RETENTION AND MIGRATION OF HEALTH PERSONNEL IN SOUTHERN AFRICA

REPORT OF REGIONAL PLANNING MEETING
3 April 2006
Lusaka, Zambia

Regional network for Equity in Health (EQUINET)

convened by
Training and Research Support Centre (TARSC), Health Systems Trust (HST) and University of Namibia (UNAM)

In co-operation with SIDA (Sweden)
and the Regional Health Community Secretariat in East, Central and Southern African (ECSA)

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1. Introduction

The Regional Network for Equity in Health in East and Southern Africa (EQUINET) is dedicated to influencing and supporting national and regional policies and practices of the countries of east and southern Africa to promote equity in health. In line with the 2006 ECSA Ministers resolutions, EQUINET, ECSA and national partners, with support from SIDA, are keen to further develop the programme of work on various aspects of HRH production, retention and migration, and the research, monitoring and evaluation that can support national work and exchange of good practice.   A meeting was therefore held on 3 April 2006 to have a dialogue with country personnel, EQUINET, ECSA and technical institutions to further plan the implementation of this work, building on what has been done to date. This was a small working meeting to further discuss and plan this work, and link it more closely to support of national monitoring and evaluation of the implementation of HRH plans.

The proposed regional programme of work aims to support research, capacity and programme support for retention of health personnel and for policy responses to the out-migration of health personnel. This work aims at supporting, organising knowledge and capabilities for and advocating measures to secure, retain and fairly treat the health personnel needed to deliver national health systems. The theme co-ordination for this work in 2004/5 has been Health Systems Trust, an independent non-government organisation established in 1992 to support the transformation of the South African health system. In 2006 the University of Namibia will join in theme co-ordination of this work. The EQUINET secretariat at Training and Research Support Centre (TARSC) provides co-ordinating support including for its cross links with other areas of EQUINET work (HIV/AIDS, financing, trade etc). EQUINET is co-operating with the East, Central and Southern African (ECSA) Health Community in this programme of work.

The Objectives of the meeting were to :
° Briefly review available evidence, current programmes and priority areas for future work to support retention and manage migration of HRH from national and regional level
° Plan a regional programme of work to support national HRH planning, monitoring and evaluation in selected countries in east and southern Africa
° Discuss and agree on institutional mechanisms for guidance and review of the follow up work programme

While there are numerous areas of policy relevance on HRH, given the time limitation the meeting focused on financial and non financial incentives for retention of HRH to outline a programme of work to gather, synthesise and review knowledge on **incentives for retention of health personnel,** particularly non financial incentives; monitor and assess policy and programme support for implementation of such incentives for their impact on HRH and support policy dialogue and programme management on retention of health personnel. An exploratory discussion was also held to map priority areas of work to gather, analyse and review evidence on costs and benefits of **HRH migration** out of east and southern Africa, and to assess and support policy measures aimed at managing HRH migration   (See Agenda appendix 2)

The meeting was convened by EQUINET in consultation with ECSA, and hosted and supported by SIDA (Sweden) at the SIDA Boardroom. The report has been prepared by TARSC.
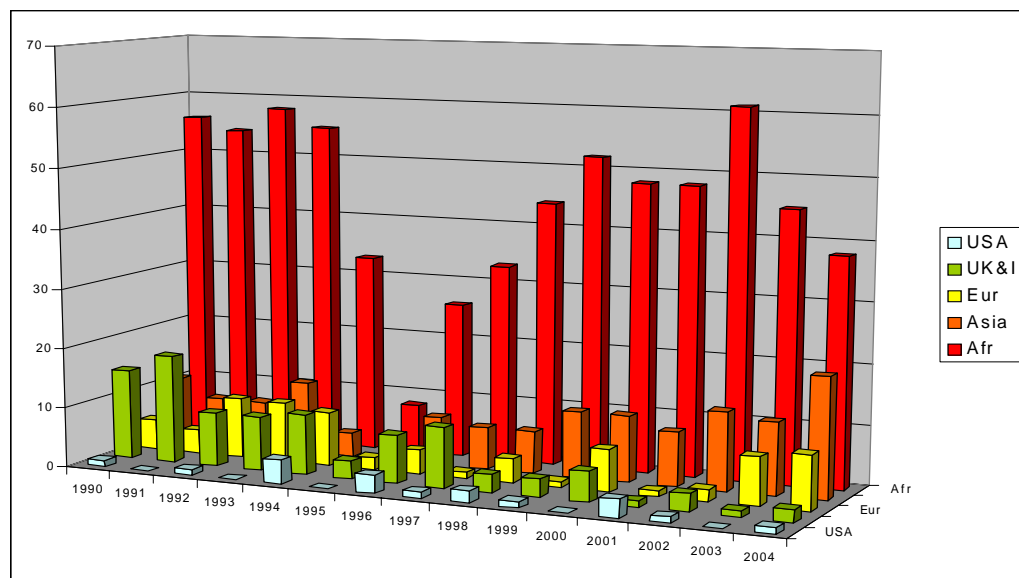
1.1. Welcome and background to the meeting

Par Eriksson (SIDA) welcomed delegates and introduced the sequence of meetings over the next three days. Delegates introduced themselves and their work on HRH (See Delegate list Appendix 1).

Rene Loewenson (EQUINET/TARSC) indicated that while equity concerns on HRH have in the past focused on the mix and internal distribution of HRH to support primary health care systems, there are new challenges emerging in the 1990s and 2000s with the outflow of health personnel from countries with high health need to countries with lower health need (See for example Figure 1).   While there are numerous areas of importance to deal with on HRH, work and dialogue using an 'equity lens' has led to identification of four major areas of focus in EQUINET, ie.

- Relevant production of HRH – mix, selection, training investments, deployment
- Retention of HRH - Financial and non financial incentives and the systems and capacities for implementing them
- Redress for perverse subsidies related to migration of HRH
- Leadership for action on HRH across sectors (See consensus statetement Appendix 3).

Figure 1: Foreign-trained physicians registered annually in Manitoba, Canada 1990-2004, by region of qualification

A review commissioned by EQUINET/HST of regional HRH policy and programmes carried out by Gilson et al (20055) indicated that while there was renewed urgency regarding HR policy, including on retention (See Table 2), policy implementation was still variable, with a lack of shared information about the policy alternatives and how to advance implementation. Hence while the policy attention has increased (See Table 2) implementation, monitoring and evaluation of specific measures to address problems has been less advanced.

Table 2: Regional initiatives

Year	Migration	Retention	Processes
2005		Fourth Ordinary Session of AU, Abuja	Call for African Centres of Excellence & Knowledge
	SADC protocol WHA resolution		
2004	MIDSA migration and health workshop	ECSA conference	
	WHA resolution		
2003	Commonwealth ethical recruitment code		
	NEPAD health strategy		
2002	WHO regional committee for Africa AU heads of state meting, Durban WHO/World Bank consultative meeting, Addis Ababa		Call for task force on HRH development in Africa
2001			
2000	MIDSA established		
1999			
1998		WHO AFRO regional HRH development strategy	Call for national advisory committees, creation of expert advisory group at regional level

This review indicated that retention is acknowledged as a key policy concern across the region, with a need for country-led policy options for non financial incentives, presented as policy packages not prescriptions, and with policy support for the institutional, financing, human resource management, monitoring and operations research to facilitate implementation. The 2006 Regional Health Ministers resolutions (See Box 1) further indicated policy concern around these areas. EQUINET is carrying out a joint programme of work with ECSA in follow up to these resolutions.

BOX 1: East, Central and Southern African Health Community 42nd Regional Health Minister's Conference 6-11 February 2006 Resolutions on HRH

The 42nd Regional Health Ministers conference urges member states to:
1. Develop national systems of continuing professional development that promote on-the- job and team-based training
2. Develop a system for tracking continuing professional development.
3. Develop and strengthen innovative mechanisms for staff recruitment based on norms that are regularly reviewed.
4. Adopt a common position on compensation for health workers recruited by developed countries.
5. Adopt a common position on ethical recruitment of health workers.
6. Develop financial and non-financial strategies to encourage retention of health professionals.

The 42nd Regional Health Ministers conference urges the secretariat to:
1. Facilitate harmonization of curricula for training health professionals.
2. Promote the establishment of centers of excellence for training of health professionals in the region.
3. Support member countries in conducting appropriate research on human resource for health e.g. in retention, effects of out-migration, work-load studies and promote evidenced based best practices.
4. Facilitate the development of human resource information systems in member states.
5. Develop guidelines for ethical recruitment and compensation for health workers.

This planning meeting was set up, taking advantage of HRH meetings being held in Zambia in April around world Health Day (April 7), to review country priorities and plan the programme of work on retention and migration. She outlined the objectives of the meeting (see earlier). The programme for the meeting, shown in *Appendix 2,* . would first focus on retention, and then on migration.

2. Retention of health personnel

2.1. Regional evidence and perspectives

Scholastika Iiipinge, University of Namibia indicated that there was now a need for research to build a stronger evidence on HRH, to focus efforts, support policy dialogue and shape strategies. This includes costing of policy proposals and setting up systems for monitoring and evaluating trends While this calls for technical expertise, it also calls for sharing of promising practices and knowledge among stakeholders including civil society groups and activities to support policy negotiation.

Incentives for retention of HRH, including both financial and non-financial incentives have both used as measures to support retention. She cited the example of research in Namibia that highlighted for health personnel the reasons they gave for leaving/ staying, ie the push- pull factors for retention. The findings are shown in Box 2 below:

BOX 2: Push-pull factors for retention in Namibia
Reasons for leaving
•Financial issues e.g. pension, salaries
•Non financial issues eg. Staff devt, career paths, staff appraisal, education, recognition
•Occupation & safe work
•Macro-environment e.g. infrastructure, supplies, communication
Reasons for staying
•Fringe and social benefits, salary
•Career path
•Job security and fear of unknown
•Loyalty, patriotism
S. Iipinge, L. van der Westhuizen, K. Hofnie: University of Namibia, M. Pendukeni: MoHSS 2005

Various retention strategies have been used in ESA. Financial incentives have included:
- Selected salary top ups eg Malawi
- Substantive salary increases – eg Kenya
- Differential salary levels for health vs other civil servants eg Tanzania
- Skills and rural allowances, bonuses – eg SA
- Allowing dual/ private practice – eg SA, Zimbabwe, Tanzania
- Assistance with school fees, medical costs, housing allowances – eg Malawi, Zimbabwe

Non financial incentives have included:
- Improved work environments, occupational safety, HIV policies
- Modernisation of facilities and improved job satisfaction
- Team work, participatory decision making, rewards systems – eg Tanzania
- Performance appraisal systems – eg Tanzania, SA
- Assistance with housing, schooling, vehicles, day care facilities– eg Zimbabwe, Malawi
- Career paths and recognition;

- Training opportunities: CME, study leave, postgraduate education for public sector workers eg Zimbabwe, Malawi

She identified potential areas for follow up work on incentives:
- Mapping and sharing of evidence on current incentives for retention of HRH
- Monitor performance, impacts of non financial incentives on retention and distribution
- Assess relative costs and benefits of financial and non financial incentives
- Assess policy and systems barriers and capacities for implementing incentives
- Specific deeper operations research, eg: workloads studies; absenteeism; working environments etc

She raised for delegate discussion questions on the priority areas of policy focus on incentives for retention to give focus for gathering and review of knowledge on incentives for retention. She also drew attention to identifying monitoring and evaluation tools to assess and support implementation, to gather and analyse evidence for policy dialogue and programme management.

Several countries then presented evidence on their HRH plans, with a specific focus on retention and on monitoring of retention strategies.

2.2. Country evidence: Namibia

Monika Pendukeni, Ministry of Health Namibia outlined the profile of Namibia. The disease burden indicates demands on the health system from both communicable and non communicable diseases. Currently, Namibia is experiencing a shortage of skilled staff with vacancy rates of different categories of personnel as below:
- 36% medical doctors
- 26% RN
- 53% EN
- 54% pharmacists
- 40% social workers
- 32% radiographers

Staff attrition is mainly due to resignation (59%) promotions and transfers (21%); retirement (7.4%) and death (10.3%). Resignations in 2002 – 2004 were primarily amongst registered nurses (191 of which 15 migrated to UK + 2 Canada); enrolled nurses : (81); doctors (33) and social workers (19). Namibia lacks a pool of prospective students to study health related courses due constraints in teaching science subjects. There is no national Medical School and no adequate finance to assist students. Added to this there is a lengthy process of recruiting expatriates.

In response, the Ministry of Health has put in place policies on social benefits; on training and to bind workers after training. The Ministry has established workloads to determine staffing norms. Retention is reinforced by awarding certificates of appreciation, giving staff access to pension funds and the setting up of an Employee Assistance Program to respond to staff needs. These programmes are monitored through monthly monitoring of staff movement and production of a bi-annual training report.
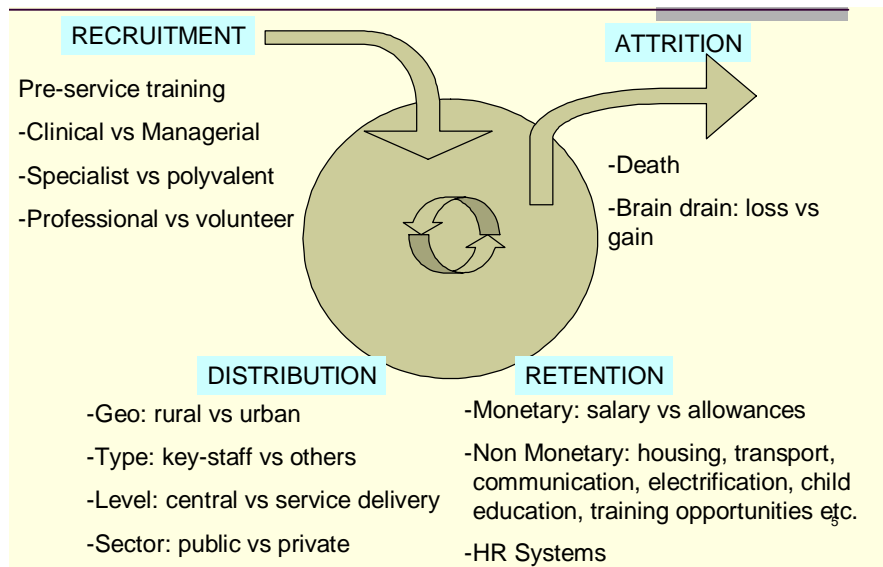
2.3. Country evidence: Zambia

Jere Mwila Chief Human resources Management Officer in Ministry of Health Zambia outlined the current HR crisis in Zambia and the solutions that have been implemented by the Ministry of Health, leading to the National HRH Strategic Plan (2006-2010). The current HR crisis was brought into focus by the Mid-Term Review Report of the National Health Strategic Plan (2001-2005) in 2004, which stated:

> *"On the human resource front, the stage is now close to being a disaster. Warning signs have been present for some years, and even the casual observer at the local level can immediately see the gravity of what is happening…..Health care is a labour intensive industry and cannot be delivered only through action plans, physical facilities or supplies. Without addressing this issue, we fear that most if not all of the essential indicators can be expected to deteriorate, to a point where the public health sector would be in danger of collapse."*

The outlined the various aspects of the Crisis (See Figure 2).

Figure 2: The face of the HRH crisis in Zambia

There are numerous signs of the severe shortage of HRH:
- many health facilities are understaffed.
- numerous rural health centres have no professional staff at all,
- 50% of rural health centres have only one qualified staff member[1].
- Service delivery in hospitals is also affected, with many Level 3 hospitals understaffed and dozens of patients being attended to by one nurse.
- Limitation of recruitment due to public expenditure ceilings

[1] Koot, J. and Martineau, T. (2005). Mid Term Review: Zambian Health Workers Retention Scheme (ZHWRS) 2003–2004. Final Report.

As a response, the Ministry of Health has implemented the following responses:
- Local District Initiatives
- Zambia Health Workers Retention scheme
- The National HRH Strategic Plan (2006-2010)

Local District Initiatives have provided top up allowances for staff in remote areas, solar panels, radio communication facilities, rental subsides for urban workers and support for transport.

The Zambian Health Worker Retention Scheme (ZHWRS) provides a contract of 3 years with district authorities with support for basic professional conditions (theatre, X-ray dept, laboratory etc.); a housing plan eligible for max. one-off €2.500,- subsidy; a monthly hardship allowance depending on remoteness of district: D (€250,-/mth) or C (€200,-/mth); education for up to 4 children paid on full cost recovery basis and access to a loan of up to 90% of the value of the 3 year contract (€6.480-€8.100) towards the purchase of vehicle or house mortgage; Also provided is an end-of-contract incentive of €1.800-€2.250. Personnel in this scheme are given priority treatment towards selection for post-graduate training. These benefits are dependent on satisfactory performance assessment. This has been approved as an official pilot within the Public Service Reform Programme (PSRP) by Cabinet Office and the Co-operating partners with Harmonisation in Practice (HIP) initiative. The scheme has contracted 66 doctors for rural areas, mainly redistributing doctors from tertiary hospitals to rural hospitals. Doctors are reported to be more enthusiastic about their work. Some challenges are noted: Preparation needs more attention, and administration and performance management also need to be improved.

Other Initiatives are being explored, including
■ Sponsored and bonded health workers
■ Recruitment of Clinical care experts at the Province
■ Construction of Staff Housing
■ training of nurse tutors, curricula review and general strengthening of training institutions

A National HRH Strategic Plan (2006-2010) now consolidates these and other areas of HRH planning. The overall aim is:
    "To ensure an adequate and equitable distribution of appropriately skilled and motivated health workers providing quality services"
It is guided by principles of tackling root causes rather than symptoms, being evidence based, providing for moderated radicalism, sustainability and institutional learning and supporting integrated HR approaches.

The plan aims to provide an effective ongoing and coordinated approach to planning across the sector, ensuring that human resource planning is coordinated across the health sector and is based on the best available data. It now needs to develop monitoring and evaluation systems to track progress of the implementation of the HR plan, make adjustments/modifications and inform further development of the plan.

The plan primarily covers strategies for increased training output by
- expanding the number of training places available
- increasing the number of applicants for training by widening participation
- strengthening in-service training system
- increasing numbers of skilled health workers in post
- improving the deployment and retention of health workers, and
- improving the productivity and performance of health workers

The plan seeks to strengthen human resource planning, management and development systems through improved performance management capacity and tools; improved occupational health and work place policies and a monitoring and evaluation system with national oversight by a high level HR Steering Committee, a Health Sector Advisory

Group (SAG) producing a monitoring report for the annual SAG meeting. At the provincial level monitoring will be integrated in the performance assessment and quarterly reports submitted to the Ministry HQ for review.

2.4. Country evidence: Malawi

Edwin Woche, Malawi outlined the general HRH situation in Malawi. (See Table 3 below)

Table 3 HRH data Malawi

Total population	12,000,000
Total Workforce	Approx. 16,000
Total no. of nurses in public hospitals	2,000
Total number of doctors in public hospitals	100
National doctor/population ratio	<1:100,000 residents
National nurse/population ratio	1.6 nurses per 1,000 residents

Malawi's main challenge is to develop, deploy and retain an adequate, well-trained and motivated workers to meet the health needs of the Malawian population within the available budget, provided through a regulated mix of public, NGO and private organizations. Specifically this means
- **Increasing the numbers of trained health workers in the sector, by**
  - Developing and introducing pre-entry/foundation programmes (ongoing pre-med programmes)
  - Reviewing entry requirements for health training programmes
  - Promoting health service careers
- **Expanding the supply of students entering health training institutions, by**
  - Developing and introducing pre-entry/foundation programmes (ongoing pre-med programmes)
  - Reviewing entry requirements for health training programmes
  - Promoting health service careers
- **Increasing training output in line with projections and targets, by**
  - Ensuring all training institutions are operating at 100% capacity
  - Improving existing tutor/student ratios in line with national standards
  - Increasing the supply of highly skilled community based HSAs to scale up ART/HIV/AIDS and EHP services
  - Expanding capacity of HTI s
- **Increasing the number of skilled and competent health workers in post, by**
  - Streamlining recruitment procedures at all levels
  - Developing appropriate strategies to attract health workers (especially graduates, retiring, retirees and unemployed)
  - Supporting Health Service Commission (HSC) in recruitment
  - Developing and monitoring contractual procedures/arrangements for the recruitment of international health workers and retiring and retired health workers
- **Improving retention of essential health workers, by**
  - Maintaining salary tops-ups and other incentives for essential cadres
  - Improving retention packages for Health Surveillance Assistants

- o Exploring the development of comprehensive, differentiated and targeted retention packages & schemes for essential cadres in remote and underserved areas
  - o Supporting districts to manage and monitor retention schemes
- **Improving productivity and performance of health workers, by**
  - o Improving health workers understanding of basic roles and responsibilities and accountabilities
  - o Designing systems for managing staff absence
  - o Updating and developing job descriptions, job plans and personal development plans for all health workers (the basis for career structures/pathways)
  - o Undertaking rapid assessment of performance management systems at all levels (contract officers, central hospital staff and other health workers)
  - o Developing capacity of heads of departments, Zone Office managers, members of District Assemblies, DHOs and other line managers to lead and implement improved performance management systems and processes and effectively utilise information to improve health worker and facility performance and productivity

These strategies are supported by **strengthened HRH policy and systems across the health sector,** through
- An HRH Strategic Framework & Plan, encompassing all HRH related plans and interventions in the private and public sectors
- Review of existing recruitment & deployment policies, strategies and practices
- A national recruitment & deployment policy and plan
- Review of the human resource for health function at all levels across the health sector (HRM/D Section, MoH Directorates, DHRM/D, regulatory bodies, HSC, Treasury, etc.) Strengthened information systems at all levels to adequately inform HRH policy, planning and practice, and
- Regular analysis and utilisation of data to inform HRH policy, strategic and operational decision making

To date the strategies have produced various outcomes across recruitment, retention and training. Top-up salaries have slowed the exodus of nurses, and are also helping attract back staff on month-to-month contracts as well as attracting new recruits. Despite the increase in overall staff numbers, losses from Ministry of Health (reflected in deletions from the payroll) are however still high (491 in 2005) and undermine efforts to improve staffing. Nearly 45% of these losses are due to death and a further 22% are due to resignation. The 52% top-ups have proved insufficient to retain highly skilled staff, who can command higher salaries outside of government service. They have not yet slowed the emigration of Registered Nurses, although it is still early for this effect to be noted as many nurses leaving will have made plans to leave before the implementation of the plan. Of 378 staff who are recorded to have left for other countries 317 were reported to have gone to the UK. The Nurses and Midwives Council suggests that many emigrating nurses might have initiated the process prior to implementation of the top-up, so it is too early to tell whether top-ups will reduce nurse migration over time.

A two-year recruitment plan has identified 1659 priority vacancies for 2005/06 and 2347 for 2006/07. Over 570 staff were externally recruited between July and December 2005 and recruitment of nearly 600 further staff has been approved. Over 1000 staff were internally promoted in 2005. Special arrangements have also been made to re-engage up to 120 nurses and 80 clinical officers on special three-year fixed term contracts at government rates (including the 52% top-up) coupled with an end-of-contract gratuity to cover a pension equivalence. Strong progress is being made on recruiting expatriate

staff: by end-April 2006, UNV and VSO will have fielded 51 doctors and 15 nurse tutors in Malawi, in addition to 15 CIM doctors, three of whom are co-funded under the Emergency Human Resources Programme.

Expansion of training capacity is progressing in line with targets. All schools have increased their student intakes in line with programme targets and in anticipation of infrastructural expansion (See Table 4)

Table 4: Student enrollment, 2004/2005 academic year

Training Institution	April 2004	Dec 2005	Target: April 2006
College of Medicine	175	242	195 (exceeded)
College of Nursing	280	384	316 (exceeded)
College of Health Sciences	1050	1073	1090 (on track)
Nursing School	880	970	895 (exceeded)

Approximately 30% of all MoH health centres are in rural areas most of which have no staff. Staff working in rural areas have highlighted the need to improve transport and communications, and provide electricity and pumped water to staff housing as well as improving maintenance. Staff feel isolated and unappreciated and felt they should be rewarded for the long hours. Preparations for construction and upgrading of staff housing have begun. National needs have been assessed and are being prioritised. More detailed costing and agreement on phasing of the work will follow. The contract for architectural work is being drawn up and will be tendered shortly.

The shortage of HR planning personnel implies a lack of counterparts and raises concerns that capacity can not be built or sustained despite the recruitment of three Technical Assistants. More robust monitoring of EHRP is urgently needed, to help Ministry determine which parts of the programme are working and where adjustments are needed.

2.5. Discussion

Several issues were raised in relation to retention during the discussion (facilitated by R Loewenson):
- There is a need to differentiate between factors that impede or enable attraction of people into employment after training vs those that retain them once in employment. Many people trained as health workers do not proceed to employment after training and barriers such as caps on employment and other conditions may need to be addressed. Further collection of evidence should focus on those practicising as health workers but also potential health workers in country but not practising as health workers.
- The high proportion of HRH losses from death reported (10%+) implies a specific focus on the barriers to health workers seeking treatment for AIDS as ARVs become more accessible. The health of the health workforce is an issue in retaining staff, and access to ARVs can be an incentive for retention if these barriers are overcome.
- Decisions on incentives imply choices and there is need to provide evidence to support choices and decision making, both in judging trade offs and in managing

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expectations of health workers. Evidence would need to support strategic planning, decisions on the priorities for who to retain, and negotiations with global health initiatives and dialogue between private and public sectors on HRH. In this there is need for systems that are flexible, that are able to present a different mix of incentives for different categories of personnel, or even for different geographical districts, able to review evidence and changing contexts and review policy measures with short lag times.

- The relative effectiveness and sustainability of financial incentives like top ups vs non financial incentives is still unclear.
- Beyond the specific HRH incentives for retention, there is need to exchange experience and build an evidence base on the systems needed to manage change in HRH policies and practices.
- The legal and financing frameworks that support retention measures are also important to explore. For example on bonding, financing approaches for training may send conflicting signals while legal measures may be difficult to enforce in a liberalised environment.
- Incentives have often been applied to specific categories of scarce professionals, professionals deployed to remote areas etc. The issue of incentives for the management of HRH at district and national level has been less well addressed. In some cases this has led to high attrition and turnover in these categories weakening the national response and the effective interaction with external technical assistance.
- It is important for retention policies to cover all health cares and not only the most skilled, even if the specific measures differ across different categories. The role of Community health workers has still been poorly explored in terms of their impact on the overall HRH mix and the conditions for health workers. Further the role of communities in supporting non financial incentives such as building housing for health workers needs to be further explored.
- A number of monitoring and evaluation tools were highlighted, including routine HRH reports (eg monthly movements, turnover, absence etc); assessments against performance benchmarks; tracer studies, exit interviews; cross section questionnaire surveys, district sentinel site surveillance and qualitative research.
- Many areas of policy impact lie outside the direct control of the health sector, such as historical decisions to sell public housing stock or public employment thresholds.

It was noted that these issues would be integrated into the afternoon discussion of the countries to identify a more focused follow up programme of work on retention. It was also noted that all countries presenting have a formal mechanism (HRH working group) for strategic planning for the national HRH response and that this mechanisms, complemented in some case by involvement of key national HRH stakeholders not yet involved, would be a focal point for entry for further work.

3. Migration of health workers

3.1. Regional evidence and perspectives
Antoinette Ntuli HST explained that migration of health workers results in a perverse subsidy by poor countries and poor patients to rich countries and rich patients. For example, UNCTAD estimates that the US saved US$3.86 billion by importing 21 000 Nigerian doctors. She cited further statistics on migration, viz:
- The external debt of the USA is at least $2.2 trillion – almost the same as the $2.5 trillion owed by the entire developing world (Jubilee Research)

- Every American citizen owes the rest of the world $7,333 while every citizen of all the developing countries only owes the rest of the world $500
- More African Scientists and Engineers are working in US than in whole of Africa
- In the next three years, Germany, Japan, USA and Ireland are recruiting 255 000 IT specialists from the south. In SA departure of 200 to 300 IT specialists annually cited as the most common cause of skill shortage

There is a reverse subsidy from the developing world of $500m per annum for health personnel alone. Southern Africa spends $60 000 per professional trained; US saves $184 000 per professional recruited.
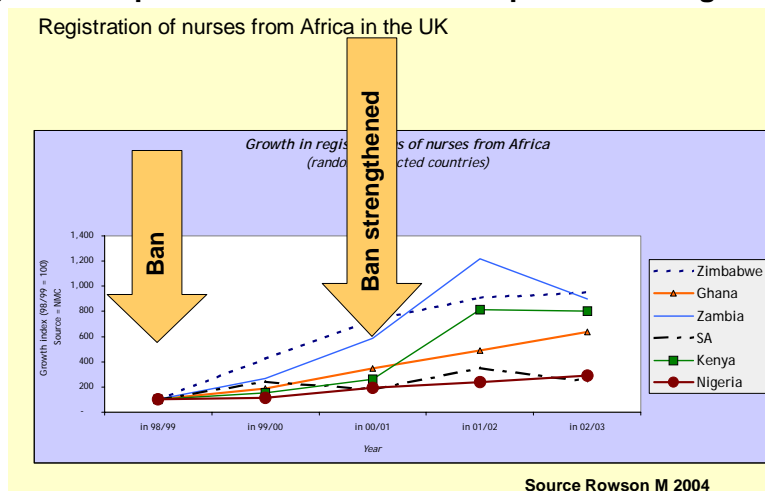
The increasingly porous nature of country borders requires recognition; coercive measures to stay are generally ineffective and appear to intensify pressure to leave. Therefore, there is a need to develop and implement policies which would tackle ethical recruitment, reverse flows and bring about reparation/ restitution.

Migration can in part be traced to the pull factor of flawed developed country staff forecasting of needs. The USA has a projected 1m nurse shortfall by 2012 and 25% of UK nurses will be over 60 years of age by 2010 (Martineau et al 2002) . Ths undertraining has been referred to as a deliberate strategy to acquire "cheap labour", excerbated by active recipient country or institution recruitment. In source countries push factors are poverty, unemployment, quality of life and crime; lack of business and economic opportunities; war, civil conflict and political repression; lack of education opportunities for children and migration of larger groups or communities.

Migration brings benefits to migrants through Income and employment returns to households through remittances, personal and child security, improved work environments and improved career paths. It does however also bring various negative effects. Those documented include negative effects on the overall functioning of health systems; loss of institutional memory and experience; unmanaged disease burdens; costs to households of seeking care at higher levels; costs to families and communities of lost members and skills and social costs to migrants themselves.

Various policy options have been tried. Ethical recruitment codes have been applied, Formal measures have included Codes of conduct on International Recruitment (UK); immigration restrictions in receiving countries including temporary work permits; restricting use of expatriate technical co-operation and thev Commonwealth Code of Practice for international recruitment of health workers – intended to balance needs of both source and recipient countries. .As shown in Figure 4 have not always been found to be effective.

Figure 4: Impact of ethical recruitment policies in England

Registration of nurses from Africa in the UK

Source Rowson M 2004

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Policies have also promoted permanent and temporary return of skilled labour (UNDP/IOM); North-South twinning programmes; recruitment of volunteers from the North and programmes to channel remittances to public domain/development. Attention has also been given to forms of reparation or compensation, including multi and bi-lateral agreements for funding HRH – training, financial and non financial incentives. Research in Canada indicated that policies for bilateral aid to support training were more widely supported by Canadian stakeholders than reparation or compensation policies.

There is increasing consensus that migration and the shortage of HRH that results is a human rights issue and a perverse subsidy from rich to poor countries and users of health care systems. The Increasingly porous nature of country boundaries - requires an international response, and there is growing acceptance that coercive measures to prevent migration are ineffective and can intensify pressure to leave.

There are however gaps in knowledge relevant to policy negotiation, on:
- Details of flows within countries: Levels of care; Professional cadres; Duration of stay; Dual employment and flows from public to private (for profit or non-profit)
- Return intentions
- Effectiveness of current policies: codes and bilateral and multilateral agreements.
- A Cost- benefit analysis of Migration, in terms of financial and non financial costs.

Financial costs and benefits include
- current and future training
- income to households, institutions and sectors, including out of pocket expenditure
- effect on utilisation of existing resources
- impact on national fiscus and country development arising from lost incomes
- trade in HRH
- remittances in and capital flight out

Non-financial costs and benefits include:
- Higher levels of disease burden
- Impact on health system and HRH, including morale and workloads for remaining staff
- Impact on institutional memory, capacities and on the education system
- Impact on families and households in source countries
- Impact on migrants and families

3.2. Discussion

The discussion on migration was facilitated by Helen Lugina (ECSA). Participants raised a number of issues:
- It may be better to frame policy responses as *managing* rather than *stopping* migration. The experience in southern Africa where movement is accepted and managed is instructive. This may call for some form of quotas for movements. It was noted that managed migration of nurses is also taking place between Kenya and Namibia, although the extent to which this is affecting posts in Kenya, the public responses in Namibia and the wider costs and benefits of this managed migration are still to be assessed.
- Assessments of policies and ethical codes need to compare those that have worked (eg the SA codes in the region) and those that haven't (eg the British

code) to identify the reasons for the   differences and strengthen effectiveness of these codes. The role of wider policies (eg on work permits, immigration) need to be covered in this.
- The push factors in source countries as do the return factors need to be identified and addressed.
- Work on migration costings will need to link with National health accounts reviews

Both on retention and migration participants strongly urged for an accessible mechanisms for regional information exchange to facilitate sharing of published and grey literature on HRH. This was identified as a gap to be filled. It was further noted that a strategic review of current policies and options on retention incentives and the evidence on their effectiveness, and the systems issues they raise would be useful to commission. It was suggested that EQUINET could commission such a regional assessment.
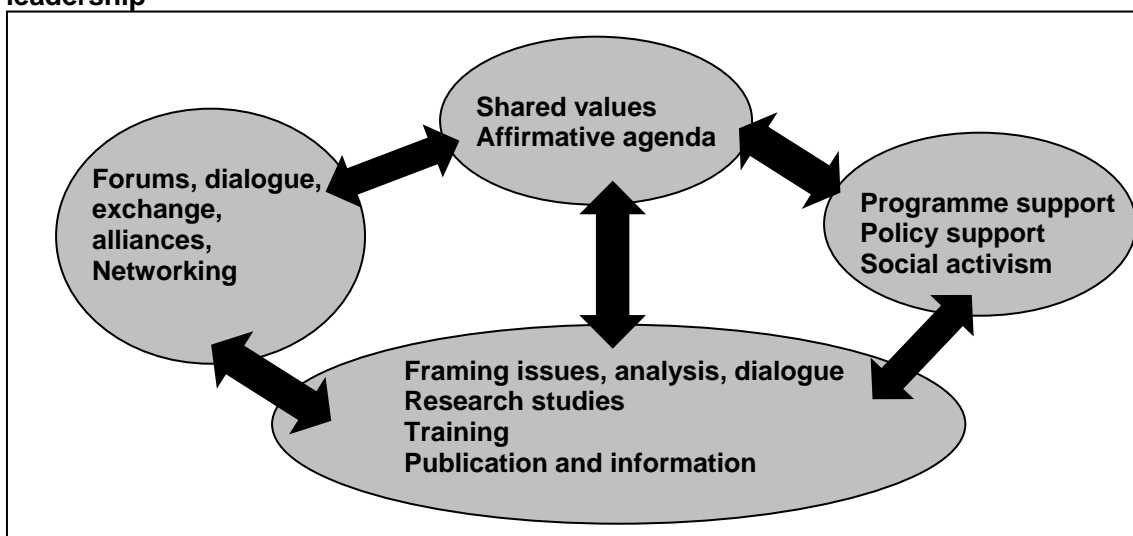
4. Discussion on future work

4.1. Information on EQUINET

Rene Loewenson (TARSC/ EQUINET) briefly introduced the wider context of equity work and resources in EQUINET to support this work. Figure 5 outlines the various areas of work EQUINET facilitates or supports on health equity.   This includes
- Research grants and studies, particuarly regional and multicountry studies to enable exchange of information across countries
- Research methods and mentoring
- Training, mentoring and skills development
- Exchange visits
- Reviews and publications
- Meetings and forums for dialogue
- Accessible information on health equity
- Alliances with parliaments, civil society and networking with regional and global institutions.

Figure 3: EQUINET is a resource for knowledge, support of policy action and leadership

EQUINET supports and ensures publications and information exchange within the region, and produces for this a newsletter and website. The website at www.equinetafrica.org

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has a searchable bibliography, and all publications are in a fully-searchable database on the site, including publications on HRH.

The network has pursued work in a number of theme and process areas co-ordinated by lead institutions from across the region on
- Macroeconomic policy, trade and health
- Household poverty, food security, nutrition and health
- Fair financing and equitable resource allocation
- Equitable and ethical policy on human resources for health
- Health systems approaches to HIV and AIDS and treatment access
- Participation, health governance and equity
- Health rights as a tool for health equity
- Monitoring equity in health
- Parliamentary and civil society alliances for health equity
- WEB, IT and information tools
- Policy analysis , and capacity building

EQUINET has also worked with country level networks on equity in health in Malawi through the Malawi Health Equity Network and Tanzania through EQUINETA and has supported enhanced equity networking in a number of other countries. Further information including on the institutional structure, secretariat and steering committee can be accessed at www.equinetafrica.org.

4.1. Follow up work on retention

A deeper discussion was held in the afternoon to review the evidence presented and identify more focused areas for follow up work on retention and migration.

Questions to explore around retention incentives
In relation to retention it was agreed that a follow up regional programme should focus *on mapping, gathering and sharing evidence on the options for retention*, following some key questions of concern on the options:
- What are the measures, how were they introduced, for which category of health workers (or differently across different categories), for which geographical areas, with any other targeting?
- What specific push factors did they aim to address? Were they aimed at attracting workers in to the sector / retaining workers or both?
- What is their time frame - from short term response for immediate impact through to sustained and systemic measures for long term impact
- What do they cost and how are they financed (including at what level, central, local etc)?
- How have global, bilateral, donor and programme funds been used as a source of financing for these incentives? With what risks and transition mechanisms for national (/ public sector) takeover?
- What legal and institutional changes were need to apply them? With what implementation and enforcement procedures?
- What measures were used to manage their introduction and with what effects for different health workers?
- How is performance and impact being monitored? What indicators and through what systems?
- What has their effectiveness and impact been – in the immediate, medium and longer term? What have been the factors in "success"?

- What are the trade offs for different choices on incentives for retention? How were these trade offs decided- with what implications for different cadres and areas of health system performance?

Focus areas of retention incentives
In the categories of incentives to be assessed it was agreed that while an initial mapping could gather information on all financial and non financial incentives, a more detailed focus could be given in deeper assessments of performance and impact on
- Salary top ups and allowances (including their role relative to non financial incentives and their sustainability)
- Training and career path related measures, including bonding and training loans
- Incentives to address social needs such as transport, housing, child education, electricity, community support
- Working conditions, health worker health and access to ART
- HR and personnel management systems

General systems issues to support retention incentives
It was further agreed that analysis is needed of the systems that support planning, monitoring and strategic review of retention incentives, including the information gathered and used and the analysis needed to support decision making. Specific institutional analysis could be implemented to identify the changes that support strategic planning, that facilitate implementation at district to national level of non financial and financial incentives and for building flexibility and responsiveness to signals.

Specific operations research
Some specific operations research questions were raised for follow up
- What role do community level cadres, support staff and allied professions – who have often not been a focus of retention incentives- play in HRH retention?
- What are the trade offs between specific areas of financial and non financial incentives? How are the relative benefits of each used? How are these trade offs managed?
- What are the barriers and mechanisms for strengthening health worker access to and uptake of ART (and the counseling, testing and other services associated with this)

It was proposed that once an analytic framework has been finalized for the work, and national authorities have reviewed and formalized participation, then regional and national level mapping and review of the incentives could be carried out in a selection of countries in ECSA as a first stage mapping. This would involve the countries involved in the meeting and support for this would be provided at regional level by EQUINET and ECSA. University of Namibia will co-ordinate this for EQUINET with support from the EQUINET secretariat.

This initial mapping and review would scope the current options and raise initial evidence on their implementation and impact. Review of this evidence by countries would support design of deeper and more focused monitoring, research and analysis of the incentives, the systems for their use and their impact, and the work to support the strengthening of national monitoring and evaluation systems for tracking and reviewing priority areas of HRH policies. It was agreed as a principle that this work should be responsive to the specific practical needs of countries, be controlled in pace and content by the countries working with support from the regional institutions, integrate within and strengthen national systems and feed into existing national and regional platforms, including ECSA and SADC.

ECSA and EQUINET will prepare a circulate a more detailed plan for this follow up programme. EQUINET will also liaise with SADC to ensure harmony with SADC work on HRH.

4.2. Follow up work on migration

The discussions on migration and issues raised will be used to prepare a follow up regional programme of work on migration supports policy negotiation.

It was proposed by participants that one part explore the differential effectiveness of different policy measures and strategies currently in place for managing migration within the region and internationally. This would explore the factors influencing successful or negative outcomes from these current measures (and how the costs and benefits of these outcomes are distributed).

One part could carry out a more detailed assessment of the distribution of costs and benefits of health worker migration (financial and non financial).

Both parts would aim to also inform policies to support the ECSA Ministers resolution to develop and adopt a common position on compensation for health workers recruited by developed countries.

EQUINET and ECSA will develop a more specific analytic framework and programme of work for this in consultation with countries. HST will co-ordinate this for EQUINET with support from the EQUINET secretariat. The technical expertise in institutions such as LATH was also appreciated and it was hoped that this networking would continue on relevant areas.

4.3. Follow up communication

Communication on the follow up will be carried out through the Ministry of Health HRH personnel, with the meeting delegates as focal persons (noting also their roles in the Ministry and in the ECSA HRH Technical Working Group (TWG)). It was agreed that national strategic working groups will be a consultative mechanism for involving other stakeholders and that further follow up would be made to explore where there may be gaps in these to see how to strengthen inclusion of key stakeholders. At regional level EQUINET and ECSA are formally co-operating in taking forward the follow up work and will co-ordinate with the ECSA HRH TWG and the EQUINET steering committee.

5. Closing

The meeting closed with thanks to all participants and to SIDA for their hosting and support.

Appendix 1: List of participants

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Appendix 2: Programme

RETENTION AND MIGRATION OF HEALTH PERSONNEL IN SOUTHERN AFRICA
REGIONAL PLANNING MEETING
April 3 2006 Lusaka Zambia

Agenda:

The agenda for the meeting is outlined below with speakers indicated:

830am — Welcome, introductions, objectives

845am — Brief outline of priority issues in research, monitoring and policy dialogue on incentives for HRH retention - EQUINET *Scholastika lipinge*

9.00am — Policies, national strategies, programmes, and monitoring systems for HRH retention:
Tanzania *A Mwakilasa*
Namibia *M Pendukeni*
Zambia *J Mwila*
Malawi *E Wochi*

945am — Discussion on incentives for HRH retention *Facilitated by R Loewenson*
° policy priorities
° knowledge gaps
° monitoring and evaluation tools

10.30am — Tea/ coffee

1050am — Areas and methods for follow up work in incentives for retention
° Country level monitoring, research and policy dialogue
° Regional monitoring, research, exchange and policy dialogue
° Institutional mechanisms and actors

1150am — Brief outline on priority issues, knowledge gaps on costs and benefits and evaluation of approaches to managing international HRH migration - EQUINET *A Ntuli*

1205pm — Discussion on methods and activities on follow up work on costs and benefits of migration – *facilitated by H Lugina*
° Country level monitoring, research and policy dialogue
° Regional monitoring, research, exchange and policy dialogue
° Institutional mechanisms and actors

1245pm — Summary conclusions and next steps

1.00pm — Closing of formal meeting and lunch

2.00pm — Informal follow up discussions with countries on specific follow up programmes of country work

Appendix 3: Consensus statement from the regional meeting on Equity in the distribution of health personnel in southern Africa, August 2005, Johannesburg, South Africa

The EQUINET regional meeting on Human Resources for Health August 19-20 2005 in Johannesburg South Africa discussed and debated Human Resources for Health (HRH) research and policy with a view to improving the equitable distribution of HRH within southern Africa. By the end of the deliberations, the delegates from government, non government, health worker, national, regional and international level at the meeting highlighted key areas of shared perspective on HRH:

The delegates noted an HRH crisis in east and southern Africa that has become more marked with the inadequate resourcing of the health sectors under economic reforms. The migration of HRH *from* the region to high income countries and the outflows of health workers from primary and district levels of health systems and from the public to private sectors leaves many low income communities with high health need with inadequate personnel for their health care services. This is a perverse outflow of public resources that undermines equity and the health system response to the major public health challenges in the region.

The multisectoral nature of policy implementation on HRH within government, and the international pull factors for migration of HRH were noted. Following the example of some countries in the region it was proposed that HRH be taken up as an issue for government as a whole and not just for the health sector, led by the highest level of government. At the same time Ministries of Health need the institutional latitude to facilitate training and strengthen retention of health workers. Constructing an appropriate policy framework given diverse contextual imperatives implies building a portfolio of policy measures and building policy implementation capacities.

Acting on HRH requires new resources, and, as raised by the African Ministers at the World Health Assembly in 2004 and again in 2005, delegates proposed international action and global transfers to address migration of and reinvestment in HRH.

It was proposed that HRH issues be addressed within the context of building and strengthening the public health sectors in the region. Towards this three areas of focus were identified for action:
- **Valuing health workers** so that they are retained within national health systems. This includes reviewing and implementing policies on non-financial incentives for HRH such as career paths, housing, working conditions, management systems and communication. To support this delegates proposed greater investment in training in HRH supervision, in management and communication systems, HIS and HRH, and measures to support health workers own health.
- **Promoting relevant production of HRH,** particularly in terms of the health personnel for district and primary care levels, and drawing on experience in the region on training of auxiliaries. For equitable distribution and retention the delegates noted the importance of appropriate selection of students and the need to locate training within career paths and incentives that recognise the HRH trained within the public health sector.
- **Responding to migration**, which requires closing the evidence gap with respect to migration (levels, flows and causes), financial flows, costs (benefits, losses) and return intentions and mapping the effectiveness of current policies. Delegates noted that migration represents a perverse subsidy calling for international policy responses that provide for reparation.