION OF THE HIGHLY SKILLED, BRAIN  
GAIN AND BRAIN CIRCULATION IN THE HEALTHCARE  
SECTOR IN GHANA:

*A CASE STUDY OF THE IOM MIDA GHANA HEALTH INITIATIVE*

*By*

Alhassan Ziblim

*Submitted to*

*The Department of Public Policy  
Central European University*

*In partial fulfilment of the requirements for the degree of Master of Arts in  
Public Policy*

Supervisor: Professor Martin Kahanec

Budapest, Hungary

2013

## ABSTRACT

It is widely argued that temporary return migration of the highly skilled can create reverse brain drain by enhancing brain gain and brain circulation between sending and receiving states. This study examined this assumption in Ghana within the context of the Migration for Development in Africa (MIDA) Health Initiative by the International Organisation for Migration (IOM). The initiative was a temporary return project involving Ghanaian highly skilled health professionals in Europe over the period 2005 to 2012. The study attempted to find out what its impact was, on the healthcare sector, and again, to identify its implications for policy. It was conducted through desk research, and relied primarily on the project's reports by the IOM, books, journal articles and research publications as well as internet sources. Overall, the findings indicated that the initiative had a substantial impact on the healthcare sector, as it concurrently promoted brain gain and brain circulation. It was found to enhance human capital accumulation through skills and knowledge transfer and professional development for some local health staff through overseas internships. Some returnees introduced innovations, while others used their international networks to secure logistics in support of local health institutions, which generally improved healthcare delivery. The findings augmented the commonly held view that, temporary return of the highly skilled has the potential to create a positive connection between brain drain and economic development in sending states. The policy implications of the initiative have been highlighted in the end.

## ACKNOWLEDGEMENT

My greatest thanks go to the Almighty God, for the good health and wisdom granted me to go through this academic exercise successfully.

My sincere thanks also go my family, friends and relatives for their emotional and moral support.

I thank my Supervisor Professor Martin Kahanec for the kind support throughout this project.

To all the DPP faculty and administrative staff, I say God Bless You for the wonderful upbringing.

My final gratitude goes to my sponsor, the European Commission for making my dream come through.

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## LIST OF ABBREVIATIONS

EU	European Union
GHS	Ghana Health Service
GIS	Ghana Immigration Service
IOM	International Organisation for Migration
MIDA	Migration for Development in Africa
MOE	Ministry of Education
MOH	Ministry of Health
UK	United Kingdom
US	United States
WHO	World Health Organisation

# INTRODUCTION

## 1. Background

The brain drain of health professionals is still one of the topical issues in recent debates around migration and development in Africa (Castles 2010), especially in the face of the serious health challenges confronting the continent (Dovlo 2004; Dovlo and Buchan, 2004). The concept of brain drain is used generally to denote “the international transfer of resources in the form of human capital,”<sup>1</sup> that is, the migration of people who possess relatively higher levels of education from developing countries to the developed world (Beine et al. 2003; 2008). Brain drain of health professionals is arguably undermining effective healthcare delivery in Sub-Saharan Africa. In 2006, the World Health Organization (WHO) reported that out of 57 countries worldwide facing acute shortage of healthcare professionals; more than 60 percent (36) were in Sub-Saharan Africa. Yet, estimates show that as at 2000, “65,000 African-born physicians and 70,000 African-born professional nurses” were residing and practising “overseas in a developed country” (Shinn, 2008).

Ghana is one of the countries in sub-Saharan Africa with exceptionally high levels of emigration among the highly skilled<sup>2</sup>, with an average of about forty-six percent (Docquier and Marfouk, 2006). Of serious concern however, is the brain drain of health professionals, particularly nurses, doctors and pharmacists (Dovlo, 2004). Within the past two decades, the country lost more than fifty percent of its professional nurses to the United Kingdom (UK), United States (US) and Canada (IOM, 2011). The same applies to doctors and pharmacists. As at 2002, vacancies within the Ghana Health Service (GHS) were estimated at 65% for

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<sup>1</sup> Human capital is defined traditionally as the accumulated total of the innate and acquired “human abilities, knowledge, skills and motivations to encourage human productivity” (Verhoglyadova, 2006, 250). According to the “new growth theory,” the quantity and quality of human capital is integral to the economic growth of any society (Romer 1994).

<sup>2</sup> Highly skilled is defined generally here as “those in possession of a tertiary degree or extensive specialized work experience.” It includes “architects, accountants and financial experts, engineers, technicians, researchers, scientists, teachers and health professionals” (Vertovec, 2002, abstract).

doctors, 56.6% for pharmacists, and 68% for professional nurses (IOM, 2011). According to the Institute of Statistical Social and Economic Research Ghana (ISSER ) out of the 10, 799 health professionals trained in Ghana between 1995 and 2002, approximately 2,505 (23.2%) left the country for greener pastures overseas (ISSER, 2003, cited in Bump, 2006).

The situation has been attributed to the complex interaction of several ‘push’ and ‘pull’ factors. Poor salaries, allowances and other conditions of service coupled with limited opportunities for professional advancement are often cited as major “push factors” (Dovlo and Nyonator 1999, Dovlo 2004). Over the last decade, the government has put in place a number of policy interventions in the health sector, including extra duty hours allowance; a separate Health sector Salary Scheme (HSS), Vehicle Ownership Scheme, bonding of trainees, opportunities for postgraduate study and more importantly, it has made flexible the procedures and requirements for re-engaging returnees in to the health sector (IOM, 2011). The aim of these interventions was to increase retention rate, and also encourage return migration among those overseas (IOM, 2011). However, the impacts of these measures have so far been far-fetched either in curtailing further brain drain or encouraging return migration.

According to Asare, the lack of comprehensive national migration policy has hindered government efforts over the years, to properly integrate migration, particularly of highly skilled in to the national development agenda (Asare 2009; IOM, 2011). It was against the backdrop of this policy gap, but also to reverse the brain drain in the health sector, that the MIDA Ghana Health Initiative was launched in 2003 by the IOM, within the broader framework of the its MIDA Programme, jointly initiated in 2001 with the Organisation for African Unity (OAU)<sup>3</sup>.

The initiative was aimed to help address the critical human resource needs in the health sector by encouraging “temporary return” of Ghanaian highly skilled health

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<sup>3</sup> The OAU is now referred to as the African Union (AU)

professionals living in Europe. The initiative is significant because, it is the first to specifically focus on return migration among the highly skilled in the health sector.

## 2. Statement of the Research Problem

The potential of return migration to create a positive link between brain drain and economic development in sending states has been recognised in existing academic research in Ghana (e.g. Asiedu, 2003; Ammassari, 2003; Black et al., 2003; Black and Castaldo, 2009). Asiedu have looked at migrants' "return visits" and their donations to, as well as investments in various institutions and sectors in Ghana (Asiedu, 2003). Black et al. also examined the contribution of low skilled return migrants to "development and poverty alleviation through the promotion of small businesses" in the country (Black et al. 2003, 1). Similarly, Black and Castaldo recently assessed the impact of return migrants on entrepreneurship in Ghana and Cote d'Ivoire (Black et al., 2003; Black and Castaldo, 2008).

However, only few studies have specifically explored the impact of return migration of the highly skilled in Ghana (Ammassari, 2003). Ammassari discussed the contribution of Ghanaian and Ivorian "elite"<sup>4</sup> return migrants to "the socio-cultural and political changes" in their societies both in the public and private sectors (Ammassari 2003, 3). He concluded that "elite emigrants accumulate relevant human capital abroad and that its transfer through return has positive impacts on the development" of the two countries (Ammassari, 2003, 21). As a point of departure, this paper has focused specifically on highly skilled return migrants in the healthcare sector, where the impact of "brain drain" has attracted serious attention among academics and policy makers in recent times.

The purpose of the study was to explore the link between *return migration of the highly skilled and "brain gain" as well as "brain circulation" in Ghana within the context of the MIDA Ghana Health Initiative*. The implications of the initiative for similar policy

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<sup>4</sup> He defines the "elite" as those people "working in top positions of responsibility and authority," both in the public and private sectors in Ghana and Cote d'Ivoire (Ammassari 2003. 4)

interventions on return migration will also be examined. The main question of the research is: *what is the impact of the MIDA Health Initiative on the healthcare sector in Ghana?* And *what are its implications for similar policy interventions on return migration?* The paper argued that the project had a significant impact in facilitating brain gain and brain circulation in the healthcare sector. Secondly, it contended that the design and implementation of the initiative can offer significant lessons for similar policies on return migration.

### **3. The Research Methodology**

The study took a closer look at the MIDA Health Initiative in Ghana, which was implemented in three phases from 2003 to 2012. The project is relevant as a case study for examining this topic, partly because, it represented one of the first comprehensive attempts in Ghana, to link highly skilled labour mobility, brain gain as well as brain circulation, within the framework of return migration. The initiative started actively in 2005 after an initial phase of feasibility study from 2003 to 2004. Hence, this paper limits itself to the second and third phases covering 2005 to 2012.

The study was conducted through desk research, and relevant data was gathered from project reports by the IOM, books and journal articles, publications by organisations such as the IOM and the WHO as well as internet sources. Owing to the absence of baseline data, the assessment of the initiative's impact was done using rather descriptive indicators, such as the number of temporary returnees, skills transfer workshops organised and the number of local professionals trained; the project's contribution to logistics and infrastructure development as well as general healthcare delivery. Stakeholder opinions contained in the MIDA project reports are also used to supplement the descriptive data. The study will not touch on the role of remittances due to the absence of disaggregated data on the contribution of health professionals in that regard.

#### **4. The Expected Results**

The study hoped to establish a significant link between return migration and brain gain as well as brain circulation in the healthcare sector in Ghana within the context of the MIDA health initiative. It also hoped to bring out important lessons that can inform subsequent policy initiatives on return migration.

#### **5. The Policy Implications**

It was expected that the topic of this research will have important academic and policy implications. In the first place, it was expected to contribute to existing research on the role of the highly skilled diaspora in fostering development in Ghana through the avenue of return migration. Secondly, through the design and implementation of the initiative, it was expected to highlight the dynamic interaction between transnational and other private actors alongside the state in managing international migration processes, and this can offer important insight and lessons regarding the institutional context of policies geared towards mobilising the diaspora for development.

#### **6. Limitations of the Study**

The important limitation of this study related to the limited time frame within which it had to be conducted. It was therefore to overcome this challenge that the scope of the present study was narrowed down to a single case study, rather than the comparative country study proposed in the initial proposal.

#### **7. The Structure of the Paper**

The rest of the paper is organised as follows: chapter one lays out the theoretical and conceptual framework. The second reviews the broad theoretical literature on the migration-development nexus and the role and challenges of return migration of the highly skilled in facilitating that link via brain gain and brain circulation. Several policy options for mobilising the diaspora for development are also reviewed. The third chapter starts with a brief

background to Ghana and goes further to present an overview of the MIDA Ghana Health Initiative, focusing on its institutional design and contribution to the health sector. Chapter four undertakes an analysis of the project's impact, strengths and challenges, as well as its policy implications; while the final section rounds up the entire paper with a brief conclusion.

# CHAPTER 1: THEORETICAL AND CONCEPTUAL FRAMEWORK

## 1.2 Return Migration

Return migration is currently considered as a convenient link between highly skilled labour migration and development in sending countries. Meanwhile, the concept itself has become a complex area of research due to the diverse categories of return: temporary, permanent, voluntary or forced return (Cerese 1974; Battistella, 2004; Khaour-Knipe and Davies, 2008). This creates definitional challenges. According to Gmelch return migration is the “*movement of emigrants back to their homelands to resettle*” (Gmelch 1980, 136). This definition is too narrow because it limits return migration only to permanent return. The United Nations Statistics Division (UNSD) also defines as return migrants “*persons returning to their country of citizenship after having been international migrants (whether short term or long-term) in another country and who are intending to stay in their own country for at least a year*” (UNSD, 1998, quoted in OCED 2008, 164). This definition has been criticised for limiting migrants’ home country to their nationality. Hence, for individuals “born and naturalised” as well as those “born as foreigners” in the host state, a definition premised exclusively on country of nationality does not seem appropriate” (OECD, 2008, 164). Also, the minimum time limit of one year makes it too narrow. The IOM also defines return migration as “*the process of a person returning to his/her country of origin or habitual residence*” (IOM, 2004, quoted in Khaour-Knipe and Davies, 2008, 6). Even though this definition is suitable, it does not distinguish between temporary and permanent return.

In this paper, “return migration” is understood to mean “temporary return,” that is “when the migrant returns, but intends to re-emigrate abroad.” King has distinguished this from permanent return where the migrant returns to settle down for good (King, 2000, cited in Khaour-Knipe and Davies 2008, 7). An important aspect of temporary return is that it is time bound. In the work of the IOM under the MIDA Ghana Health Initiative, the term “temporary

return” is used to denote the temporary return of highly skilled health professionals to Ghana for a minimum period of three months within the project period (IOM, 2012). This definition has been adopted in this paper because it suits the operational context of the case study been considered.

## **1.2 Brain Drain, Brain Gain and Brain Circulation**

The concept of “brain grain” and “brain circulation” have dominated discussions in recent times regarding the connection between highly skilled labour mobility and development. The concept of brain circulation is understood as a replacement of the old dynamic of “brain drain” versus “brain gain” (Saxenian 2002; 2005). On the one hand, underlying the idea of “brain drain” is generally the argument that international migration of the highly skilled adversely affects the development of sending states due to the loss of the much needed human capital for development (Todaro 1985; Haque and Kim 1995).

On the contrary, scholars who dispute this view predict positive net returns from brain drain in the long term, through the corresponding theory of brain gain (Mountford 1997; Vidal 1998, Beine et al., 2001). The “brain gain” theory posits several important assumptions. First, the theory assumes that “the possibility of own future emigration may prompt a net increase in the rate of human capital accumulation in origin countries.” Secondly and also of interest in this paper, is the assumption that, emigration may “generate human capital gains to origin countries through return migration and the transnational networks that the “diaspora” has developed over the years (Batista et al. 2007, 4).

More recently, the concept of “brain circulation” coined by Saxenian (2002) emerged from the growing debate between brain drain and brain gain (Daugeliene and Marcinkeviciene, 2009). The theory of “brain circulation” is quite similar to the idea behind “brain gain,” but unlike the latter it advances the argument that the frequent mobility of highly skilled migrants between sending and host states facilitates a two way transfer of human

capital, which results in a “win-win” situation for sending and host states (Daugeliene and Marcinkeviciene 2009). Citing Blitz (2005), Le (2008), Saxenian (2002); Tung (2008) and Teffera (2004), Daugeliene and Marcinkeviciene assert that “brain circulation replaces the traditional concepts of “brain drain” versus “brain gain” because of the growing mobility of human talent” across several countries (Daugeliene and Marcinkeviciene 2009, 50). According to Tung, brain circulation has been made possible due to structural factors, such as increasing globalisation, reduction in “the barriers to immigration and emigration,” as well as dual citizenship regimes (Tung, 2008 cited in Daugeliene and Marcinkeviciene 2009, 51).

The theory of “brain gain” and “brain circulation” both link quite well with idea of temporary return migration that underpins the design of the MIDA Health Initiative examined in this paper. The two theories predict net gains in human capital to sending states, through return migration and “diaspora” or “network effects” (Batista et al. 2007, 4) but unlike “brain gain,” which essentially implies a one way injection of human capital in to the origin country (Tung, 2008); “brain circulation” emphasises the two-way transfer of human capital between sending and receiving states, associated with temporary mobility. However, this paper argues that the MIDA temporary return initiative did not only enhance brain circulation but simultaneously promoted “brain gain,” through human capital “spillovers” or skills and knowledge diffusion to local health staff.

## CHAPTER 2: REVIEW OF RELEVANT LITERATURE

### 2.1 The Migration-Development Nexus

The relationship between migration and development is widely debated in the theoretical and empirical literature on migration and development (Castles, 2008; Castles and Miller, 2009; De Haas, 2007, 2010). In the 1950s and 60s dominant views in development theory saw international migration as having significant potential to propel the economic take off of developing countries. Return migrants were particularly perceived as “important agents of change and innovation in the sending societies.” They were expected to bring back “not only money, but also new ideas, knowledge, and entrepreneurial attitudes” (De Haas 2010, 5).

However, pessimism set in around the late 1960s to the 1970s with scholars (mainly) from the historical-structuralist perspectives arguing that international migration exacerbates the spatial inequalities in development between the developed and developing economies, by draining the latter of their “scarce skilled and professional labor resources in which [sending] states have invested many years of education” (De Haas 2010, 7, citing Baldwin, 1970). Furthermore, deep seated concerns over “brain drain,” the threat of potential “migration syndrome”, domestic inequalities in sending societies as well as arguments regarding “cumulative causation” (Myrdal, 1957, cited in De Haas, 2010) were all advanced against labour mobility. International labour mobility was essentially seen as an appendage of the capitalist mode of exploitation, necessitated by the demand for cheap labour in the developed world (Massey et al. 1993).

From the 1980s and 1990s there was resurgence of optimism following the emergence of pluralist perspectives such as the New Economics of Labour Migration (NELM) (Stark, 1991 cited in De Haas, 2010), the livelihood approaches and the transnational turn in migration studies (De Haas, 2010). The “transnational turn” looks at the integration of migrants into receiving societies, but again emphasises among others, their potential to keep

transnational ties with their home societies, thanks to globalisation and innovations in communications technology (Vertovec 1999; Guarnizo et al., 2003, cited in De Haas, 2010). The transnational perspective marked a revolution in the migration-development nexus, as it implied that migrants' *"integration in receiving societies and commitment to origin societies are not necessarily substitutes, but can be complements"* (De Haas 2010, 21). According to De Haas, empirical studies have indicated that migrants need not return permanently to engage with their home countries, since they can do so through "telecommunications, holiday visits and pendular migration patterns" (De Haas 2010, 21). This is where temporary return migration can also provide avenue for migrants to transfer valuable knowledge and skills and other resources to the benefit of the home states.

## **2.2 The Impact of Return Migration on Brain Gain and Brain Circulation**

Whereas there are genuine concerns over the negative implications of brain drain on the development of sending states (e.g. Bhagwati and Hamada, 1974; Haque and Kim, 1999), empirical studies suggest that there are equally enormous potentials for return migration of highly skilled professionals to foster economic development through brain gain and even concurrent brain circulation (Saxenian, 2002, 2005; Batista et al. 2007; Le, 2008).

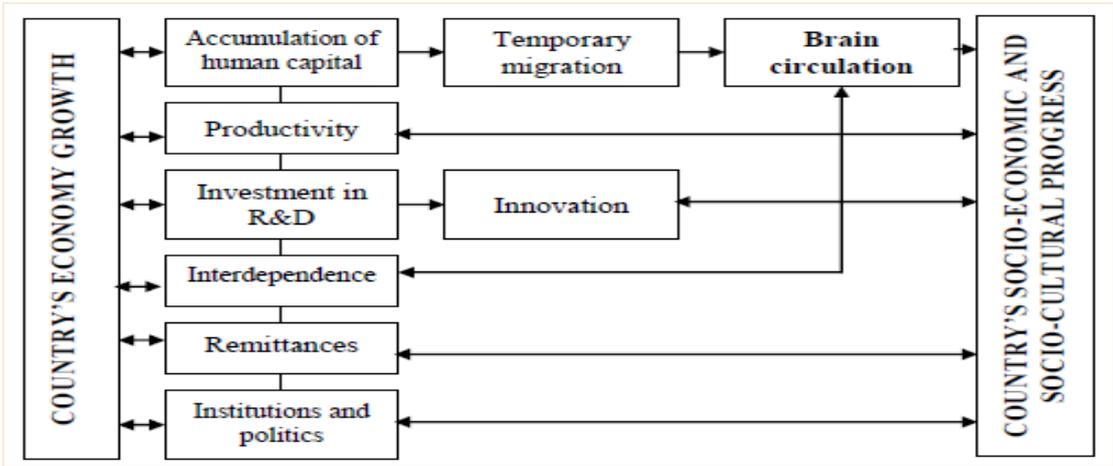
It is generally assumed that the highly skilled professionals who emigrate acquire additional higher skills and expertise, as well as financial and social capital in the host countries. Financial capital basically refers to monetary remittances, whereas social capital on the other hand, denotes "the aggregate of actual and potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual acquaintance or recognition" (Pierre Bondieu 1985, 248, quoted in Portes, 2004, 3). In this regard, return migration is perceived as the channel through which the accumulated human, financial and social capital of migrants is transferred to their home countries, which results in overall net capital gains for the sending state (Saxenian, 2002, 2005; Batista et al., 2007). The

positive connection between human capital and economic development has been well noted by the “new growth theory” which argues that “the size and the quality of endogenous factors [such as] the human capital stock, correlates positively with the degree of economic growth” (Uwe 2002, 3; see also Romer 1994).

Daugeliene has identified several factors, which he argues foster the growth of nations’ economies (Daugeliene, 2007, cited in Daugeliene and Marcinkeviciene, 2009). In his conceptual framework (see *Figure 1 above*), the author recognises among many others, that the “accumulation of human capital,” and “brain circulation through [...] temporary migration” are crucial for stimulating economic growth (Daugeliene, 2007, cited in Daugeliene and Marcinkeviciene, 2009).

**FIGURE 1: Factors Fostering Countries Economic**

**Growth**



Source: Adopted from Daugeliene and Marcinkeviciene (2009, 51)

Blitz also commented that the “combination of temporary migrations, sustained investment in R&D[Research and Development] as well as remittances being sent back home has [...proven] that the net result of [...]skilled labour flows may increase economic growth for both sending and receiving countries in the long term” (Blitz 2005, cited in Daugeliene and Marcinkeviciene 2009, 51).

Further empirical studies also point to a positive connection between return migration and knowledge-induced growth in sending states. In a study among Asian immigrants in the Silicon Valley in the United States (US), Saxenian concluded that the *“U.S-educated engineers are transforming developmental opportunities for formerly peripheral regions as they build professional and business connections to their home countries [...] in a process more akin to “brain circulation”*(Saxenian, 2005, abstract). Thanh Le also investigates the relationship between labour mobility and technology transfer in 19 OECD countries between 1980 and 1990, using panel co-integration method (Le 2008). The findings strongly support the view that international labour mobility has the potential to transfer technology across borders from sending to receiving states and “vice versa” (Le, 2008).

Similar findings have been noted by other authors, example Straubhaar (2000), Batista et al. (2007), Black et al. (2003) and Teferra (2005). Using a household survey in Cape Verde in Africa, Batista et al. concluded that *“there may be substantial human capital gains from allowing free migration and encouraging return migration”* (Batista et al. 2007, abstract). Wiesbrock supports this view when he concluded in a comparative study of China and India that *“return migration of the highly skilled can benefit all, the sending country, the receiving country and the individual if it is supported by adequate policies and environment”* (Wiesbrock, 2008, 31). The views of Batista et al. (2007) and Wiesbrock (2008) imply that the policy context is as important as the return itself in achieving optimal outcomes through highly skilled labour mobility.

On the reverse, there are authors who have challenged the migration-development nexus via return migration of the highly skilled (Straubhaar, 1992). Michael Todaro points out that the “brain gain” and “brain circulation” arguments are based on two assumptions: *“First, [they assume] that emigrants find overseas employment that involves greater skills than they used at home and hence become more skilled. “Secondly, [they also assume] that*

*the workers will return home [either temporarily or permanently] and will be able to apply their new skills domestically*” (Todaro 1985, 268, quoted in Straubhaar, 1992, 100). Writing in the 1990s, Thomas Straubhaar alluded to several researches by the Organisation for Economic Cooperation and Development (OECD, 1975; 1978; 1979, cited in Straubhaar, 1992) which suggest that the reality behind the above assumptions is quite the opposite.

Other studies contend that jobs normally available to immigrants are often unskilled or low skilled; and the emigrants who succeed in getting higher jobs that bring greater skills are less likely to return, because for them “advancement may be better overseas” than at home (Todaro 1985, 268, quoted in Straubhaar 1992, 100). In addition, potential mismatch between acquired skills and the human capital needs of the home country, the lack of employment opportunities, or even an enabling environment to apply the new knowledge and skills acquired might create human capital redundancy or wastage (Straubhaar1992; Battistella, 2004). Empirical studies in several south-east Asian countries confirm the above challenges among return migrants (Battistella, 2004).

### **2.3 The Challenges after Return: South-East Asian Experiences**

Several Asian countries such as Philippines, Taiwan, Indonesia and India are well known for the implementation of temporary migration policies (Battistella, 2004). However, Battistella has observed that even though “*return is a permanent feature of [labour] migration, [...] it appears that no adequate return migration policy has been effective anywhere in Asia, including the Philippines.*” In Many East Asian countries, return is a “structural” element of migration, as the “system” is designed in such a way that migrants abroad have to return after the expiration of their contracts (Battistella, 2004, 3).<sup>5</sup>

While return can have the potential to facilitate the development of sending countries through knowledge and skills transfer, much also depends on the social, economic and political context in the home state (Thomas-Hope, 1999; Battistella, 2004). As noted earlier,

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<sup>5</sup> However, evidence also suggests that some manage to evade return by illegally overstaying their contracts.

unemployment after return appears to be one of the main challenges for effective utilisation of returnees' skills. In Pakistan, writing in the 1980s, Gilani indicated that only half of return migrants were able to find employment after return and approximately 30% remained unemployed for more than two years (Gilani, 1986, cited in Battistella, 2004). Nair found similar challenges in Kerala (Nair, 1991, cited in Battistella, 2004). In Sri Lanka, unemployment among return migrants reportedly doubled compared to the pre-migration period; and according to Mahmood, it was more than 41% in Indonesia (Gunatilleke, 1991; Mahmood, 199, cited in Battistella, 2004). The lack of adequate finance and the limited investment opportunities in the home societies sometimes inhibit returnees' ability to start up their own initiatives (Abella, 1986; Battistella, 2004). Micro studies in the 1980s indicate that while "only 44% of returnees to the Philippines sought wage employment" merely "half [...] found jobs, usually within 5months." Again, while "some 17% sought self employment" another "39% did not seek local employment" either "because local wages were low" or they were still seeking another job overseas" (Go, 1986, cited in Battistella 2004, 11).

Despite that the above challenges are quite realistic; most of them do not seem to affect temporary return migration in the nature of the MIDA Ghana Health Initiative. Practically, the "need-based," "tailor made" and "flexible" design of the MIDA project (IOM, 2012) can help to avert some of the major challenges that hinder the effective utilisation of returnees' accumulated human capital.

## **2.4 Policy Options for Mobilising the Diaspora for Development**

The diaspora is defined as "*populations of migrant origin who are scattered among two or more destinations, between which there develop multifarious links involving flows and exchanges of people and resources: between homeland an destination countries, and among destination countries*"(Castles and Miller 2009,70). Perceptions about the diaspora have remarkably shifted, and governments of receiving and sending states as well as international

development organisations have increasingly recognised them as “heroes of development” in their home societies (Castles and Miller, 2009, 71).

Over the last two decades, efforts to mobilise the diaspora for development have become commonplace. For example: In India, the *“Ministry for Indians Overseas supports the Diaspora Knowledge Network, designed to connect highly skilled emigrants with opportunities at home. Mexico’s government supports community investments through [Home Town Associations] (HTAs). In the Philippines, the Commission for Filipinos Overseas (CFO) supports LINKAPIL (Link for Philippine Development) to mobilise resources of the diaspora”* (Castles and Miller 2009, 71). Around the 1970s, the Taiwanese government established the National Youth Council (NYC) with the “task of linking skilled emigrants with the Taiwanese business community.” The council also function to maintain links with the highly skilled abroad by among others creating “a database of emigrants, travel subsidies and temporary job placements for emigrants who consider [returning].” The database enable “Taiwanese emigrants to find employment in Taiwan, and Taiwanese employers to head-hunt highly skilled nationals abroad” (Wiesbrock, 2008, 33).

The above initiatives contrast with others by nongovernmental actors. For example, in 2006, the American International Health Alliance Inc. (AIHA) and Visions for Development Inc (Visions) alongside other private stakeholders, initiated the Ethiopian Volunteer Diaspora Programme (EVDP) in active partnership with the Ethiopians in North America Health Professionals Association Inc. (ENAHPA), with funding from the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) (Tedla and Terrazas, 2011). The programme, which is still ongoing, is aimed at mobilising highly skilled Ethiopian health professionals in the US to undertake “temporary return assignments” back in Ethiopia, so as to contribute towards the fight against the HIV/AIDS epidemic and to improve general healthcare delivery (Tedla and Terrazas, 2011). The MIDA programme initiated by the IOM together with the

African Union (AU) in 2001 form part of the recent initiatives (De Haas., 2006b). The pioneer project under the MIDA programme was the MIDA-Italy project initiated for Ghana and Ethiopia and funded by the Italian government (De Haas, 2006b).

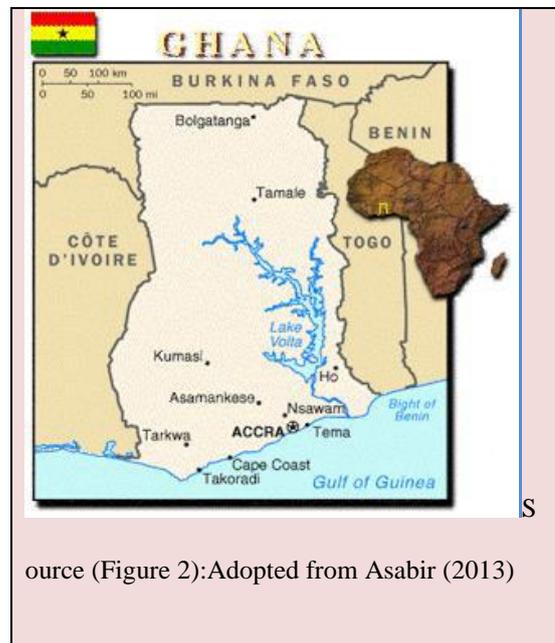
However, unlike the governmental initiatives identified above (Wiesbrock, 2008; Castles and Miller, 2009), the MIDA programme is typically donor driven, both in design and implementation with the passive involvement of country governments (De Haas, 2006b). What is noteworthy is that, the different strategies for mobilising the diaspora practically have diverse implications for the sustainability of the programmes. For example, the MIDA-Italy project aimed to engage Ghanaians in the diaspora in developing micro-enterprises in the agricultural sector, while in Ethiopia, the goal was to create a comprehensive website that would facilitate information exchange for the diaspora (De Haas, 2006b). However, De Haas reports that the project generated mixed results amidst several problems (De Haas, 2006b). “Lack of commitment” on the part of governments, resulted in less “support for the project’s activities and ultimately led to unsatisfactory outcomes” (De Haas 2006b, 21). He notes that the Ethiopian government “was particularly unsupportive of the project” and despite that the website was created, it was quickly abandoned after the project ended. Even the Ethiopian diaspora in Italy reportedly had limited interest in it (p. 21). In Ghana, it was realised that the investment initiatives undertaken under the MIDA project “*were isolated from national economic efforts and other development initiatives and in the end it became clear that the ministry in charge was not interested in small-scale investments such as those promoted by MIDA*” (De Haas, 2006b, 21).

It is therefore instructive to note that, like any donor development initiative, country “ownership”, implying “the degree of *control* recipient governments are able to exercise over policy design and implementation” (Renzio et al. 2008, 2) is arguably crucial to ensure effectiveness and long term sustainability.

## CHAPTER 3: THE COUNTRY CONTEXT AND CASE STUDY

### 3.1 Country Context

Ghana finds itself at the centre of the West African Sub-region, sharing borders with Burkina Faso in the North, Togo in the East, and Cote d'Ivoire in the West, with the Gulf of Guinea in the South (see Figure 1). It has ten (10) administrative regions and 216 districts, with total population of around 24 million and Gross Domestic Product (GDP) of about US\$75 billion



Source (Figure 2): Adopted from Asabir (2013)

(Ghana Statistical Service, 2011; CIA Factbook, 2012). The population is predominantly youthful with 36.5% within 0-14 years, 60% between 15 and 60 years while only 3.6% is above 60 years (IOM, 2011). Literacy rate is 67.3% and the labour force is estimated at 11.4 million with unemployment rate around 11% (CIA Factbook, 2012).

Health service delivery in Ghana is a joint responsibility between the Ministry of Health (MOH), the Ghana Health Service (GHS) and to a large extent the Ministry of Education (MOE). The MOH is responsible for policy formulation, implementation and monitoring, while the GHS is an agency directly in charge of the delivery of primary, secondary and other specialist healthcare at the community, district and regional levels (IOM, 2011). The GHS owns about “half of the health facilities;” the private sector (with maternity homes inclusive) runs twenty-one per cent; whereas the remainder is owned by the Christian Health Association (Global Health Workforce Alliance (GHWA, 2008, 3). The training of health professionals is also a joint responsibility of the MOH and MOE (IOM, 2011). On the

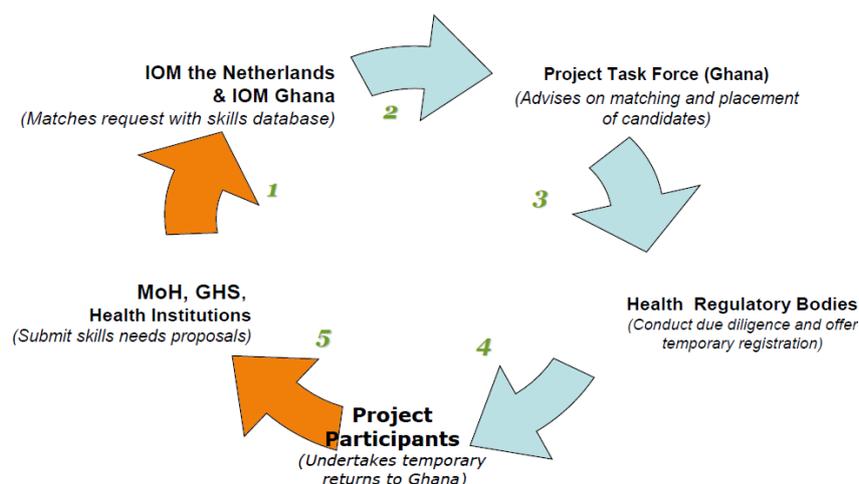
other hand, migration issues fall directly under the domain of the Ministries of Interior and Foreign Affairs as well as the Ghana Immigration Service (GIS).

### 3.2 Overview of the MIDA Ghana Health Initiative

The MIDA Ghana health initiative by the IOM was a temporary return project implemented from 2005 to 2012. The objective was to “build a bridge between available resources of the Ghanaian diaspora and [the] needs, opportunities and policies in the health sector in Ghana.” It was intended to “facilitate the temporary return to Ghana of Ghanaian health professionals from the diaspora residing in the Netherlands, United Kingdom (UK), Germany and other European Union (EU) countries for the benefit of local health institutions” (IOM Report 2012, 1).

The project involved a number of key stakeholders, namely; the IOM in Ghana and the Netherlands, Motec Life-UK<sup>6</sup>, the Dutch government as well as the Ghana Ministry of Health (MOH) and the Ghana Health Service (GHS). As Figure 1 below indicates, the project had a very comprehensive design with each actor playing a coordinated role in the overall scheme of the project.

**Figure 3: MIDA Ghana Health Initiative Concept Process**



Source: Adapted from Asabir, K. (2013) Health Labour Market Analysis: Ghana’s perspective.

<sup>6</sup> A UK based medical charity which provides educational training as well as healthcare services to underprivileged areas in West Africa (<http://www.moteclife.co.uk/>)

At the first stage, IOM Netherlands makes request for proposals from Ghanaian health institutions. The proposals contain a list of their critical human resource needs. The IOM then matches the proposals with the skills and expertise of volunteers who have registered on their database. At the third stage, there is a project task force set up in Ghana that advises on the placement of the volunteers. This is necessary because in most cases the human resource needs of the health institutions will exceed the number of participating volunteers. In addition, the IOM collaborates closely with the GHS in order to facilitate the placements in terms of the regulatory requirements. The health regulatory institutions in Ghana have to make sure that the skills and expertise of volunteers meet the specific requirements of their assigned tasks. After due diligence has been done by the regulatory agencies, temporary registrations are offered to the volunteers that will enable them to practice in Ghana (IOM Report 2012).

### ***3.2.1 The Role of the Ghana Government in the Initiative***

As indicated earlier, the project was a donor initiative. The IOM Netherlands was the initiator and primary coordinating organisation for the project, alongside the IOM Ghana and Motec Life UK. The Ghana government through the MOH was later involved only as a stakeholder, despite that the project was dealing directly with institutions under the GHS. Moreover, the funding for the project also came from external donors. This issue was very central to the sustainability of the project as the initiative had to phase out in 2012 due to the end of funding by the Netherlands government (IOM Report, 2012).

In terms of the diaspora mobilisation, participation in the project was framed as volunteering, and that depended absolutely on the volunteers' will and availability. The mobilisation of the volunteers reportedly posed as a challenge at some point, thus, informing the need for more of the involvement of the Ghana government and the Ghanaian Diaspora networks in Europe so as to encourage the health professionals to participate. Alexander van Omen, the Health and Gender Advisor at the Netherlands Embassy in Ghana at some point

appealed to the Ghana government to “make a stronger moral appeal to those involved in the diaspora to stimulate their involvement. Their country needs these men and women,” he asserted (IOM Report 2012, 5).

In this view, the Ghana government “decided to cooperate in the project as part of the efforts to encourage Ghanaian health professionals in [the] diaspora to contribute towards making healthcare accessible to the people living in Ghana” (IOM 2011, 9). The IOM finally lauded the efforts of the Ghanaian Diaspora in the various EU countries for their assistance in encouraging volunteers’ participation (IOM Report, 2012).

### **3.3 Contribution of the Initiative to the Health Sector**

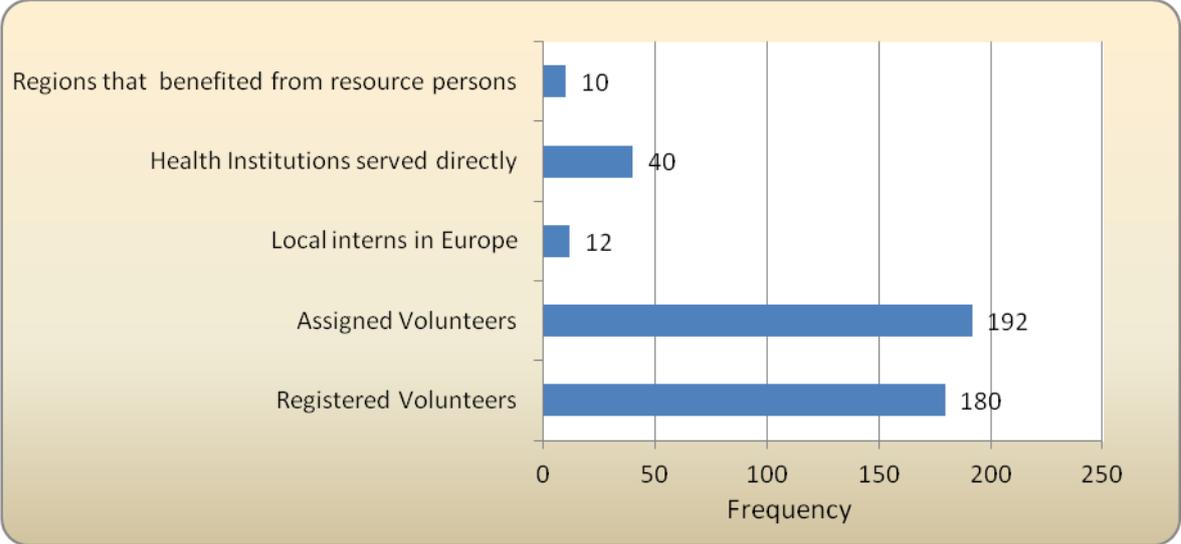
It was envisaged that the project will contribute to the health sector in three main broad areas. That is faculty development through knowledge and skills transfers, continuous professional development and the provision medical services (Sam, 2012) (see Figure 3 below). In order to realise this goal, the assignment of volunteers focused on five thematic areas, namely: “teaching, public health education, research and feasibility studies, clinical practice and health management and ICT [Information and Communication Technology] support” (Sam 2012, 24). Sam also indicates that the specific skills engaged in such areas related to: “mental health and psychiatry, Orthopaedics and anaesthetics, public health, accident and emergency medicine, sports medicine, ICT, pathology and systems management” (Sam 2012, 24). Another important aspect was that some local health personnel were given the opportunity to undertake internships in institutions in the Netherlands, UK and Germany and other EU countries in order to develop themselves professionally and come back to serve (IOM Report, 2012).

#### ***3.3.1 Mobilisation of Diaspora and Temporary Assignments***

In August 2012, at a colloquium on the engagement of the Ghana Diaspora organised in Accra, the IOM Field Manager in Ghana, Daniel Sam outlined some of the success stories

of the MIDA initiative. As *Figure 3* below shows, in terms of mobilisation of health professionals in the diaspora, it was able to register 180 on its volunteers’ database, and realised 192 temporary assignments as at August 2012. The higher number of assignments compared to the registered volunteers implies that some volunteers undertook more than one round of temporary assignment. Through these assignments, about thirty health institutions in Ghana benefited directly from the services of the resource persons. More importantly, the assignments covered various health institutions across the ten regions of Ghana. This ensured that at least all the regions benefited, even if not equally (IOM Report, 2012).

**Figure 4: Descriptive Summary of MIDA Health Project Accomplishments, 2005- 2012**



Source: The Author, from data presented by Sam (2012). Migration and Development: MIDA Ghana Health Project

**3.3.2 Capacity Building through Skills and Knowledge Transfer**

A significant part of the project related to skills and knowledge transfer. According to Sam, as at August 2012, around thirty thousand (30,000) local health workers and students benefited from capacity building workshops facilitated by over 150 highly skilled professionals who were on volunteer assignments under the MIDA project (Sam, 2012). These workshops, as indicated earlier, covered areas ranging from mental health and psychiatry to ICT and systems management (IOM Report 2009, 2012). Aside the workshops,

on the job knowledge transfer through the performance of sophisticated operations constituted learning grounds for local experts. The Chief Executive Officer of the Accra military hospital said the diaspora professionals performed “*orthopedic surgeries such as complex joint replacements and corrective surgeries*” and through that they also trained “*our medical staff, in other words capacity building in a broad sense. Their commitment and transfer of expertise has had a great impact on our hospital*” he added (IOM report 2012, 10). Similarly, one medical doctor at the Volta River Authority hospital also said “*initially hip and knee replacement, cruciate ligament fixation and other orthopedic surgeries were not performed in Akosombo or other hospitals in Ghana and patients had to travel to Europe or to North America and South Africa,*” but thanks to the diaspora experts, such operations can now be done at the hospital (IOM Report 2012, 12). One nurse who had lived in Europe since 1986 and came down for the volunteer assignments narrated that: “*One time I gave a training session about asthma. That same evening, a patient suffering an asthma attack was brought in. The nurses without hesitation put him on the nebulizer I had just demonstrated to them, and treated him accordingly. For me, that was wonderful to see*” she said (IOM, 2012, 19).

### **3.3.3 Professional Development of Local Health Staff**

The project also offered opportunities for some local personnel to develop themselves professionally through the MIDA internship component. Daniel Sam, the Field Manager of IOM in Ghana indicated that as part of the internship component, 12 local health professionals were on internship placement in various hospitals in the Netherlands, Germany and the UK (Sam, 2012) (*See Figure 3 above*). Some of the interns who have already gone through the internship were back to serve their hospitals in critical areas where skills are lacking (IOM Report, 2012). One beneficiary of the internship in “intensive care services” at the Northwick Park hospital in the UK said that “*for a long time Ghana did not have any formal Intensive Care Units [ITU’s] in its hospitals, and even now there are only three formal*

*ITU's – which have limited resources.*” “*I think this is the best way to build a strong national work force of clinicians,*” she noted (IOM Report 2012, 23). Asabir also indicate that the internships have created opportunities for further collaboration between the local health institutions and their respective counterparts in Europe (Asabir, 2013).

### **3.3.4 Improved Logistics and Other Health Services**

The Health Worker Migration Policy Council<sup>7</sup> in May 2012 selected Ghana “as winner of the Innovation award” in respect of the MIDA Health Initiative (Sam 2012, 26). The project was generally viewed as one of the creative attempts to promote reverse brain drain in the health sector in Ghana (IOM Report 2012). The volunteers did not only transfer knowledge but also they helped to improve the infrastructure in some of the hospitals. In the Tamale Teaching Hospital, one of the Netherlands based volunteers; Clement Adu Twum had since 2011 managed to set up an Information Technology (IT) infrastructure for the entire teaching hospital in order to enhance patient care. According to him, he realised during his first assignment in 2011 that “*the IT infrastructure in the Tamale Teaching Hospital [in northern Ghana] was fragmented and in poor shape*” and patients waited in queues for several hours to be served. Twum liaised with his employers and co-workers in the Netherlands to mobilise computers and other experts who helped him to set up the IT infrastructure (IOM Report, 2012). As he put it: “*I don't do this alone. I ask my employer in the Netherlands-ROC Mondriaan-to donate computers that were in good working order but no longer used. With assistance from the IT staff at the hospital, I work with two Dutch colleagues and six students day and night to set it all up*” (IOM Report, 2012, 18). The IT infrastructure according to the IOM report has improved upon the patient registration and also the X-ray systems of the hospital. Referring the X-ray system, Twum said: “*before, the*

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<sup>7</sup> It is a “taskforce of high level policy makers from sending and receiving states” as well as experts, established as part of the Health Worker Migration Initiative (HWMI) around 2007 “to review and promote global, regional, and national policy action” towards “more ethical management of global health worker migration” (see <http://www.who.int/workforcealliance/about/taskforces/migration/en/>)

*hospital has to buy expensive special film, but now they can view the X-rays on the computer”* (IOM Report, 2012, 18).

The introduction of new performance and efficiency standards such as “patient theatre verification forms” and other evaluation reports by the returnees which before, were not present in some of the hospitals, has reportedly improved staff and patient satisfaction in such hospitals (IOM Report 2012, 12). The Medical Director of one of the hospitals said: *“The project has improved quality of our patient care, improved the knowledge and skills of our staff and expanded the scope of specialized services in our hospitals to the benefit of our staff and the community at affordable cost”*(IOM Report 2012, 12). Overall, the initiative was seen to have contributed in diverse ways to improving healthcare delivery in the health sector.

## CHAPTER 4: ANALYSES AND POLICY IMPLICATIONS

### 3.1 Brain Gain and Brain Circulation

The theories of “brain gain” and “brain circulation” are based on the presumption that highly skilled labour mobility can positively affect the economic development of sending countries in the long term, through the potential net human capital gains that comes with return migration as well as the supplementary social capital embedded in the transnational social networks created by migrants overseas (Beine et al., 2001; Batista et al., 2007). The ensuing discussion examines these assumptions in light of the evidence on the MIDA Ghana Health Initiative presented in the previous chapter.

#### 4.1.1 *Human Capital Gains through Knowledge and Skills Transfer*

The potential of highly skilled return migrants to act as “agents” of innovation and knowledge-based development in sending states has been well noted within the literature on “brain gain” and “brain circulation” (Saxenian, 2002; 2005; Daugeliene, 2007). For example, commenting on Asian return engineers from the U.S., Saxenian asserts that “*as experienced engineers and managers return home, either temporarily or permanently they bring the [knowledge and skills as well as] worldviews and identities that grow out of their shared professional and educational experiences*” (Saxenian 2002, 2-3).

Statistics indicate that from 2005 to 2012, the MIDA health initiative facilitated the temporary return of (192) highly skilled health professionals with diverse skills and expertise ranging from mental health and psychiatry to ICT and systems management (IOM Report, 2012). Even though this number arguably, might be considered relatively minute compared to the estimates of Ghanaian health professionals living in Europe (Docquier and Marfouk, 2006), the “new growth theory,” emphasises the significant role of the “quality” of human capital and not merely the “quantity” as an essential catalyst for innovation and growth in a knowledge-based society (Romer, 1994).

To a large extent, return migration of the highly skilled can have “positive externalities” on local experts (Straubhaar, 2000) through the possibility of knowledge diffusion, that is, the spread of knowledge, skills, ideas and experiences through formal or informal channels (Ernst and Kim, 2002; Lucas, 2005; Green et al., 2009). Within the period 2005-2012, the returnees reportedly carried out among others complex “*orthopedic surgeries such as complex joint replacements and corrective surgeries*” (IOM Report 2012, 10) and in the process, the local personnel had the chance to understudy them, either formally or informally. As one of the local experts indicated: “*initially hip and knee replacement, cruciate ligament fixation and other orthopedic surgeries were not performed [...] in Ghana and patients had to travel to Europe or to North America and South Africa,*” (IOM Report, 2012, 12). The temporary return has therefore enabled the “circulation” of these much needed human capital to the benefit of the Ghana health sector. This confirms the assertion of Blitz that “*in an increasingly global migration market characterized by temporary movements of skilled labour, professionals may act as knowledge carriers and thus enable intellectual resources to be shared across states, rather than be permanently transferred from one state to another*” (Blitz, 2005, cited in Daugeliene and Marcinkeviciene 2009, 50). The formal or informal on-the-job learning has been noted as an important channel for “knowledge diffusion” (Ernst and Kim, 2002).

In addition to “brain circulation,” the return migration of the diaspora simultaneously facilitated “brain gain.” This is based on the view that, even though the diaspora experts re-emigrated to Europe at the end of their assignments, there still remained in the country human capital “spillovers” which can inure to the benefit of the country for a relatively sustained period, because the local experts who understudied them continue to practice in the country with the new skills at least for some time. The argument concurs with the view of Thanh Le, when he noted that, “international labour movement may help transfer [knowledge and]

technology across borders in both directions: from donor countries to host countries and vice versa” (Le 2008, 618) either temporarily or permanently.

The capacity building workshops for students and local health experts formed another dimension of “brain gain” associated with the return migration project. From 2005-2012, about 30, 000 local personnel and students were reportedly trained in up-to-date clinical methods and practices and 14 local personnel were also placed on internships in various EU countries to develop their knowledge and skills and return (Sam, 2012). In this light, it is important to state that the temporary return was not only an isolated mechanism of “brain circulation,” but also, it involved a concurrent process of knowledge and skills transfer that ensured “brain gain” in the health sector. In effect, provided that the local personnel trained do not themselves emigrate immediately, the effective utilisation of the acquired skills will have a “multiplier effect” as the knowledge will “diffuse” to those who did not participate directly in the workshops (Ernst and Kim, 2002).

The above findings resonate with several studies that have pointed to the instrumental role of highly skilled returnees as active agents of development in sending states (Klagge et al., 2007; Saxenian, 2005). In the early 1980s, returnees from the U.S. were identified as the backbone of venture capital industries in Taiwan and Israel, as they brought along “*technical and operating experience, knowledge of new business models, and networks of contacts in the United States*” (Saxenian 2005, 3). In a comparative study of return migration in India and China, Wiesbrock came to the conclusion that return “*of the highly skilled can benefit all, the sending country, the receiving country and the individual if it is supported by adequate policies and environment*”(Wiesbrock 2008, 31). This assertion resonates with the evidence on the MIDA initiative so far analysed above.

Furthermore, the brain gain and brain circulation literature also emphasises the additional transfer of “worldviews” and professional experiences through return migration of

the highly skilled (Saxenian, 2002). According to Saxenian highly skilled returnees do not only circulate skills and knowledge, but also shared professional values, attitudes and experiences in relation to international best practices (Saxenian, 2002). This has been highlighted in the contribution of the MIDA initiative when some of the diaspora professionals reportedly introduced innovative practices in patient care such as “patient theatre verification forms”, and modern IT infrastructure for their hospitals, which as the reports indicate, have gone a long way to improve patient and staff satisfaction in the respective hospitals (IOM Reports, 2012). The medical director of one hospital said, the initiative “*has improved [the] quality of our patient care, improved the knowledge and skills of our staff and expanded the scope of specialized services*” (IOM Report 2012, 12). These positive professional world views and experiences are attitudinal “spillovers” which represent “positive externalities” of return migration of the highly skilled on local personnel in Ghana. This is an important aspect of human capital transfer which been noted by Saxenian among Taiwanese and Israeli return migrants in the 1980s (2005). The above evidence also concurs with the view of Ammassari, who argued in her study that “elite” returnees in Ghana and Cote d’Ivoire “have a [comparatively] broader frame of reference that is helpful in identifying innovative solutions” to local problems (Ammassari, 2003, 21).

#### **4.1.2 Social Capital through Transnational Migrant Networks**

The “brain gain” and “brain circulation” literature further underscores the significance of the transnational social networks of migrants as important resource that can be mobilised for development (Beine et al., 2001; Lucas, 2005; Batista et al., 2007). In this view, it was interesting to find from the MIDA initiative that, some returnees such as Adu Twum had utilised his networks with his employers in the Netherlands to secure material and human resources, when he mobilised computers and the expertise of six of his co-workers that enabled him to “set up” modern IT infrastructure for the Tamale Teaching Hospital in

northern Ghana (IOM Report, 2012). The findings here appears to confirm the developmental potential of transnational social networks noted quite well by Saxenian, when he observed that Asian engineers who return home from the Silicon Valley in the U.S., “*are transforming developmental opportunities for [their] regions as they build professional and business connections to their home countries*” (Saxenian 2005, abstract).

It was further intriguing to find that, the diaspora experts did not only use their transnational professional connections to secure resources for the local institutions as in the example of Adu Twum, but also, they left at the disposal of the local institutions, durable social and professional connections, which can help facilitate their access to the human capital of other professionals abroad. This assertion is confirmed when a medical officer at the “37 Military Hospital” in Accra said: “*through the participating migrants we are able to get in touch with other experts available through the MIDA Ghana project*” (IOM Report, 2012, 10). The above findings here are in line with Newland’s argument that in an era of “*cheap transportation and communication,*” [...] “*social and economic capital can no longer be segregated analytically,*” [...] and “*transnational networks are today the most important developmental resources associated with international migration*” (Newland, 2003, quoted in Lucas, 2005, 207). Asabir also indicates that the internship component of the initiative has also created networks and opportunities for further collaboration between the respective EU and local health institutions (Asabir, 2003).

In general, the analyses so far suggest that there was substantial and explicit connection between the temporary return of the highly skilled health professionals and a concurrent brain gain and brain circulation in the health sector in Ghana. To a large extent, it corroborates the view of Daugeliene, when he suggested in his conceptual framework (see Figure 1) that temporary migration can facilitate the circulation of the accumulated human

capital of the highly skilled, which he has identified as an essential complementary factor in enhancing the socio-economic growth of countries (Daugeliene, 2007).

## **4.2 Return Migration, the MIDA Ghana Approach**

Return migration has been recognised as a convenient way to break the “vicious cycle” of brain drain (Castles, 2008) by circulating the human capital of highly skilled migrants to the mutual benefit of both sending and receiving states (Straubhaar, 2000). The task here is to examine the MIDA approach to return migration of the highly skilled in light of other national initiatives reviewed in Chapter 3 in order to bring out the strengths and challenges of the former so as to enhance policy learning.

### **4.2.1 Strengths of the MIDA Ghana Approach**

As fashionable as return migration has become in recent efforts to promote brain gain and brain circulation (Wiesbrock, 2008), empirical research suggests that the “*social and economic environment largely conditions the extent to which skills and talent as well as the financial capital [of returnees] are effectively utilized*” (Thomas-Hope 1999, abstract). Around the 1980s and 1990s, studies conducted on return migrants in several south-east Asian countries (for example Philippines (Go, 1986), Kerala (Nair, 1991) Indonesia (Mahmood, 1991) Sri Lanka (Gunatilleke, 1991) and Pakistan (Gilani, 1986) shared the view of Thomas-Hope (1999). The studies generally suggested that the lack of employment opportunities, poor salaries and other conditions of service as well as the absence of an enabling investment environment, are potential barriers to the effective utilisation of the human, social and financial capital of returnees (Go, 1986 and Gunatilleke, 1991, cited Battistella, 2004).

It appears that the above noted challenges are to a large extent characteristic of the “structured” and compulsory return embodied in the temporary migration policies of the south-east Asian countries (Agunias, 2008) which were examined in those studies (Battistella, 2004). In the case of the MIDA project presented in chapter 3, the evidence does not point to

any manifestations of the above challenges. This presumably stems from the need-driven and flexible design of MIDA project, coupled with its underlying logic of “voluntarism” (IOM Report, 2012).

First, due to collaboration among the IOM, diaspora professionals, the host states, and also the relevant Ghanaian institutions, the returnees under the MIDA initiative still keep their jobs, and their residency status was not comprised (IOM Report, 2012). Secondly, the return was preconditioned by the existence of placement opportunities in the local health institutions, thus, circumventing the challenges of “economic reintegration” (Battistella, 2004) which can potentially lead to human capital or “brain wastage” of returnees (Mattoo et al., 2005), due to either unemployment or underemployment (Battistella, 2004).

Moreover, under the project, return is considered a “volunteering service,” where only living allowances were offered (IOM, 2012) and thus, precludes such factors as poor wages, salaries and other conditions of service which normally act as disincentive to return among the highly skilled and therefore inhibit brain gain and brain circulation (Todaro, 1985; Battistella, 2004). Earlier, Todaro has raised reservations about the presumed positive link between return migration and brain gain as well as brain circulation in sending states. He advanced the argument that, the propensity to return among the highly skilled emigrants with greater skill-enhancing jobs overseas are rather low, because for them opportunities for further “advancement may be better overseas” than at home (Todaro 1985, 268, cited in Straubhaar, 1992). Even though the evidence of the MIDA Ghana project does not necessarily dispute this assertion, it does suggest that temporary return constitute an innovative mechanism that has the potential to promote brain gain and brain circulation without recourse, necessarily to permanent return.

## **4.2.2 Challenges of the MIDA Ghana Approach**

On the other hand, despite the strengths of the project, it was not without challenges. First, the evidence reveals that (1) mobilization of the diaspora experts was not easy and the approach also did not create enough room for country “ownership” and (2) financial sustainability was also key challenge (IOM, 2012).

### **4.2.2.1 Country Ownership by the Government of Ghana**

In the first place, the mobilisation of the diaspora health experts was done by the IOM using its own institutional mechanisms, with little recourse to the Ghana government (IOM, 2012). This approach was problematic in the sense that it made the project “donor-driven” with the Ghana government acting only as a passive partner and beneficiary of a donor development initiative. Even though, there is little evidence to suggest that, the approach accounted for the relatively low participation of the diaspora professionals (only 192) on the project over the period 2005-2012 (Sam, 2012), it nevertheless became clear from the reports that the Netherlands embassy had to prevail on the government of Ghana at some point to make a “passionate moral appeal” to the diaspora to participate in the project (IOM Report, 2012). This is similar to the report of De Haas that the lack of commitment on the part government accounted for the poor results on the earlier MIDA Italy project, which was also implemented in Ghana around 2003 (De Haas, 2006b).

Empirical research reviewed in Chapter 3 have shown that in many of the diverse policy initiatives to mobilise the diaspora for development in sending states, the homes states (examples; Taiwan, Mexico, Philippines, China) are the ones which have made persistent efforts through national programmes and institutions to reach out to the diaspora (see Wiesbrock, 2008; Castles and Miller, 2009). This does not only create a sense of “ownership” but it also empowers the domestic institutions and generates a sustained “will” to reach out to the diaspora. This is practically the opposite of the IOM MIDA approach. Indeed, De Renzio et al. shows that country ownership of donor development initiatives is crucial for their

effectiveness and sustainability (Renzio et al. 2008; see also OECD, 2003). It is also argued that ownership “comes through people and their own institutions taking responsibility, learning from experience, and building up the organization and practices needed to sustain progress.”<sup>8</sup> As shown in Figure 2 of Chapter 3, the relevant institutions responsible for migration (ministries of Interior and Foreign Affairs as well as the Ghana Immigration Service) were not part of the design of the initiative. Again, even though the GHS, which directly manages the health institutions was involved, the policy formulating institution itself (Ministry of Health) was only involved later as part of efforts to mobilise the participants (IOM Report, 2012); meanwhile, issues dealing with the diaspora, including those of health professionals is the responsibility of the ministries of Interior and Foreign Affairs in Ghana (Constitution of Ghana, 1992).

#### 4.2.2.2 Funding Sustainability of the of MIDA Initiative

Finally, another limitation related to its financial sustainability, as the project came to an end following the cessation of funding by the Dutch government (IOM Report, 2012). This was not a challenge to project implementation per se since funding was available for the project period budgeted for. However, it is a structural limitation to the continuity of the initiative and others of its kind over a long period. Commenting on the planning and sustainability of community health programmes in the United States and elsewhere, Shediak-Rizkallah and Bone observe that “*considerable resources are spent implementing community-based health programs that are discontinued soon after initial funding ends*” (Shediak-Rizkallah and Bone, 1998, 87). Glaser however argues that: “*not all innovations should last or endure for long periods of time.*” He notes that “*when a validated, more efficacious, more suitable or more cost-effective means for meeting a given problem comes to light, the former modus operandi [...] may be supplanted. Or the problem the given innovation was designed to*

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<sup>8</sup> Source: Policy Brief No. 4: Evaluation of the Paris Declaration. Country ownership of development: Political correctness or a practical key to better aid?  
(see [http://www.cso-effectiveness.org/IMG/pdf/pde\\_policy\\_brief\\_no\\_4.pdf](http://www.cso-effectiveness.org/IMG/pdf/pde_policy_brief_no_4.pdf))

*address may have changed or disappeared*” (Glaser, 1981, quoted in Shediak-Rizkallah and Bone, 1998, 88).

While the observation of Shediak-Rizkallah and Bone (2008) confirms the reality on the MIDA project; on the contrary, the evidence on the project does not support the view expressed by Glaser (1981). The shortage of personnel in the health sector is still a major challenge to healthcare delivery (IOM, 2011). On the flipside, the reports on the project also suggest significant levels of stakeholder satisfaction about its effectiveness, including a promise by the Dutch government to secure further funding to revamp the initiative (IOM Report, 2012). The project also won the “Innovation Award” for 2012 from the Health Worker Migration Policy Council. And according to Sam, in light of the projects contribution; the government of Ghana has now incorporated the role of the diaspora in to its Human Resources for Health Strategic Plan for 2011 to 2017 (Sam, 2012). In this regard, the regard, the reasons for the discontinuity of the project appears not to corroborate Glaser’s assertion (1981, cited in Shediak-Rizkallah and Bone, 2008). Instead, the challenge of funding remains a structural limitation, which needs to be tackled holistically within subsequent designs of the initiative.

#### **4.3 Policy Implications of the MIDA Ghana Health Initiative**

The analysis in this chapter has revealed relevant issues, which have implications for similar policy initiatives on temporary return migration. Generally, the assessment of the initiative’s impacts indicates that well managed temporary return migration of the highly skilled can promote a positive link between migration and economic development in sending states. However, it has also become evident that the successful implementation of temporary migration initiatives, which entails frequent mobility between sending and host countries will require much closer collaboration between the former and the latter, as well as other relevant institutions and agencies, including the diaspora themselves. In the case of the Ghana health

sector, the analysis suggest that linking return migration with human capital transfer calls for a multi-sectoral approach not only involving the Ministry of Health (MOH) and the Ghana Health Service (GHS) but also, the Ministries of Education, Interior, Foreign Affairs and the Ghana Immigration Service.

Again, while national level initiatives to mobilise the diaspora for development (example in the Philippines, Mexico, Taiwan and China etc.) are different from the MIDA Ghana approach, the two approaches can be mutually reinforcing. In this view, it is suggested that a complimentary policy approach involving the two, will have the potential to generate country ownership and commitment. In other words, the MIDA can be redesigned within the framework of existing national development or diaspora initiatives; or with recourse to the sending states' national institutions as the main implementers, whereas the IOM will only function as a facilitator. Such an approach will empower local institutions to manage such initiatives and subsequently encourage governments to also incorporate them in to their national development frameworks to ensure sustainability.

In addition, the design of the initiative also suggest that a need-based policy approach to return of the highly skilled can help address the many challenges associated with economic reintegration into the domestic economy, and thereby maximise the utilisation of the accumulated human capital of returnees. However, the MIDA example further implies that such an approach needs to be sector-specific so as to facilitate effective human resource needs assessment and to match that with the skills available in the diaspora. Hence, such initiatives will normally be small-scale in design and implementation.

Finally, funding remains a structural limitation to the long term continuity of donor initiated return migration initiatives in the nature the MIDA Ghana Health Initiative. In this regard, a more collaborative and holistic funding arrangement is needed and this should take in to consideration the role of sending and receiving states as well as other private actors.

## CONCLUSION

The purpose of the study was to examine the link between return migration of the highly skilled and brain gain as well as brain circulation in the healthcare sector in Ghana. The temporary return of highly skilled health professionals under the MIDA Ghana Health Initiative constituted the case study. The research sought to find out the impact of the initiative and also identify its implications for similar policy interventions on return migration. The paper started with the assumption that the initiative had a significant contribution to the healthcare sector in terms of brain gain and brain circulation. It further contended that the approach of the Initiative can offer important policy lessons for the design and implementation of similar of its kind on return migration.

In the end, the study found adequate evidence in support of the argument that the initiative made a substantial impact by promoting brain gain and brain circulation in the healthcare sector. The findings showed that, the highly skilled returnees contributed to human capital development through knowledge and skills transfer, while some local personnel also benefited from further human capital development through internships in Europe. In addition, some brought innovations that have improved upon healthcare delivery, whereas others also utilised their international networks to mobilise resources and infrastructure for the local health institutions.

In terms of policy implications, the study suggested that there should be further collaboration between sending and receiving states, more ownership of policy initiatives by the sending states, and a multi-sectoral approach to managing return. It is believed that this can improve upon sustainability and impact. It was further recommended that a complimentary policy approach which incorporates subsequent MIDA diaspora development initiatives into home-grown ones or national level development frameworks can enhance ownership, impact, and sustainability. A shared and collaborative funding arrangement should

also be considered holistically within the design and implementation of subsequent MIDA policy initiatives on return migration in order to guarantee financial sustainability.

Finally, it is important to state that the findings of this study has generally reinforced wider arguments that encouraging return migration of the highly skilled has the potential to positively affect the economic development of sending states through the avenue of brain gain and brain circulation. In this regard, the study has made a significant contribution to the ongoing academic and policy debate on the nexus between highly skilled labour mobility and the economic development of sending states.

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