Impacts of health worker migration on health systems in east and southern Africa

Regional research workshop REPORT

July 14-16 2009
Harare, Zimbabwe

World Health Organisation (AFRO)
Regional Network For Equity In Health In East and Southern Africa (EQUINET)

in co-operation with
the East, Central and Southern Africa Health Community (ECSA-HC) and Southern African Development Community (SADC)

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1. Background and objectives

Migration of health professionals is a global phenomenon. It is particularly marked in east and southern African countries, which continue to lose many skilled health workers to higher income countries. Research has been done on the push and pull factors influencing migration, and countries are putting in place incentives to retain health workers. Discussions on ethical recruitment and bilateral agreements between source and recipient countries need further to be informed by evidence on the manner in which migration affects health systems functioning, particularly of low income source countries, to mitigate harms and enhance any benefits. This is not currently clear and there is limited research evidence on this.

Literature review and research carried out by EQUINET and ECSA-HC and by WHO on the levels and impacts of health worker migration have revealed difficulties associated with data collection. It is necessary to develop appropriate standardised methodologies for research that aims to yield policy relevant evidence,. A regional meeting was thus planned to bring together the cross section of stakeholders from WHO/AFRO, SADC, ECSA-HC, EQUINET, government officials and researchers from the region to develop a harmonized approach for follow up research on health worker migration.

1.1 Objectives

The workshop aimed to:

- Discuss the key policy issues arising nationally, regionally and globally on the impacts of health worker migration on health systems; and identify key evidence gaps in negotiation of policy and agreements relating to protecting negative health systems impacts of health worker migration.
- Review and discuss existing conceptual frameworks, parameters and indicators used for assessing health worker migration flows; and for assessing dimensions of health systems; and propose a conceptual framework and parameters for measuring impacts of health worker migration on health systems;
- Review existing research initiatives on health worker migration in the region, the methodologies (design, tools) used; their limitations; and discuss and develop a shared standardised method for capturing evidence and analysing the impacts of health worker migration on health systems (in source countries) in line with the conceptual framework in (1) above;
- Identify research capacities (research teams, funding, and political will) for the follow up work on health worker migration in the region, and a coordinated and harmonised approach to follow up research on health worker migration in the region.

The meeting was co-organised by WHO (AFRO), EQUINET, ECSA-HC and SADC with financial support by WHO AFRO and EQUINET (SIDA Sweden). Background technical work on the programme was provided by Training and Research Support Centre and University of Limpopo (in EQUINET), meeting facilitation by Prof Y Dambisya University of Limpopo, EQUINET; and the report was prepared by TARSC (R Loewenson, M Makandwa) with input from Dr John Koku Awoonor-Williams for

WHO and Prof Dambisya for EQUINET. The delegate list is shown in Appendix 1 and the programme in Appendix 2.

2. Opening session

After a security briefing from a UNDP official, Dr Prosper Tumisimwe, WHO IST/ESA HSS Focal Point, as chair of the opening session welcomed the host organizations and delegates. Dr Rene Loewenson (EQUINET Programme manager) added her welcome to Zimbabwe and noted the fruitful co-operation between WHO, EQUINET, ECSA, HC and SADC in work on health workers and in preparing for the meeting. She explained EQUINET's mandate to promote research, dialogue and capacity development in advancing health equity in East and Southern Africa and observed that EQUINET saw the issue of health worker migration as a key factor affecting health equity and the ability of health systems to respond to it. She welcomed the collective contribution from the participants to review methods for strengthening the evidence base on the issue.

Mr Ityai Muvandi Monitoring and Evaluations Officer, SADC, in his welcome remarks, commented on the need to explore methods that can be used to understand the levels and impacts of migration of health professionals, noting that SADC has developed a strategic plan on health workers and is monitoring its implementation. He expressed a wish that the delegates ensure that the objectives for the meeting are met by its conclusion.

Dr Helen Lugina, ECSA-HC (Manager HRH) welcomed the opportunity provided to explore the issue of health worker migration given its policy significance, and expressed a desire to continue collaboration in taking the work developed at the meeting forward. She indicated that the platform was a valuable opportunity to develop solid research protocols that could inform policy and programmers on the way forward in addressing issues of migration of human resources for health (HRH).

Dr Dapo Walker, the WHO IST/ESA Director was introduced by the chair. In his opening speech for the meeting, he informed delegates that the HRH issue was perceived as important by WHO, and raises policy, management and programme issues. He observed that migration is here to stay, whether we like it or not, and our focus should be on how we address it, noting that it is a complex issue. Towards this, WHO has been working on an international code of practice for ethical recruitment that sets parameters for ethical recruitment and for managing the impacts. The globalisation of information through internet, the global markets in goods and services, and the range of pull and push factors all contribute to migration. He urged delegates to focus on where the impacts are, particularly on health systems, deliver a workable protocol that is practical and feasible to implement, and that we can take forward as a consortium of organisations with our different capacities and roles.

Finally, Prof Dambisya outlined the workshop objectives (as provided in Section 1), and presented the outcomes that the convenors hoped to achieve, ie:

- A conceptual framework, parameters and indicators measuring impacts of health worker migration on health systems;

- A shared standardised method for capturing evidence and analysing the impacts of health worker migration on health systems (in source countries) in line with the conceptual framework above;
- Identified research teams, roles and follow-up steps for research on health worker migration in the region.

3. Ongoing activities on HRH migration in east and southern Africa

Dr Helen Lugina, ECSA HC, outlined the content of the **ECSA HRH Strategy 2008-2012**, and the gaps identified as being important to address. These included:

- Lack of accurate data, calling for support for reliable human resources information systems (HRIS)
- Low HRH training capacities; with poor infrastructure and management systems.
- High attrition rates, low productivity, and poor workforce performance; leading to low efficiency of health systems.
- Low funding for the health sector in the context of high disease burdens
- A demand to scale up interventions, including for HIV and AIDS, malaria, TB and other diseases, and to achieve the Millennium Development Goals (MDGs).

The ECSA HRH Strategy is framed to address these priority HRH concerns above, to strengthen HRH to provide better quality health care, to enable member states to achieve the MDGs. The strategy covers training and capacity building, HRH intelligence, leadership, management and resource mobilization. The plans for the strategic objectives in these areas have been costed, as shown in the table below:

Strategic area **To:**	**Estimated budget (US$)**
Contribute to best practice models of HR utilization in member countries	305 000
Strengthen member states capacity in human resource leadership and management	815 000
Strengthen HR intelligence in member states	605 000
Strengthen ECSA learning and resource centres, including ECSACON and COSECSA, and support their participation in country HR plans and programmes	300 000
Strengthen capacity in financial resource mobilization, and effective collaboration, partnership and networking between public sector and private sector	290 000
Monitor and evaluate HRH programmes and activities within ECSA-HC	450 000

The methods and benchmarks for achieving these targets include

- Reviewing country HRH plans, needs, production and utilisation to inform responses

- Strengthening HRH management approaches based on best practices, including programmes on health worker health, productivity and efficiency, retention strategies and responses to migration
- Promotion of ECSA HC as a knowledge hub for coordination, harmonisation and standardisation of education and training, the development and functioning of ECSACON and COSECSA, and establishment of the ECSA College of Medicine/Health Sciences
- Developing, strengthening and facilitating partnerships with stakeholders within member countries, and with regional and international partners.

Magda Awases WHO, outlined the **WHO/AFRO programme on HRH migration and retention**. Of the 57 countries in the world with a critical shortage of health workers, 36 are in sub-Saharan Africa. These countries have a workforce density of just 0.8 health workers per 1000 population, compared to North America with 9.9 health workers per 1000 population, and Europe at 10.3 / 1,000 population. These workers experience low wages, poor working conditions and poor career mobility. Member states adopted the Resolution WHA57.19 in 2004 on "International migration of health personnel: a challenge for health systems in developing countries", and in 2006 Resolution WHA59.23: "Rapid scaling up of health workforce production".These resolutions among other items requested the Director-General and member states to take action on the issue of international migration, including the development of a Code of practice on the international recruitment of health personnel as well as give consideration to the establishment of mechanisms to mitigate the adverse impact on developing countries of the loss of health personnel through migration respectively.

WHO seeks therefore to improve information and evidence on health workforce migration, to support development of effective policy responses to migration and evaluate the effectiveness of international and national interventions to manage migration, such as through the proposed code of practice. WHO has advocated for a global code of practice for ethical recruitment of health personnel, building on prior initiatives by the Global Health Workforce Alliance (GHWA), , Realizing Rights and WHO (Health Worker Migration Policy Initiative), launched in May 2007.As part of developing the Code, WHO reviewed existing Codes of Practice and memoranda of understanding. These included:

- Commonwealth Code of Practice (covering 52 Commonwealth countries)
- Regional Codes: Pacific Islands Code of Practice, Caribbean Single Market and Economy and the ASEAN Mutual Recognition Agreement
- Bilateral agreements: UK- SA, UK- Philippines, Kenya-Namibia, Kenya – Lesotho.

Furthermore various consulations were held on the issue of migration, these include A joint WHO-OECD high policy forum with Members States in March 2008 and the Health Worker Migration Policy Initiative which consist of two entities. *A Migration Technical Working Group* (TWG) is led by WHO technical experts from international agencies, professional organizations, NGOs, Member States to provide robust data and rigorous research on migration support WHO's work on the development of the Global Code of Practice, while a *Health Worker Policy Advocacy Council* brings together high level policy makers from source and destination countries, international organizations and governmental agencies . These two groups worked together and produced a Framwork for developing a Code of Practice and subsequently WHO produced a draft Code of Practice.

She raised a number of research and policy questions on the issue of HRH migration, including:

- the factors influencing health workers' choices of employment location;
- the design of retention interventions to improve staffing of rural health facilities; and
- the effectiveness of different HW retention interventions.

With regard to the work **on retention**, WHO and its partners in 2008, embarked upon work on increasing access to health workers in remote and rural areas through improved retention **.** This work is based on three pillars:

- **Building the evidence base** on effective retention strategies through literature reviews, case studies, expert consultations, synthesis of the evidence, identification of knowledge gaps and commissioning research
- **Supporting countries** to evaluate and adapt retention strategies work with interested countries to evaluate past and on-going strategies and to develop and implement country-specific plans
- **Developing and disseminating global recommendations** on increasing access to health workers in remote and rural areas through improved retention

As part of the development of guidelines and recommendations for retention of health workers in rural areas, the evidence is classified into what works and why? and what doesnt work and why? It focuses on the following questions

- What is the role of different factors in influencing health workers' choices of location and how best can they be identified? How do they vary by category of health worker?
- How should effective retention interventions be designed and implemented to improve staffing of rural health facilities?
- What are the pre-requisites for the design and implementation of retention strategies?
- How effective are different HW retention interventions in influencing health worker location?
- How can the effect of retention strategies be measured and evaluated?

Dr Rene Loewenson, TARSC / EQUINET reported on the **work done by EQUINET on health worker migration** to date. She noted that migration of health workers is one of a range of ways resources are flowing out of health systems in ESA. Internal migration from peripheral to higher level services, from lower to higher paying services and external migration from low to high income countries represents an equity issue as it often leaves health systems and communities in low income countries and regions under-served. There are equity gains to recipient countries (eg migrant deployment to remote areas) and losses to source countries (losses from remote areas) with costs, sometimes impoverishing, to households in seeking care from more distant services due to staffing issues.

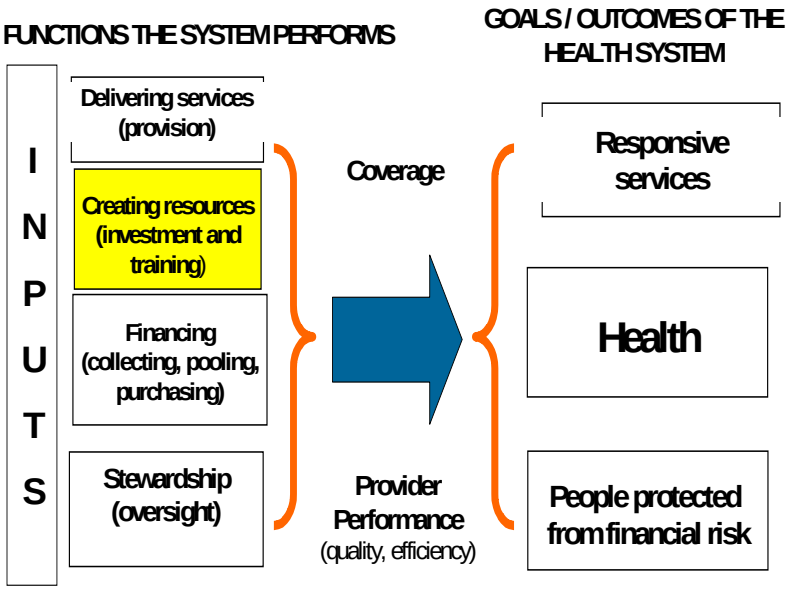
The pull, push, stay and stick factors for this migration have been studied by EQUINET and by other researchers, and she gave examples of the studies that have identified economic, political, welfare and systems factors driving migration. As a result

of this EQUINET has implemented a programme of work on incentives for health worker retention that proposes options to address some of these factors. Countries have in response to migration of health workers whether internal or external.

- Expanded training capacities and established new cadres;
- Re- defined roles; re-engaged retired personnel; and initiated diaspora return programmes;
- Strengthened retention incentives and welfare support and initiated measures to attract, retain people in critical posts (eg teaching; 'critical skills areas'); and
- Strengthened management, monitoring and information systems linked to strategic sector wide plans, while reorienting international funding to encourage sector wide support.

EQUINET has commissioned a review of literature on cost and benefits of migration which include distribution of costs needs to be taken into consideration in relation to training and attrition, functioning of health systems, institutional memory and experience, disease burdens, households of seeking care, migrants, families and communities, economic returns to households, remittance returns, household security, skills transfer and career paths. Ethical recruitment policies such as Codes of conduct on International Recruitment (UK), immigration restrictions in receiving countries including temporary work permits, restricting use of expatriate technical co-operation and Commonwealth Code of Practice for international recruitment of health workers intend to balance the needs of both source and recipient countries. A review of the codes indicates that they have largely been voluntary and poorly enforced. Agreements appear to have more promise as they recognise and manage the costs and benefits of migration. She therefore noted the need to better map the impacts on health systems, both in terms of their functions, as shown in the figure below, and their ability to enhance equity in health (eg through intersectoral action, social empowerment, closing gaps in access and coverage and redistributing resources towards need.

Functions of the health system



Dr Scholastika Iipinge, University of Namibia/EQUINET gave an outline of the **EQUINET –ECSA-HC programme support health worker retention** that was in line with the ECSA RHMC resolutions 2006, 2007 and with SADC Resolutions on Health workers. This programme aimed to support country programmes to monitor, evaluate and manage incentives for retention of health workers, particularly non financial incentives.
A background paper was commissioned by EQUINET-ECSA - HC on health worker retention incentives in ESA, and after a methods meeting in March 2007, country field studies were implemented on retention incentives in Kenya, Zimbabwe, Tanzania, Swaziland and Uganda in 2008. A regional meeting in February 2009 came up with recommendations from the work (separately reported) that were fed into SADC, ECSA-HC Ministers of Health, WHO and will be reported at the EQUINET Regional conference in September 2009. The work has also informed inputs to country, regional and international policy dialogue.

Prof Yoswa Dambisya, University of Limpopo outlined the **European Union/ International Organisation on Migration (IOM) collaborative project on HRH migration.** The programme is analyzing HRH migration flows and impacts, evaluating policies addressing migration and developing recommendations concerning these policies. Both quantitative and qualitative approaches are being used, triangulating different sources of evidence to review health system, health sector and health outcomes. Final analysis of the study findings will be done in June – September 2011.

Ityai Muvandi, SADC, outlined the **SADC HRH Strategy and SADC HRH Technical Working Group on HRH Migration.** The 2005 SADC Health Ministers meeting found that the failure to meet some MDG targets was due to non-availability of skilled health professionals. SADC aims for citizens of one Member State to have the right to work in another Member State, subject to the laws of that State. SADC migrant workers that meet those conditions must be treated in the same way as national workers in relation to working conditions, wages, taxation, etc. SADC developed in 2006-2009 a *Human Resources for Health Strategic Plan*, which aims to ensure adequate production, recruitment and retention of the required HRH in the region by 2019. The objectives include:

- managing the impact of HIV and AIDS;
- managing the “Brain Drain” and migration;
- developing policies and strategies to attract and retain health professionals;
- developing a Regional Qualifications Framework;
- identifying, establishing and developing regional centres of specialisation and excellence; and
- creating a framework for a suitable skills mix.

In November 2006, the *Policy Guidelines for Attracting and Retaining Health Professionals in the SADC Region* were put in place. These guidelines urged Member States to put in place measures to improve working environments and create conditions of service - such as competitive salary packages, to attract, recruit and retain health professionals. At the same time workplace HIV and AIDS programmes were also recommended to mitigate the impact of HIV and AIDS. In November 2008 SADC produced a concept paper on the ‘brain drain’ and skills circulation – *The Migration and Management of Human Resources for Health*. This concept paper

indicates that "brain drain" is when people leave the region or the health sector, but movement within the region's health sectors is not regarded as brain drain. SADC has also

- established a Technical Committee to report to ministers; and
- set up the SADC Committee of Deans, AMCOSA and SANNAM.

In the discussion on the presentations delegates raised a number of issues: Delegates noted the need to more actively disseminate available HRH information in the region and agreed that it was necessary to deepen the knowledge base on migration.

The loss of personnel was felt to track back to getting the politics right, paying a living wage and having decent services as work environments. However it was raised that remittances may be perceived as adequate return from migration, so it was necessary to involve finance ministers and economists in the work on migration for them to appreciate the health systems issues and costs.

It was thus noted that the research protocol needs to be clear about its target audience (eg health, finance), and ensure that the evidence generated will be credible to this audience. Delegates perceived that from the policy initiatives that African Ministers of Health appear to be concerned about the issue of HRH so it would be important to engage the political leadership at the early stage so that they appreciate the process and outcomes planned in the meeting.

4. Priorities on HRH migration for future research

A wide ranging discussion was held on priorities and approaches for future research on migration (and retention). Generally it was noted that

- Addressing challenges of health workforce migration calls for a multi-sectoral and multi-agency approach. *"The problem is we have been talking to ourselves in the health sector and it is time to engage others".* There is the need to talk to (with) other ministries and stakeholders, including Finance and Economic Planning sectors.
- The work needs to be holistic in approach, ie to address supply and the demand side factors, to look at factors within and beyond the health sector, and to pay attention to the work environments health workers work in.
- The terms- migration, circulation, health worker, health professional - need to be defined.
- An assessment of inflows and outflows of HRH needs to be done. Delegates were interested in identifying whether there is a real difference between brain circulation and migration for member states and individuals.
- There is need to assess the impact on the health systems and on the individual health workers of health worker migration: to identify any areas of harm and benefit, the financial costs and returns. This includes assessment of the impact of health workforce return to their own countries, and the extent to which the health system itself is a push factor for migration.
- The work should explore how countries (in different sectors) are dealing with health workforce migration and aim to share experiences with other countries in ESA and in other parts of the world, particularly best practices and examples of what has worked.

- A further question was raised on how countries strengthen Primary Health Care in the midst of health workforce migration.
- At international level, delegates suggested that we have a knowledge gap on the impact international agencies and agreements (including for World Trade Organisation) are having on health workforce migration and its health system impacts. Further questions were raised on this: How effectively are the countries using regional blocs (SADC, ECSA) to negotiate around agreements on health workforce migration? What impact are external funds having on HRH migration impacts on health systems? What influence are global health initiatives having on HRH migration and its impact on health systems? How far are policies like the World Bank promotion of private sector a response to the HRH crisis?

In the discussion it was noted that there is need for a working definition for the programme of HRH migration.

The work should focus on the effects (harms and benefits) to the health system of health worker migration, including:

- the economic, social and public health costs and benefits;
- the impact on health workers;
- on the ability to deliver key health policies, such as PHC;
- on the key functions, capacities and goals of the health system (see figure on page 7) and
- on the health system as a push or pull factor in migration.

5. Experience of research on HRH migration

Mr Charles Dulo of Mustang Management Consultants presented a study supported by IOM, EQUINET and the Kenya Working Group on Migration on HRH migration in Kenya and the impact on health service delivery. The study aimed to identify determinants, benchmarks and indicators of the costs and benefits and distributional impact of the migration of human resources for health on health services in Kenya and to make policy proposals for intervention. It used review of secondary evidence and field surveys and he presented some of the problems encountered, including difficulties with data access, and numerous data gaps. The study explored the impacts on the different functions and goals of health systems, and observed impacts on losses to training and supervision, gaps in staffing compromising service delivery, increased workloads for staff left behind, and effects in terms of overstretched, overburdened and de-motivated staff, resulting in deterioration of service provision. The study used the evidence found to make recommendations for managing both the health systems impacts and the push factors. It was less easy to quantify the financial costs and returns from remittances due to HRH migration, or to provide any balance sheet on this. The study indicated the complexity and range of difficulties in doing research on impacts of HRH migration on health systems.

In discussion delegates noted the need to explore outcomes beyond financial costs and benefits given the difficulties highlighted, and particularly to explore the public health costs and benefits, and the systems ability to deliver key health policies, such as primary health care.

6. Designing the research on HRH migration impacts on health systems

The meeting then held a series of working sessions to take the research design forward. These are summarised in the report and the protocol shown in the final section.

6.1 Research questions

It was noted that HRH migration refers to:

- for external HRH migration, the movement of health care workers from their home country to another country
- for internal migration, the movement of health care workers from rural to urban, primary health care level to secondary primary health care level, public to private sector and vice versa; and from health care to non-health care sectors and or to management positions or to project funded programmes.

There was some discussion on the time frames for how long a movement out should be to regard it as external migration. It was suggested that the actual time frame be collected noting that different studies have used different time frames, for comparability.

Delegates focused the range of issues and knowledge gaps around three questions for the research:

1: What are the effects of HRH migration on health systems?

2: What are the country responses to HRH migration and the impacts on health systems and how effective are these responses?

3: How are regional and international level agencies and agreements impacting on HRH migration and the health systems impacts, and how far are they supporting the responses by countries to manage HRH migration and its impacts?

The effects on the health system were noted as:

- **Economic:** eg –in terms of employment/unemployment, salaries, costs of replacement of health care workers migrated, tax revenue.
- **Social:** political and social stability, family relations, social networks.
- **Public health costs**: health and health care outcomes (see below)
- **On the health workers:** workload, morale, motivation, personal income, knowledge and skills.
- **On the ability to deliver key health policies e.g. PHC**: referral chains
- **On key functions and capacities of the health system:** (see below)
- **On the health system as a 'push and pull' factor in migration:** workload, staff morale, and burnout, management of facilities, equipment and supplies.

6.2 Conceptual framework and parameters for assessing impacts on health systems

The WHO framework for health systems functions shown on page 7 was used as a basis for mapping health systems impacts. Integrated with these were other dimensions commonly used in assessing health sector performance, ie

- Clinical effectiveness
- Extent to which services are patient centred
- Production efficiency
- Staff orientation
- Safety
- Responsive governance

Also noted were the different levels of evaluation of health service coverage, noting that for this study availability, accessibility, acceptability and contact coverage would all need to be assessed (See chart on page 13).
INPUTS, or the independent variable include:

- Net inward / emigration rates
- Migration densities
- Migration trends

Following the areas shown in the chart on page 7, possible parameters identified are shown below. It was noted that not all of these may be used in the protocol with selection based on power, feasibility, availability of data.

FUNCTIONS

DELIVERING SERVICES (CLINICAL EFFICIENCY; PATIENT CENTREDNESS)

- Health worker availability- public sector share of doctors, nurses, pharmacists, midwives, dentists, lab technicians, environmental health officers
- Staff ratios
- Staff turnover, vacancies, absenteeism/ presentism
- Functioning of referral chain
- Procurement and planning
- Availability of medicines/ vital and essential drugs
- Availability of specialised services (eg laboratory; maternity)
- Availability against essential health package

CREATING RESOURCES (PRODUCTION EFFICIENCY)

- GDP/capita
- Training services- universities, professional colleges
- Production and supply of health workers
- time trends on number / density of health workers trained
- Staff supervision and mentoring
- Staff Knowledge
- Career path
- Local Medical technology and drugs: production vs imports
- Diaspora insurance and drug flows to households
- Foreign, Public sector and private investment in the health sector
- Flows to health sector from remittances

FINANCING

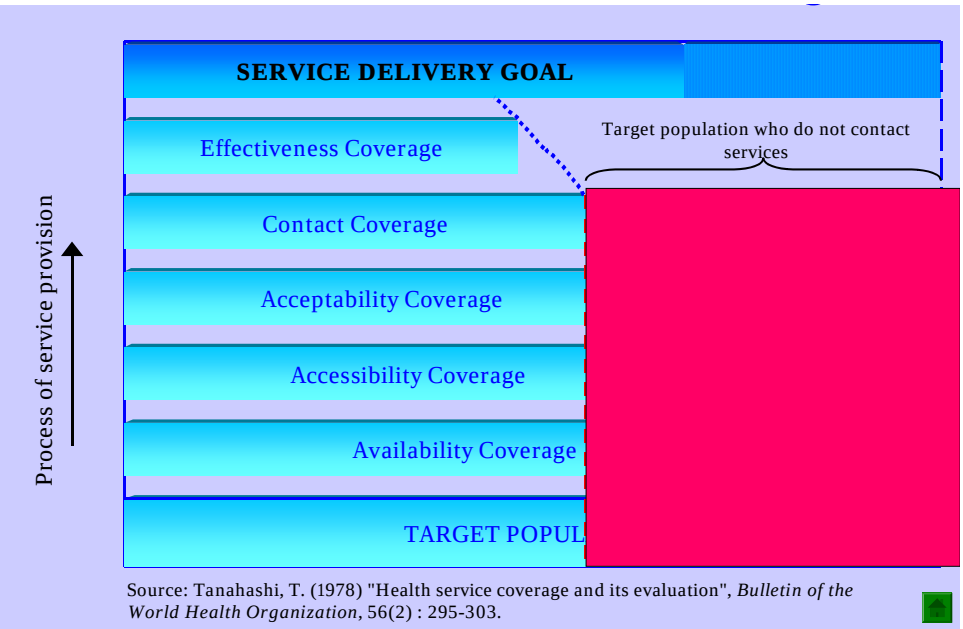
- Collecting- perceptions of willingness to contribute;
- Remuneration levels; PPP; as a share of total financing; by source;
- Pooling: insurance coverage; public – private shares of payments
- Purchasing: % shares to different levels; % public ; private
- Allocation- capacity to absorb at different levels

STEWARDSHIP (PATIENT CENTREDNESS; responsive governance)

- Policy development and negotiation
- Policy implementation and co-ordination
  - Capacities for staff and service management
- Oversight and accountability
- Access to information, internet;
- Professional association functioning
- Public participation

COVERAGE

- Availability
  - OPD per capita
  - Referrals outside district; outside country
- Accessibility
  - ANC, VCT, PMTCT coverage
  - Length of stay in hospital
- Utilisation (Within and outside home catchment area)
  - Assisted deliveries
  - Immunisation
- Differentials / equity in access and utilisation



Source: Tanahashi, T. (1978) "Health service coverage and its evaluation", *Bulletin of the World Health Organization*, 56(2) : 295-303.

PROVIDER PERFORMANCE (staff orientation; safety)

- HR workloads (HW to patient ratios) and burnout
- Efficiency in resource use

    - Task shifting
- Quality of services:
    - quality perceptions by health workers
    - quality perceptions by community
    - waiting time
- Workplace safety; workplace acquired infections

GOALS

HEALTH AND SOCIAL OUTCOMES

- maternal health outcomes
- Neonatal mortality rate
- TB incidence, TB default, TB-XDR
- Clinical vs confirmed cases of malaria
- Maternal and infant mortality rate
- Family disruption for health workers and families; acquisition of personal, family & societal wealth

RESPONSIVENESS (staff orientation; responsive governance

- service provision vs disease burden
- quality perceptions by health workers
- quality perceptions by community
- respect for patients and care givers
- patient / health worker perception of communication health worker to client
- consultation time

PROTECTION FROM FINANCIAL RISK

- cost to consumers
- payments by communities to facilities/ providers
- payments for service use (transport, etc)
- lost work time
- remittances/ total income

6.3 Design and data sources

It was noted that the design would need to involve a mix of methods, with options raised including.

- Literature and secondary data review
- A retrospective cross sectional study to assess migration trends and impacts using purposive, or stratified sampling;
- Comparative analysis between facilities and areas of high and low migration;
- Qualitative approaches through key informant interviews, focus group discussions
- Use Diaspora networks
- Discrete Choice Experiment (Conjoint Analysis)
- Document and Content Analysis (Records Analysis)
- Facility Patients Exit interviews
- Observation: eg facility level, staff attitude, customer care, waiting time
- Action and Participatory research through dialogue with relevant stakeholders: establishing a working group as part of the research process.
- Policy analysis – including content analysis, interviews

Individual country studies would be complemented by multi-country analysis of evidence from the different countries involved in the study, as long as designs and parameters used were comparable.

Migration issues are context driven and key economic, political and health system context features need to be documented as part of the study.

Sources of original evidence identified included

- Ministries of health, labour, finance and economic planning, immigration, education
- Central Bank
- Central Statistics Office
- Training Institutions, public and private
- Health providers and facilities
- Research Councils
- Employer federations
- Professionals and their regulatory bodies/registrars, including professional bodies outside the countries;
- Agencies dealing with migration e.g. IOM

From past work it was noted that there are challenges in implementation and accessing evidence, due to information gaps; unwillingness to provide information; the quality and inadequacy of information and the procedures, bottlenecks to address in accessing evidence.

Towards addressing this and communicating findings it was suggested that researchers and policy makers be engaged from the beginning through a steering committee.

It was agreed that further development be done on the protocol and Y Dambisya (U Limpopo, EQUINET) was tasked to work further on a draft protocol using the input from the meeting. To assess the impact of global and financial agencies and aid flows it was suggested that follow up be made at the EQUINET regional meeting on Health Financing in September 2009 for possible joint protocol development.

The group in the meeting formed a regional working group on migration (RWGM) that would guide the work. The RWGM will

- Provide overall guidance to the implementation of the study
- Provide technical assistance when needed (e.g. facilitation in development of data collection tools for this study)
- Act as an advisory group on retention and migration

7. Next steps for the research on HRH migration and health systems

7.1 Next steps

Delegates agreed on the next steps and time frames for the follow up work on the proposal as shown below:

STEP	TIMING	Lead RESPONSIBILITY
Meeting report	27 July	R Loewenson
Development of a full draft protocol for the research programme at country and regional level	14 August	Y Dambisya
Feedback on draft	31 August	RWGM
Finalisation of draft	4 September	Y Dambisya
Peer review of draft protocol	Sep 4-30 2009	EQUINET, WHO, ECSA, SADC to identify and send to two peer reviewers each
Presentation of draft proposal to DJCC and EQUINET conferences and to SADC focal points for feedback; ECSA request fir a focal point to liaise on the studies.	Sep 1-30 2009	EQUINET, ECSA, SADC
Funding for protocol development and pilots secured.	Sep 2009	WHO. ECSA-HC, SADC
Fundraising for full study.	August- December 2009	WHO
Integration of feedback and finalizing protocol Development of terms of reference and call for country teams	Oct 1- October 16 2009	Y Dambisya
Feedback on draft	30 October 2009	RWGM
Finalisation of draft	16 November 2009	Y Dambisya
Country pilots initiated in 2-3 countries	March -May 2010	Selected members of RWGM, WHO, YD
Protocol finalized	May 2010	RWGM, YD
Call for country teams circulated.	January 15 -April 30 2010	EQUINET, WHO, ECSA, SADC
Country teams peer reviewed and selected	May 2010	EQUINET, WHO, ECSA, SADC
Methods workshop for country teams	July 2010	EQUINET, WHO, ECSA, SADC
Research process commences	August 2010	

A proposal will be developed for “A Multi country Study on the Impact of Health care Worker Migration on Health Care Systems in Eastern and Southern Africa” with the protocol and including

- Background information – justification, rationale
- Development process
- The problem, the questions
- Aim and Objectives
- Design and methodology
- Timelines

- Resources

The background will include information on

- The HRH crisis in the region, poor health indicators, quest for the achievement of the MDGs.
- The paucity of reliable data on HCW migration; different methodologies, different contexts, difficult to compare. Work has been done towards understanding the drivers of HCW migrations (the push and pull factors). Less work on the effects of HCW migration, and even less on the effects of HCW migration on the health systems. Countries in the region do not have, therefore, have sound evidence to inform responses to HCW migration.
- The need for coordinated response by the region to the issue of HCW migration and for countries to design responses to HCW migration, to maximise its benefits without infringing on the rights of the migrants or in-country populations.
- Relevant contextual issues.

The proposal will cover the aims and objectives of the programnme, viz: To assess the trends and impacts of HRH migration on health systems, and the responses to the impacts in East and Southern Africa. This study will generate evidence to guide countries responses to the problem of health care worker migration. It will address the research questions shown on page 11.

Objective 1: To assess the impact of HRH migration on health systems, including the economic, social and public health impacts; the impact on health workers; the impact on the ability to deliver key health policies e.g. PHC; the impact on key functions and capacities of the health system and on the role of the health system as a push or pull factor in migration.

Objective 2: To assess the country level responses to HRH migration, in terms of:policies and programmes; actors, contexts and policy measures, mechanisms for engagement of HRH in the diaspora and the engagement in regional and international agencies on health systems impacts of migration. ..
Objective 3: To assess the impact of international agencies , agreements global health initiatives on HRH migration and health systems impacts and on country responses.

Objective 4: Policy To develop policy recommendations for action at: national, regional and international level.

7.2 Closing

The host organisations closed the workshop with thanks to the delegates for their contributions and wishes for safe travel home.

APPENDIX 1: LIST OF PARTICIPANTS

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APPENDIX 2: Meeting Agenda

DAY ONE – JULY 14 2009

Time	Activity	Responsible
08:30 – 9:10	Welcome WHO, EQUINET, ECSA HC, SADC Introductions	Magda Awases Rene Loewenson, Helen Lugina, Lebogang Lebese ALL
	Objectives of the workshop- EQUINET	Yoswa Dambisya
Session 1: Overview of ongoing or proposed work/activities on HRH Migration in the Region - Chair: WHO delegate		
09:10 – 10:30	ECSA-HC HRH Strategic Plan and ECSA HMC Resolutions on HRH migration (15 min)	Helen Lugina
	SADC HRH Strategy and SADC HRH Technical Working Group on HRH Migration (15 min)	Lebogang Lebese
	EQUINET work implemented to date (aims, methods): On HRH Migration (10 min) On HRH retention (10 min)	Rene Loewenson Scholastika Iipinge
	Aims and methods of the WHO/AFRO programme on HRH migration (15 min)	Magda Awases
	Aims and methods of the IOM/EU Mobility of health professionals project (MoHProf) (15 min)	Yoswa Dambisya
10:30 – 11:00	Break	
11:00 – 11:45	Moderated discussion: Priority policy areas for future work on migration Knowledge gaps to be addressed	Moderator: TBA ALL
Session 2: Key Evidence Gaps and prospects for further work Chair: Helen Lugina		
11:00 – 13:00	Impact of HRH migration on health systems: the Kenyan case study (15 min)	Charles Dulo
	Data from health workforce observatories: use, limitations and opportunities (15 min each)	2 country reports – to provide names
	Moderated discussion: Issues and options for design of research work Issues and options on sources of evidence Other learning from past work	Moderator: Y Dambisya ALL
13:00 – 14:00	LUNCH	

Session 3: Group Work Session 1 Chair: SADC		
1400-1445	Consolidated summary of 1. areas of focus for follow up research 2. design and evidence issues Discussion of conceptual frameworks Introduction to working groups	Y Dambisya
14:45 – 16:00	Working groups on 1. Design and sampling methods 2. Parameters, indicators and tools	ALL
16:00 – 16: 15	Break	
16:10 – 17:00	Report back on Working Groups Discussions of group work Discussion on country level and regional level work	Chair: Lebogang Lebese

DAY TWO– JULY 15 2009

Time	Activity	Responsible
Session 4: Research programme development Chair: Magda Awases		
08:30-09:45	Presentation of consolidated proposals for follow up research at country and regional level Discussion • Adoption of research objectives, frameworks and methods • Areas for further work and development (and roles)	Y Dambisya All
Session 5: Research Capacities and resources in the Region Discussion facilitator: Rene Loewenson		
09:45 – 11:00	Mapping of existing research capacities for the work at country and regional level Roles to be played in the work Capacities and potential roles • Regional: EQUINET, ECSA-HC, WHO/AFRO, SADC, IOM, other? • Country: Country researchers, observatories Discussion o Research teams o Synergies and linkages with other work Co-ordination and mentoring	ALL
11:00 – 11:30	Break	

Session 6: Setting the Research programme (Group Work Session 2)		
11:30 – 13:00	Working groups on the proposed programme: Group 1: Regional group- • resources, co-ordination, communication, mentoring, policy engagement on findings, publications Group 2: Country group – • methods issues, logistics and permissions, involvement and feed in to national authorities, budgets, support needed	All
13:00 - 14:00	LUNCH	
14:00 – 15:30	Report back on working groups and recommendations for proposed programme of work	Chair: Magda Awases
15:30 – 15:45	Break	
Session 7: Group Work Session 3 – Consolidation of proposals and recommendations for Research Programme Chair: Busisiwe Bhengu		
15:45 – 17:00	Working groups on proposed programme of work Group 1: Focus areas of work, methodologies and approaches Group 2: Coordination, collaborative arrangements, resource mobilisation/distribution	ALL

DAY THREE– JULY 16 2009

Time	Activity	Responsible
Session 7: Group Work Session 3 – Consolidation of proposals and recommendations for Research Programme (contd) Chair: TBA		
08:30-09:45	Report back on group work on proposals and recommendations 1. Focus areas of work, methodologies and approaches 2. Coordination, collaborative arrangements, resource mobilisation/distribution	ALL
09:45 – 10:00	Break	
10:00 – 11:30	Drafting of final report on "Methods for Follow Up Work on Impacts of health worker migration on health systems" Networking	Select Committee – Convenor: Magda Awases ALL
11:30 – 12:30	Presentation of Draft Report on methods Discussion of draft report Adoption of draft report	Y Dambisya ALL
12:30 – 13:00	Closure of Workshop	WHO, EQUINET, ECSA HC, SADC