

EQUITY IN THE DISTRIBUTION OF HEALTH PERSONNEL IN SOUTHERN AFRICA

**REPORT OF REGIONAL MEETING
18 to 20 August 2005
Johannesburg, South Africa**



**Regional network for Equity in Health (EQUINET)
and Health Systems Trust (HST)**

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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.

1. Introduction

1.1. Welcome and background to the meeting

Rene Loewenson (EQUINET) welcomed delegates and described the role of EQUINET in the region. She observed that the human resources within health systems need to be examined at the widest level to include all health workers and also those people in communities and other sectors who contribute to health systems. Thus HRH includes community members, primary healthcare workers, parliamentarians and those who generate knowledge of health systems, as well as those who work in hospitals. A gap in a particular group of health workers can weaken the input of a wide range of different people not all of whom are directly employed within the health sector. It's not just the numbers of health workers that are relevant, but also the orientation and the knowledge and how these come together. While bemoaning the loss of HRH, we should also not forget to value the people that we do have. EQUINET is interested in a broad perspective on HRH with a particular focus on equity. This meeting is intended to support collaborative approaches to identification of problems and potential solutions that take this 'equity lens' into account. This raises issues beyond numbers such as the distribution of health workers, the mix of health workers and the measures to avoid losses in those areas of the health system most needed to ensure health care access for the poorest communities.

1.2. Objectives

Antoinette Ntuli (HST, Human Resources theme EQUINET) outlined the meeting objectives which were to:

- update and recap on major policy issues and positions on HRH in east and southern Africa at the country and regional level;
- briefly share presentations on the work that has been done under auspices of EQUINET;
- identify policy positions and issues that require further research;
- explore capacity building and policy intervention within the region; and
- see how can we take forward priority issues in order to deliver clear agendas for action, and identify some key collaborations to assist in taking the work forward effectively.

The programme for the meeting is in *Appendix 2*.

2. Policy perspectives, priorities and key goals on HRH

In the chair was, Andrew Criten, national Department of Health, South Africa

2.1. Policy perspectives and key goals on HRH in Namibia

Monika Pendukeni from the Namibian Ministry of Health indicated that, as in other countries, Namibia is facing an HRH challenge even the public health system is still functional and not yet in crisis. There are a number of challenges including:

- *HRH Skills shortage* - apart from a staff shortage, Namibia also has a skills shortage.
- *Poor institutional capacity for HRH production* because there is no medical school and only a limited number of trainees in fields such as social work, nursing and radiography. Professionals are mainly trained in South Africa, but it is impossible to train sufficient numbers of doctors and pharmacists in SA at any one time.

- *Skewed distribution of health professionals* - most health workers are living and providing service in urban areas, and in the private sector, not public hospitals.

From a policy perspective the legal framework is in place including: the Labour Act No 2 of 1992 amended in 2004; the Affirmative Act No 29 of 1998; the Public Service Act No 13 of 1995; Vision 2030 and the NPDII. These laws guide the arena of *general* human resources, not just *HRH* specifically. However within this there is a lack of policy guidelines and of a general national Human Resource plan to guide a Ministry of health (MoH) HRH plan.

She explained that priorities and key goals in Namibia are to:

- complete an HRH situational analysis;
- finalise the country HR policy so that the HRH policy can be finalised;
- increase HRH by recruiting from other countries including Zambia, Kenya and Cuba
- work with the Ministry of Education to increase training capacity and review the education system to ensure all school leaver’s qualifications are suitable for entry to South African medical schools; and
- improve motivation of current health workers to deliver quality healthcare as they are exhausted and overworked, using both financial and non-financial incentives.

HRH is not only an issue for the MoH; other government departments and sectors must be consulted, but the MoH must pull together all available resources to resolve this crisis.

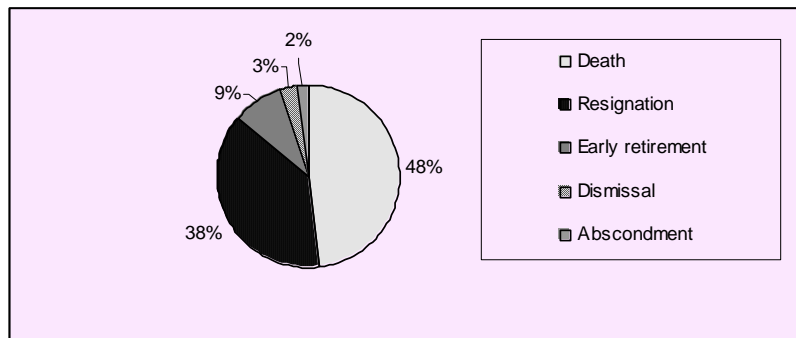
2.2. Policy perspectives, priorities and key goals on HRH at regional level

Steven Shongwe of the Commonwealth Secretariat ECSA Health Community said that there is a growing crisis in the region due to the high burden of disease including HIV/AIDS, TB, malaria, compounded by a decades-long HRH shortage. This manifests as:

- *inadequate allocation of resources* for HRH due to economic problems;
- the *impact of HIV/AIDS* on the workforce in terms of sickness, absenteeism and death;
- *attrition* caused by factors such as: low remuneration, poor working conditions, low job satisfaction, lack of equipment and technical support, and political and civil strife; and
- *migration*.

While 51% of health workers have AIDS-related illnesses; 57% of nurses report absenteeism on a weekly basis citing HIV/AIDS, attendance of funerals and nursing sick family members as the most common reasons. Causes of attrition in Malawi are shown in *Figure 1* below.

Figure 1: Causes of attrition among six selected districts, Malawi, 1996-2002 (n=527)



In order to ensure good human capacity development we need a functioning health system, appropriate levels of remuneration and incentives, good supervision and a system which enables client feedback. The role of regional organisations in this is to:

- play an advocacy role for human capacity development;
- document and share experiences on best practices;
- support relevant research including situational analysis in countries; and
- co-ordinate efforts in implementing country-driven HR plans and policies.

We need a holistic approach, with co-operation from a broad range of stakeholders, to resolve the HRH crisis. ECSA has already:

- researched the impact of HIV/AIDS on health workers (Kenya, Malawi and Tanzania);
- undertaken a situational analysis of HRH in seven countries;
- supported harmonisation of training of health workers (ECSACON- Nurses and midwives, COSECSA – Surgeons);
- disseminated best practices/better practices in HRH management;
- reviewed staffing standards for delivery of essential healthcare packages;
- reviewed infection prevention and control in member states as many health workers are working in dangerous conditions resulting in health workers becoming sick; and
- provided a forum for policymakers, programme managers, researchers and health professionals (Conference of Health Ministers, Directors Joint Consultative Committee and workshops for HRH Experts).

2.3. Continental perspective: Africa region of WHO

Magda Awasas, WHO AFRO said appropriate, evidence-based policies, especially at the national level, are at the heart of any successful response to the HRH. However, policy determination in the region has weaknesses: Policies are created without evidence and not finalised, leading to problems such as non-adherence at the implementation stage. The main constraints to HRH include:

- poor human resource development policies and practices;
- poor financial resources and inadequate staff;
- uneven distribution of health workers at different levels;
- high attrition and low replacement rates;
- inappropriate and inadequate training with curricula that are not needs-based;
- theoretical partnerships between public and private sectors, but no implementation; and
- poor HRH monitoring information.

The key challenges underlying these constraints are:

- years of investment in disease control and under-investment in HRH and health systems;
- global shortages of nursing staff leading to increased migration;
- unequal economic development across regions leading to increased migration; and
- changing disease patterns: chronic diseases, aging populations and double burdens of disease in the region (due to HIV/AIDS, TB and malaria).

The health sector has realised the importance of HRH, but education is slow to catch up, with a lack of investment, poor facilities and poor materials, exacerbated by teacher migration. Therefore, we must give policy attention to:

- addressing the macro-economic factors that make employment of workers difficult;
- the workplace situation to improve morale, motivation and retention;
- sectoral policies that value health workers;
- remuneration pay and incentives;
- migration and ethical recruitment agreements, founded on a strong evidence-base;
- expansion of health workers, with the right mix of health workers whether it be creating multipurpose health workers or new cadres;
- effective HRH leadership in countries; and
- mobilising more HRH resources.

Global processes influence national policies, for better or for worse. International organisations may act as pressure groups, raising consciousness or encouraging countries to take a stand on policy. Some key global processes that are putting HRH on the global agenda include:

- UN Millennium Development Goals – 4 health related goals
- WHO's recognition of the need for HRH to ensure implementation of health programmes
- World Health Assembly Resolution on International Migration (2004,2005)
- the JLI Report
- the high Level Forum on Health MDGs (January-Geneva, December-Abuja 2004)
- UN Global Commission on International Migration
- World Health Report and World Health Day 2006 to be devoted to health workers.

Regional processes and strategies that have been adopted to support HRH development, include:

- Regional Strategies for development of HRH 1998, 2002
- WHO-WB stakeholders consultative meeting in Addis Ababa recognised the HRH crisis
- presentation of a paper on HRH at the AU summit in Durban in 2002
- WHO-IOM discussion of migration during RC53 - draft resolution taken to WHA 2004
- AU Policy Framework on Migration 2004
- regional consultative meeting on tackling the HRH Agenda (WHO/NEPAD/ACOSHED).

Some possible regional responses could include to:

- develop a guide to policy options (describing advantages/ disadvantages of each policy);
- support policy analyses to provide empirical basis for preparation of policy briefs;
- hold policy review meetings for critical HRH subject matters;
- implement research in support of HRH policy, planning and implementation;
- share country experiences and tested best practices;
- develop regional HRH planning and policy expertise/experts/consultants;
- promote HRH masters and short certificate courses in the region; and
- promote advocacy and dialogue in country and regional organisations (AU, WHO, ECSA).

2.4. Discussion on the presentations

The need to develop regional clarity on remuneration/ reparations from northern countries, including costings and mechanisms for payment were highlighted and would facilitate advocacy in northern countries. Given high levels of attrition the possibility of overproduction for financial gain was mooted. More research in this area is needed.

The strength of political will to tackle HRH challenges was questioned. Criticism was directed at international organisations which dictate policies based on their own agendas that can be detrimental at country and regional level. Delegates questioned the promotion of private-public partnerships, given the weak return from private health care providers to the public sector through training and work experience and given that public health care is more equitable.

While there was support for regional training and collaboration, it was acknowledged that regional training and collaboration can only work in an environment of common educational standards. Regional quotas for health worker training need to be examined. In-country training is still relevant given that health workers should be able to work and train concurrently. In Namibia training is difficult due to limited capacity for training supervision at hospitals and lack of trainers. The production of health workers has been stepped-up because of AIDS but this will take time to have an impact. Namibians can train in other countries subject to the quotas set by the host-countries. However scholars often do not have the requisite qualifications.

To encourage effective implementation, policies need to be backed by legislation. The problem of absenteeism in Malawi was discussed and it was noted with concern that health workers are often absent because they were attending funerals. There is a need to develop appropriate and culturally sensitive policies for this. In addition many health workers in Malawi are absent because of illness - often HIV/AIDS. Further research is required to establish levels of occupational infection.

3. EQUINET HRH research findings

Chair, Honourable Blessing Chebundo, MP Zimbabwean

3.1. Context and overview

Antoinette Ntuli explained that the EQUINET HRH research took place in the context of an international absolute shortage of HRH, exacerbated in Africa by globalization, HIV/AIDS, fragile health systems, poverty, and net outflows of health workers. The research takes place in a changing landscape: previously there was a dearth of information and isolated pockets of research, a discourse confined to discussing push/pull factors, and policy options chosen ad hoc with limited effect and at great cost to the health sector. Now there is a sense of a shared problem, but with different diagnoses and a mushrooming of initiatives to tackle the problem. While there has been some discourse around ethical and redistributive justice, there is also a bewildering array of policy options, policy debates and choices, with insufficient synthesis of options and a reduced capacity of source countries to investigate options. Policy options focus primarily on production of health workers, migration (in-country/region/international), and retention.

3.1.1. Production

Policy around the production of health workers focuses on *training* and *skills mix*. With regards to the skills mix of health workers, there is need to explore how to produce alternative cadres of health workers, and research further the role of invisible workers,

such as traditional healers and community health workers. With regards to training, more attention is needed on:

- the relationship between maths and science at school level and entry into medical schools;
- curricula based on health priorities rather than not training ideally suited for export;
- the language of instruction;
- the impact of migration on training institutions e.g. depletion of academic staff;
- health resource management (little work has been done in this area); and
- the need for increased production in the North.

The main dilemmas facing policy makers with regard to the production of health workers are:

- producing health workers is a long, slow process, causing a time lag, therefore this is often not a popular policy option;
- lack of recognition and valuing of professionals; and
- resistance to alternative cadres from professional health workers and from planners who confine their attention to the doctor-nurse paradigm, which is a legacy of colonialism.

3.1.2. Migration

Migration 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. 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.

3.1.4. Retention.

Challenges within health systems lead to poor recognition or job satisfaction, creating a push for migration. Many retention issues also lie beyond health sector. However, retention strategies should include:

- the removal of ceilings on public sector spending imposed by donors;
- strengthening health systems;
- developing human resource management capacity; and
- financial and non-financial incentives.

There needs to be a balance between financial and non-financial incentives, but more research is needed on how to achieve that balance. The enormous array of incentives is outlined in the table below:

Table 1: Incentives for health worker retention

Financial incentives	Non-financial incentives
<ul style="list-style-type: none"> • salaries • scarce skills and rural allowance • housing allowances (Zimbabwe urban and rural) • permitting dual practice • additional Duty Hours Allowance (ADHA) • reasonable access to loans (Caribbean states) 	<ul style="list-style-type: none"> • sound HRM policies and practices • improving job satisfaction • occupational safety • career paths; training opportunities: CME, study leave • adequate day-care facilities • recognition • deployment procedures • housing, schooling and other infrastructure

The EQUINET and HST focus to date has been to outline major dimensions of (in)equity, examine policy options across SADC, and discuss and review findings. Our activities have included: a literature review; a call for research proposals, a 2004 meeting to develop the framework and refine research, a 2005 meeting to share research findings and develop a way forward, and follow-up activities such as dissemination, policy briefs, advocacy, research. Within the EQUINET framework, we have sought to understand:

- the development of **equitable** HR policy;
- the development on **ethical** HR policy – what will make workers stay; and
- the **impact of HIV/AIDS** epidemic upon distribution of health personnel.

To date we have undertaken five country research studies complemented by a study on the policy environment at regional and country level.

3.2. Distribution of Pharmacists Trained at the University of the North, RSA: Factors Influencing Choice of Workplace/Sector

Yoswa Dambisya of the University of Limpopo highlighted the inequitable distribution of pharmacists between the public and private sector, between rural and urban areas, between bigger and smaller urban areas, and between richer and poorer provinces. Only 10% of pharmacists work in the public sector, where there is an average of 3.1 pharmacists per 100 000. The objective of the research was to:

- trace the whereabouts of graduates trained by University of Limpopo;
- investigate the factors that influenced location to present stations;
- assess the relative contribution of various factors to the choices made by graduates;
- assess satisfaction of graduates;
- solicit suggestions for improvement; and
- initiate and encourage the involvement of graduates in the Pharmacy School activities.

The research methodology included descriptive participatory quantitative and qualitative studies with graduate pharmacists, 449 of whom were registered, with some still pending registration. 233 questionnaires were circulated and received 129 responses were received.

Those from rural areas were more likely to be working in rural areas, and those from rural areas were also most likely to be working in the public health sector. The top four reasons given by graduates for choosing their present job included:

- the job provided an opportunity for professional development;
- they were able to provide service to the community;
- a combination of the above two factors; and
- they had no other choice.

Only 3.6% cited pay as the sole reason for choosing their job, although 18.8% said they chose their job because of the pay in combination with other factors.

While 28% of respondents did not provide a reason as to why they might change jobs, the most common reason cited was pay, followed by the opportunity for professional development, and then a combination of these two factors. A further reason why pharmacists might be motivated to change jobs is to seek better job satisfaction elsewhere. Respondents said they would choose pharmacy as a profession, if they had a chance to qualify for something else, because the profession was enjoyable, challenging, lovable, interesting and dynamic, and employment opportunities were good. But some said they would not choose pharmacy again because of poor pay, too much work, the government attitude and regulations, and poor job satisfaction (with no relationship indicated between income and job satisfaction).

While 65% of graduates were working in the public sector and 56% in public hospitals, in the long-term most did not anticipate they would stay in the public sector. Graduates indicated they would consider work in rural areas if there was:

- better pay and more incentives;
- improved infrastructure: schools, roads and shopping facilities;
- a clear promotions structure;
- recognition of the profession;
- less government interference; and
- better administrative structures.

In conclusion, outward migration was not a major issue with these graduates, many of whom are working in the public sector, but they expressed the intention to leave the public sector, mainly for pay reasons, even though pay is not a factor in determining job satisfaction.

3.3. Distribution of public sector health workers in Zimbabwe

Oliver Mudyarabikwa of the University of Zimbabwe attributed the HRH shortage in Zimbabwe mostly to attrition, particularly for nurses and doctors. Lack of incentives, poor salaries and poor conditions of service underpin attrition. Attempts to retain staff have had limited impact: 24.6% of health workers have HIV, 40% of nurse posts and 55% of doctor posts are vacant. Most health workers are employed in the public sector, the major healthcare provider. The private sector is growing but data on this is limited; there is also almost no data on how many health workers are employed in the NGO sector. The research sought to establish the exact sectoral distribution of health workers in Zimbabwe (including rural and urban distribution), identify policy gaps impacting on equitable distribution, and make recommendations in this regard.

The Public Service Commission (PSC) and Ministry of Labour determine technical policies about the conditions of service of all workers, including health workers. There is a mismatch between staffing levels needed by the MoH and the PSC allocation. For example, the MoH says it needs 1532 doctors and dentists, the PSC recommends the employment of only 690. However in 2000 only 545 of those posts had been filled. In addition, deployment policies are biased towards where the capacity is strongest. The absolute shortage of HRH is compounded by maldistribution which particularly affects rural areas, so there is need to create more posts and policies for rural areas. Initiatives to correct maldistribution have had little impact so far, although decentralisation into specialised units has the potential to achieve improved health equity.

Optimising HRH requires concerted action, including:

- gathering more information on how many health workers work in the private sector;
- declaring a moratorium on expansion in urban areas, while prioritising expansion in the rural areas, by encouraging health workers to move there;
- the speedy restructuring of the Health Services Board (HSB) to retain the momentum of changes in the distribution on HRH; and
- inter-sectoral coordination to optimize HRH activities.

There is need to develop mechanisms for each sector to contribute to the national health system, increase the productivity of available HRH, and learn lessons from each other.

3.4. Perceptions of health workers on conditions of service in Namibia

Scholastika lipinge of the University of Namibia indicated that the MoH is the main employer of health professionals in Namibia. However, migration to the private sector and from rural to urban areas is increasing. Qualitative research, undertaken in the

Khomas region, attempted to discover the reasons behind the movement. Using focus group discussions and individual interviews with health managers, doctors, nurses, environmental health officers and social workers, the research asked:

- Why are health professionals moving?
- Why are they staying?
- What suggestions do they have for retention?

The research describes the health professionals' perceptions of current service conditions, suggests improvements to current service conditions, and makes recommendations to the MoH.

Health workers highlighted the main reasons for leaving their previous jobs as:

- financial issues such as accessing pension and getting better salary in private care;
- occupational issues such as work-related stress, burn out, the risk of infection with poor preventative programmes;
- human resource management issues such as career movement and staff appraisal; and
- macro-environmental issues, e.g. infrastructure, supplies, communication and recognition.

The reasons for staying in existing jobs included fringe benefits and social benefits, salary, job security, loyalty and patriotism, and fear of the unknown. Suggested retention strategies include:

- rural workers should be given incentive packages;
- a bonding period;
- career development for professionals, with career paths opened up; and
- address staff shortages.

Overall, health workers want recognition and acceptance, and better conditions of service.

Recommendations emerging from the research are:

- improve service benefits, especially privation allowances for rural and high risk;
- allow workers to access their pension if needed;
- revise HRM systems, including promotion, capacity-building and appraisal system;
- explore horizontal diversification;
- revise the staff establishment to correspond to the current patients' needs; and
- introduce a bonding system through loans and bursary to health students.

3.5. Survival and Retention strategies for Malawian Health Professionals

Adamson Muula of the Malawi College of Medicine said the shortage of health professionals in Malawi was a result of the low output of training institutions, attrition due to ill health and death, and health worker migration. From a pool of 3000 nurses, 80-120 nurses are leaving a year; a quarter of doctors trained in Malawi doctors had gone abroad for further education and 36% of doctors in Malawi are non-Malawian. This research aimed to identify possible strategies to help retain staff and determine sources of income for health professionals, working practices of health professionals influencing retention, and the attitudes of health professionals towards various forms of out-of-formal employment incomes.

HRH in the public sector use a range of strategies to survive. *Cost saving measures* include working close to the home village, choosing to work in rural areas and walking to work. *Income supplementing strategies* include: using benefits that accrue from short

and long term training, allowances and per diems from meetings, doing additional locum or part time work, and working overtime at public health facilities. More *controversial strategies* include treating private patients during official work hours, getting double salaries and salary supplementation, consultancy duties, providing services to their places of work, involvement in small to medium sized businesses, stealing drugs, and use of institutional resources for non-work related personal use. Health workers perceptions of these survival strategies are mixed.

Recommendations from the research include the expansion of recruitment and training of medical, nursing and paramedical workers, strengthening the Health Sciences Commission, increased opportunities for both local and regional post-graduate training for medical doctors, and reviewing the impact of the policies that had already been put in place to ameliorate the loss of HRH including the introduction of new cadres, increasing enrolment at training colleges, reviewing the recent 52% salary increment, and the re-employment of retired personnel.

3.6. Supporting retention of HR: SADC policy context

Lucy Gilson from the Centre for Health Policy reported on their research which undertook regional and national (in Malawi, South Africa and Tanzania) rapid appraisals of HR initiatives/policy action to stem migration. National, regional and international documentation were reviewed and interviews were conducted at a national, focusing on staff retention in rural and public services. While there was renewed urgency regarding HR retention, policy implementation was limited, with a lack of clarity about the policy alternatives and how to get implementation. At an international and regional level, the wave of initiatives (see *Table 2*) which focus mostly on migration, HIV/AIDS and global initiatives, can be enabling, but can also impose additional pressures.

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	ECSCA conference	
	WHA resolution		
2003	Commonwealth ethical recruitment code		
	NEPAD health strategy		
2002	WHO regional committee for Africa AU heads of state meeting, 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

While retention is acknowledged as key, there is a need for country-led policy options, action and implementation. There is little agreement on the amount and kind of external support needed, whether it is technical assistance or creating an enabling environment. National policy environments have in common an absolute shortage of HRH with exaggerated difficulties of staff retention in rural areas. These are influenced by socio-

political transition, macro-economic policies and public/health sector reform programmes, creating an unstable environment that is difficult to manage, with a resulting detrimental impact on health workers. In addition, in South Africa the for-profit sector is raising expectations of working conditions and salary levels. A number of national policy options are being explored including: recruitment, financial incentives, skills development, non-financial incentives, production, structural and migration. While Malawi has a special commission tackling HRH, Tanzania has centralized HRH recruitment, and South Africa has created a number of bilateral agreements. Implementation is limited and there is no coherent package of actions to strengthen non-financial incentives or production.

With regard to policy development, past experience often informs how problems are tackled, the specific context shapes what is or is not considered and what is feasible, and international actions also drive and shape change. However, the key challenge is implementation, while:

- there is a limited high level political support (except in the case of Malawi);
- there is contestation around policies, with strong professional groups whose voices need to be heard;
- the health sector is often a weak player, for example, in persuading Ministries of Finance to give more resources to the sector;
- individuals tasked with doing this work are often few with limited networks;
- each country has complex reform environments which we must work with in order to bring about necessary changes;
- difficulties of government co-ordination, especially across government departments;
- it is easier to go for simple solutions, like financial incentives, but there is concern about impact of financial incentives on health workers' view of themselves, therefore it is important to look at non-financial incentives, using multi-sectoral approaches, with dialogue and action across a range of actors, including the health workers themselves;
- actions must be responsive to the local contexts; and
- review what we already know and provide information on the various options.

4. Plenary discussion on the research

Chair, Uta Lehmann, School of Public Health, University of the Western Cape. The discussion explored key issues raised in the research and the reporting of this is clustered in major areas.

4.1. Regional agreements

Delegates discussed agreements between SADC countries not to poach from each other. Namibia, for example, does not poach workers, but has agreements with other countries – not individuals – to employ some of their health workers. South Africa, has put in place measures to restrict employment of HR from neighbouring countries. Potentially more agreements could be made through organisations such as the AU, the Pan-African parliament and SADC. International institutions should support plans made within the region. Some delegates questioned the fairness of regional agreements as they prevent health workers from making choices about where they want to live and work and may in fact stimulate health workers to seek work outside the region.

4.2. Production of health workers

The over-production of health workers by the South to service northern countries was not seen as viable. It was considered unlikely to happen according to terms set within the region, and the production of human resources for 'sale', with the governments of the region profiting from the exploitation of the health workers in the host countries was not

seen to be desirable. Health worker production could be improved by registering and recognising other categories of health workers such as traditional healers and community health workers (for example some pilot projects underway in South Africa are building mutually beneficial working relationships between primary healthcare workers, medical practitioners and traditional healers in attempts to strengthen responses to HIV/AIDS). Delegates called for lifting of freezes in countries in the region on hiring healthcare workers for the public sector, given that these result in unemployed health workers to seek employment elsewhere and leave gaps in health systems.

4.3. Migration

There is a huge imbalance in how migration happens, with workers from the south moving to the north and expensive consultants, demanding high salaries, from the north coming to the region. Northern countries often do not invest enough in producing their own healthcare workers and use migration to cut costs. While HRH migration might not always be bad, the loss of health workers from the region where they are critically needed, to regions that need them less is fuelling inequity. HRH movement is undermining our ability to deliver equitable public health systems; therefore we need to focus on retaining public-sector workers and improving equitable distribution of health workers.

The migration of health workers from public to private sector creates access problems for the poor as (e.g. in South Africa the private sector serves only 17% of the population). In some countries, like Zimbabwe, it is not as big a problem since most migration is not to the private sector, but to other countries. It is possible to have a public-private mix, for example in Canada, the public sector is the main provider, but private practitioners may operate under strict guidelines. However, the public sector is proven most effective in delivering healthcare to the poor.

4.4. Tackling staff retention and absenteeism

Given the effective freeze on or limits to hiring of healthcare workers, there was discussion about how efficiency could be improved in the present circumstances. This covered, for example, tackling absenteeism by using incentives similar to those used to retain staff. HIV/AIDS related absenteeism, highlighted in the Malawi case study, could be alleviated by targeting health workers for HIV/ AIDS care (e.g. providing medicines and counselling). In Malawi 70% of health workers are receiving ART; similar strategies should be adopted in the rest of the region.

The efforts of Zimbabwe towards staff retention were highlighted, although it is still too early to tell if these strategies are working. Two specific strategies discussed:

- providing post-graduate education in the public sector, with preference given to those who have worked in the public sector and/or rural areas for a long time; and
- allowing for joint public/private sector work, which was illegal until 1998.

Regarding pharmacists in South Africa, promotions structures were a major factor contributing to migration out of the public health system, as pharmacists could only secure promotion if another post became vacant. Pharmacists strongly felt that their ranking should improve as they gain experience, not only if they move to another post, so that they would not be motivated to move from rural areas to urban areas to seek a higher ranked post.

4.5. Communicating with policy makers

The importance of developing a strategy to keep these issues on the agenda and of taking the research results and discussions to policy-makers was highlighted. In

particular, the research on pharmacists was highlighted as needing review by the South African Health Portfolio Committee.

4.6. Issues for further discussion

Uta Lehmann highlighted issues that need further discussion and exploration:

- how health workers are being looked after;
- keeping the diaspora on the agenda;
- the interaction between local, national and international policy and implementation; and
- the possibility of over-producing health workers to supply richer countries.

5. Group discussions and report back

Chair, Lydia Nashixwa, Ministry of Health, Namibia

Three areas of policy were identified for further exploration. These were how to:

- value health workers through non-financial incentives (career paths, management, information systems, access to ART, access to housing and services);
- respond to regional and international migration of health workers from our region to other parts of the world and also within the region – strengthening individual countries and also regional capacity to act as a block; and
- strengthen the relevant production of HRH.

Delegates formed three groups, each tackling one of these topics, and structuring discussions around:

- What should be the policy focus around equity dimensions?
- What policy implementation issues should we flag, and with regards to implementation, do we need better co-ordination or new co-ordination?
- What are the evidence or knowledge gaps?
- What are the priorities for action?

5.1. Group 1: Policies that value health workers

Specific areas of policy focus were identified, viz training and policy in supervision/management to improve these areas; review of existing policies to see how that can be improved, synergized and implemented; improvement of workplace programs and OH&S programmes and information on health workers health, including mental health, HIV/AIDS.

Overcoming barriers to implementation include promoting consultation including through professional organizations, communication between levels and ensuring that there is an implementation plan as part of policy-making process. Research and exchange on best practices can support this.

Non-financial incentives are a major factor in valuing health workers. These include improving: working conditions, relationships between health workers and managers, and workplace programs to address health concerns of health workers (OH&S, mental health, etc.) In rural areas, incentives such as the provision of housing, education, water and electricity for health workers are also essential. Strong labour relations and union/employer bargaining councils, such as those in South Africa, are essential to negotiating incentives.

5.2. Group 2: Policies that respond to regional and international migration

There are gaps to be addressed, viz: information about who is going where and how, within and outside the region; levels of remittances; costs of migration and reasonable reparation based on a better understanding of the complex causes, including the costs of training; lack of treatment for patients – resulting in worsening illness and death and impact on productivity cost. Better evidence is needed of the impact of globalization, GATS and neo-liberalisation on healthcare; of which healthcare workers want to come home and what are the barriers and how best to channel funds from reparations.

Follow up work is needed to examine policies between UK and SA on ethical recruitment to find out if ethical recruitment is working; what the restrictions are on ethical recruitment in terms of not violating human rights; and whether bilateral agreements are effective and should we rather focus on cohesive regional agreements. Such work should identify how host countries can address training, salaries and incentives for health workers in their own countries and subsidise salaries in poor countries. There is also need to review the retirement age.

Host countries should lobby International Financial Institutions (IFIs) such as the IMF and World Bank to: address Structural Adjustment Programmes (SAPs) which create ceilings on the employment of health workers in the public sector; rapidly administer debt cancellation; have less rigid policies to encourage HRH retention; and not impose further conditionalities in order to alleviate push factors. There needs to be follow-through on theoretical agreements to self-sufficiency (WHA 2006).

More thought on regional issues is needed. Some delegates believe the region should engage with precision costing and analyses of health system requirements to establish what kinds of reparation required. It is an issue of justice issue, and this perspective should not get lost in the technicalities of costing issues. Trade and finance ministries in the region lacked the policy and will to collaborate on a number of issues pertaining to HRH, and refused to take up the issue of remittances. While a lot of research has been done highlighting the impact of policies like GATS on the health sector, trade ministries are not making interventions on this level when adopting policies.

5.3. Group 3: Policies that strengthen the relevant production of HRH

Relevant production of HRH should:

- be needs-driven → adequate numbers, appropriate skills mix
- create regional harmony on production of HRH (SADC, ECSA, WHO Afro)
- ensure implementation of SADC protocol of health, including HRH, which broadly defines health in the region and has been ratified by most countries.

There has already been debate, standard-setting and policy-harmonisation around high-level health workers, such as doctors and nurses, but these debates, standards and policy-harmonisation need to be extended to mid-level health workers “foot soldier” cadres.

On training, tertiary institutions are rigid on curriculum and it is difficult to influence changes. While WHO provides some common standards for institutions, such as the 8-star pharmacist, it was unclear if the region had any influence on determining these standards. Research is needed on how to:

- break barriers in HR production across different countries;

- create curricula that are needs-driven and transformative, e.g. inclusion of community-based activities, PHC, HIV/AIDS counselling, etc.;
- influence regulatory bodies, e.g. HPCSA, SAPC, SANC to move training institutions towards appropriate HRH production; and
- integrate traditional healers and community workers into the public health system, as well as understanding their skills, competencies and the roles they are best suited to playing.

There was some inter-sectoral collaboration in countries:

- in South Africa the departments of social services, health, welfare, education work together to produce curricula and budgets for HRH;
- in Zimbabwe, there is liaison between the Ministry of Health and the University of Zimbabwe in setting targets and budget justifications;
- in Malawi the university is autonomous, with the budget directed to treasury, although a government official is a member of curriculum committee; and
- in Namibia the process of curriculum development is co-ordinated by the Ministry of Education, although the MoH identifies priorities.

But regional harmony on inter-sectoral collaborations for HRH training and common standards for professionals such as doctors and nurses were lacking.

There is an absolute shortage of health workers and, therefore, we need to look at training of community health workers and traditional healers and midwives especially in the field of HIV/AIDS, as is being done in South Africa. We also need to develop policies around this. Regional harmonisation is starting to happen as there is a strong and vocal push with regard to this issue, especially related to procurement of medicines. The production of health workers needs to be understood through an equity lens, i.e. ensuring: a needs-driven focus, an equitable selection of students, and an equitable resource allocation in terms of funds and budget.

6. Policy perspectives and actions across by regional and international level

Hon Siza Njikelana, Member of Parliament, SA chaired the session

6.1. Brain Drain of Health Professionals from South Africa to Canada

Ron Labonte of the University of Ottawa pointed to the fact that without foreign-trained health workers, the Canadian health system would be in crisis. Their research sought to identify trends among health professionals, summarise push/pull factors (see *Table 3*), examine costs/ benefits, and summarise views of Canadian policy stakeholders.

Table 3: Push/ pull factors for health workers moving to Canada

Push factors	Pull factors
<ul style="list-style-type: none"> • No jobs, no promotion • Poor pay, deteriorating facilities • Inadequate supplies • Stress, overwork • Political/racial upheaval • Gender discrimination • Gender violence • Personal insecurity (theft, violence, HIV) • Poor accommodation, lack of transport • Poor education for children 	<ul style="list-style-type: none"> • Reasonable remuneration • Regular workload • Reasonable working conditions • Canada 'safe, not corrupt' • Canada 'tolerant' with good quality of life • Available jobs • Greater opportunities for children

Interviews were conducted with South African-trained physicians and Canadian health policy stakeholders, Canadian data on foreign-trained health professionals working in Canada was analysed, and a literature review was conducted.

One in five Canadian physicians is foreign-trained, with 8% of South African doctors and 6% of Ugandan physicians now practicing in Canada, and a surge in Nigerian physicians. About 7% of nurses are also foreign-trained: although most of these come from the UK and Philippines, 432 registered African nurses were working in Canada in 2002. The Federal government controls immigration, but decisions on health systems staffing are made in, so that, for example, the province of Manitoba uses mostly African-trained professionals. None of the health workers in our sample had been actively recruited, but had been encouraged to move by family and friends already living in Canada and the desire to seek better opportunities. While all Canadian policy-stakeholders were against active recruitment, passive recruitment was taking place by:

- word of mouth, with the internet making passive recruitment active;
- advertising positions globally, because of poor local HRH planning; and
- easing the immigration process for health professionals by:
 - allowing physicians to take evaluating exams in 8 other countries;
 - introducing an immigration points system based on education biases in favour of health professionals (notably physicians); and
 - introducing new federal funding to assist health professionals migrating to Canada and to increase training spaces for registration of foreign-trained health professionals.

An agreement between the Federal and provincial governments on a “Provincial Nominee Program” allows the fast track migration of skilled workers for provinces which have a deficit, by making jobs available and streamlining the process for health professionals to enter Canada. Although there is not yet data on the actual numbers of health professionals being recruited, nor on their countries of origin, in British Columbia more than 25% of the nominees in this programme are health workers, and in Saskatchewan 22% of nominees are now health workers.

Canada has poor HRH training program - worse than other OECD countries – with a focus on controlling costs, rather than the need for trained professionals. Now the call is growing for Canada to create domestic self-sufficiency. This means exploring policy options of voluntary mandatory codes of ethical recruitment, improved HRH planning in Canada, and bilateral and multilateral agreements to mitigate problems at source. While respondents mostly agreed that better HRH planning was needed in Canada, there was a concern that the USA would benefit unduly from this. Most agreed that health systems should be strengthened in source countries, but felt that it was outside the mandate of Canadian health systems. While there is strong support for proper HRH production in Canada, there is only limited awareness and not much political will to tackle or address source countries’ health system problems. Most respondents did not support the policy options of bonding, training lesser-skilled workers in source countries, immigration restrictions, or reparation payments.

The next steps in this research will be to:

- finish quantitative analyses and study of PNP;
- hold a policy colloquium in Ottawa; and
- analyse the Memorandum of Understanding between Canada and South Africa.

It was noted in discussion that calculating a figure for reparations was a complex issue, but in any case it seems as if health workers in Canada do not acknowledge that

practitioners from southern Africa have been trained at tax-payers expense and this is the basis of reparations claims. To get reparations back on the agenda, Canadian researchers are investigating a formula, while acknowledging that this process should be driven by southern African countries and the region, not by donors who might impose conditions, etc. which will do more damage than good. It was emphasised that human rights discourse around migration should not be used to mask the inequities. It was suggested that Canada only recruit public health workers, who had already “paid back” with service to their respective countries-of-origin, but it was noted that most South African doctors in Canada were from the public sector; therefore such a policy was unlikely to have an impact.

6.2. Southern African Development Community (SADC)

Erika Malekia from the SADC Health Secretariat said the main objective of SADC is to assist co-ordination between countries. SADC has need of policies to enable effective functioning of HRH and there for additional funding, monitoring and training agreements. The SADC approach to HRH is guided by three policies, the human rights agreement, the health protocol and the education protocol (with specified qualifications framework, centres of excellence). A unit to deal with HRH is working with EQUINET and others, and SADC is developing a regional HRH policy. After this meeting, they anticipate needing help to draw up a draft concept paper and terms of reference to facilitate the development of draft HRH policy guidelines to be submitted to the Ministers of Health for approval. Hopefully, these would then be presented and endorsed at a regional summit next year, in order for each SADC country to start adopting the policy.

6.3. SIDA

Par Erikson said SIDA was supporting the development of HRH work in the region, including:

- international initiatives such as the Oslo consultations;
- regional organisations and projects such as EQUINET, HST and SADC; and
- in-country programmes, for example, in Zambia SIDA worked with the MoH to address HRH issues, develop a human resources crisis plan, fund research into retention and computerise handwritten nursing council information.

6.4. International organization on migration (IOM)

Liselott Joensson of IOM (www.iom.org.za) said this intergovernmental organization was started to bring back migrants displaced by World War 2. However, the remit of IOM work now includes migration and development, facilitating migration, regulation of migration and forced migration. Since 2001 the overall framework has been to assist governments to achieve the MDGs by mobilising human and other resources from the SADC diaspora and encouraging them to return home. IOM has been involved in facilitating: dialogue on migration policy options, small-scale enterprise development, information campaigns, skills transfer, assessment surveys and database development, and management of remittances. Practical examples of IOM work include:

- creating an IOM-WHO database of health professionals in the diaspora;
- assessment of skills among the Zimbabwean diaspora in the UK and South Africa;
- assessment of skills migration in Angola and Zambia and recommendations for action (health and education Sector); and
- creating a database on Ethiopian expatriates and a website about the Ethiopian diaspora.

IOM responses to health worker migration include:

- improved data collection and analysis on migration flows;
- dialogue on migration policy options;
- the return of African health workers and dialogue with the diaspora;
- recruiting foreign health workers to Africa (with a focus on ART rollout);
- technical cooperation to improve migration management; and
- advocacy to put health worker migration on national and regional development agendas.

6.5. HRH Advocacy: Perspectives from the United States

Eric Friedman of Physicians for Human Rights (PHR) described their HRH advocacy work. At the G8 in July 2005 there was no US HRH initiative despite intense advocacy efforts. However, a commitment was made to support improved African health systems, training and health worker retention, but targets, timelines and funding levels must still be developed. The pending Global Health Corps bill to create a corps of volunteer health workers; and in PEPFAR (US AIDS initiative) HRH was seen as a major obstacle. \$93 million was given to retention activities, salary support, human capacity development and congress was required to develop strategies to meet HRH needs. However, PEPFAR still had no staff headquarters and the process lacked focus, investment and strategic HRH planning.

Proposals were submitted for the Global Fund to Fight AIDS, Tuberculosis and Malaria to include health system strengthening and PHR was part of the initiative towards a WHO resolution at the WHA in May 2005 to develop: strong HRH/health systems strategies and funding proposals, integrate health systems and HRH strengthening in vertical disease programs, and promote national progress in HRH and health system strengthening activities. They are now participating in drafting the UN MDG summit which commits to launch a global initiative on health systems to strengthen HRH and health system needs required to achieve the MDGs.

There were advocacy opportunities to speak to USAID country representatives (by 29 September 2005) about developing country operational plans, including a health workforce plan, and a computerised nursing database (created by CDC and Nursing Council of Kenya). Other opportunities for taking the advocacy work forward are:

- Africa Partnership Forum meeting in October 2005 with G8 countries, other donors, African countries, international institutions to clarify G8 commitments.
- The next round of Global Fund discussions (which may only occur in 2007 due to funding shortfall) to push for strong technical support to grantees to ensure successful implementation, and clearer guidelines on HRH and health system strengthening.
- At the next G8 meeting in Russia in 2006 we should push for firmer HRH commitments.
- Pressure the World Bank to provide more HRH funding, including through AIDS grants

In future PHR will engage PEPFAR on the need for continued increase in health workforce investments, and work to ensure HRH strategies are developed and funded in all focus countries. "PEPFAR 2", is a PEPFAR follow-up with a health systems focus. Through the Global Health Workforce and Health Systems Initiative there is a proposal to budget for HRH and health systems or for additional funding to come through PEPFAR. The Health System Action Network also aims to support advocacy, catalyse partnerships,

share information, network people and organisations, and create databases of lessons learned. This can work to develop clear targets to drive action on HRH and health systems. PHR is delivering the message to the US and other wealthy nations that we cannot meet health targets (AIDS, MDGs) without investing in health systems and health workers.

The PEPFAR initiative was discussed, with a concern expressed that community health workers (in Mozambique and Angola) should be supported, but not used as cheap labour, as this has become increasingly difficult under current economic climate. More money is needed to develop these plans at a regional level, possibly with the invitation of SADC. There is also a concern that northern advocacy initiatives should not generate additional demands on the south, further undermining health systems, and therefore it is important that these initiatives are country-driven.

7. Proposals for key areas of follow up

Rene Loewenson, EQUINET summarised the discussions so far in terms of the policy proposals arising, the equity lens on these and the regional issues for EQUINET and other regional organisations. This is summarised in the three major areas below:

7.1. Valuing health workers, noted to imply areas of

- *Policy review/ support for policy implementation*: through non-financial incentives, training in HRH supervision, management and communication, HIS, and health worker health;
- *Review and dialogue on policy implementation*: on how policies are implemented, best practices, exchange programs, roles of professional associations and industrial relations.
- *Equity lens*: particularly on how far policy packages, capacities, systems for policy implementation across all areas of government support equitable HRH distribution and retention.
- *Regional issues*: arise in information exchange, exchange programmes and policy dialogue, and harmonization of systems, policy measures, standards on working conditions.

7.2. Relevant production of HRH, noted to imply areas of

- *Policy review*: i.e. adequacy, selection, inter-sector collaboration standards, mechanisms for influencing training institutions on needs, equity orientated HRH training
- *Equity lens*: is applied in defining how far needs are driving policies, how we are reflecting this through selection criteria and how a focus on career paths supports auxiliary levels, especially district and primary care level cadres?
- *Regional dimension*: arises in exchanging info, standard setting and standard setting processes, harmonised production of HRH and regulatory bodies.

7.3. Responding to migration, noted to imply areas of

- *Closing the evidence gap*: on migration (levels, flows and causes), financial flows, costs (benefits, losses), return intentions
- *Mapping effectiveness of current policies and assessing policy options*: agreements and codes currently in place; agreements to self-sufficiency; lifting IFI ceilings; debt cancellation, political commitments.
- *Informing a regional policy framework for international engagement (especially the WHA resolution)*: Within the region issues arising are review of retirement age:

bonding, return/retention incentives; internationally this implies attention to reparations form (aid, training, salary subsidy) and cost, training in recipient countries.

- *Equity lens*: The equity question is what is fair policy? How to operationalise it?
- *Regional issues*: arise in giving policy attention on HRH, building a policy framework, policy engagement at regional level, supported by an evidence base and monitoring.

Delegates in groups were asked to discuss what actions/work must be taken forward, by whom and at what level on each of these areas. The feedback is reported within the three major areas below.

7.4 Actions on valuing health workers

- Management systems should be put in place*: supervision guidelines, job descriptions, induction guidelines.
- Managers need to use systems*: need skills, resources to do work including research, need to be motivated from below and above, be given authority to implement
- HIS for HR*: workplace systems and programmes in place to gather information about motivation, absenteeism, hours of work, workloads, etc.
- Training*: workers and managers need training with equal opportunity to attend any training, including hands on training, teaching moments in workplace and monitoring of in-service training, with information kept on the kinds of training undertaken so that there is info on that.
- Non-financial issues*: facilities, housing and schools in areas where health workers are working needs to be looked at across sectors, such as health, transport and public works.
- Research*: Before any changes can be brought in to assess workplace conditions and needs; then implementation, followed by research on effectiveness and impact of implementation.

These actions need to be taken by a chain of managers across the system, at local, regional and national level, training institutions and researchers. Most of these issues need to be tackled at a national level, but sharing of ideas on a regional level is also important. At an international level, WHO could monitor and record country's performance and communicate that to other countries.

Organised labour should provide leadership around HRH at national and regional level, and also help to monitor recognition for improved skills, personal interactions between management and workers, and recognition of good managers. EQUINET could add value by taking up the issue at a regional level and assisting with workplace research.

7.5 Actions on relevant production of HRH

The group identified follow up actions in

- auditing research, policy and collaborations at local, national, regional and international levels
- On a regional level: rationalising and harmonising efforts, resources and donor activities and identify centres of excellence within the region, and building capacity at other centres if needed;
- Co-ordinating regionally to influence the policies of WHO, AU, etc., and for policies to act as guidelines, rather than rules.
- At national level: developing country mechanisms to absorb or internalise externally-driven initiatives (from international bodies)

- v. At a national level: identifying country specific priorities with an inter-sectoral approach (e.g. training traditional healers appropriate to local settings to enhance skills
- vi. Developing regional and international information exchange to give concrete support to SADC initiatives, while SADC should also own the process by interacting with all stakeholders.

7.6. Actions on Migration

Actions can be taken

- i. To lobby sending countries to take the lead in generating data to build comprehensive
- ii. For recipient countries to release annual data related to their registered health professionals.
- iii. In WHO to have a HRH Observatory to provide, monitor and store data
- iv. To share data between donor countries and recipient countries.
- v. To explore policy options to promote remittances for development purposes (not purely private transfers to individuals) with governments matching those funds locally.
- vi. By WHO/ILO to hold a conference with recipient countries next year, on cost assessment: to aid discussions with recipient countries and to analyse different costing models.

At a regional level, we need policy initiatives around migration and mutual recognition of professional standards. We could also try to establish the return intentions of the diaspora and develop a relationship with those who have left to encourage their return, although this is not quite as urgent. At an international level we need to:

- examine the effectiveness of existing codes and develop new codes of ethical recruitment with clear objectives and targets, to bind and inform policy processes in recipient and sender countries, and ensure they are not used to promote mass recruitment initiatives;
- lobby for international agreements to make recipient countries self-sufficient in the production of health workers;
- lobby for lifting of IFI restraints;
- lobby for unconditional debt forgiveness;
- monitor bonding systems, while moving away from this ineffective policy; and
- review data on increasing retirement age.

8. Closing and future work

Antoinette Ntuli remarked that the equitable distribution of HRH is a complex, multi-layered and challenging area, with a strong equity dimension both within and between countries. The decades-long HRH shortage has now reached a crisis point. Health workers are often undervalued and asked to perform work outside their areas of expertise, creating patient-service problems, so there is a need for relevant HRH production, with an expansion of the right mix of health workers and right level of cadre. In responding to migration, advocacy is often focussed at an international level, as international inequities are easier to pin point, but we need to keep regional inequities on the agenda. The responsibility for HRH lies beyond the MoHs, and even beyond the health sector, requiring action by many actors on many different levels. Regional leadership must be supported and strengthened: we all need to commit ourselves to contributing to this and facilitate stronger resources within the region. Alliances and joint work from organisations at this meeting, will hopefully lead to collaborative work at

sectoral, national, regional and international level. As part of the EQUINET programme on the equitable distribution on HRH we will:

- distribute the report from this meeting within a month;
- distribute four country level studies and 2 regional syntheses as policy briefs and peer reviewed journal publications;
- feedback to MoHs at senior level; and
- hold country level stakeholder meetings from MoH and other ministries, professional associations, unions, etc.

This will be underpinned by maintaining network of researchers to strengthen capacity and regional responses.

The consensus statement from the meeting will be used to take forward to our governments in various arenas, including WHA 2006, as political advocacy is key to making progress in this field. The statement could help in developing strategies that dovetail at various levels in different parts of the world, and especially in gaining support for the need for reparation from northern governments, as well as promoting the improvement and self-sufficiency of health systems in countries that are losing health workers.

It was also agreed that it is not enough to push for policies and mechanisms, without locking those into implementation and legislative processes. The work needs to be taken forward in national health departments and regional structures such as the SADC Health Desk, with the work being integrated into a timetable for upcoming events.

Rene Loewenson provided the wider context of equity work and resources in EQUINET to support this work in line with SADC priorities on health, As shown in Table 4, these priorities increasingly reflect health systems issues, including HRH.

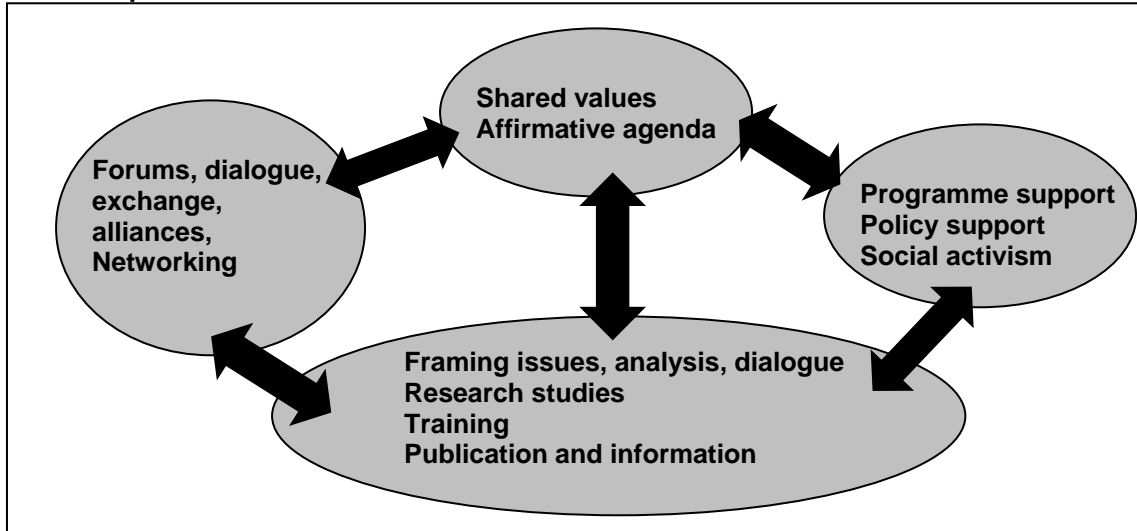
Table 4: SADC health priorities

SADC 2002	SADC 2005
<ul style="list-style-type: none"> • food insecurity; • access to safe water, sanitation, energy, transport, shelter; • HIV/AIDS, TB, Malaria and other diseases; and • illness and mortality related to reproductive roles. 	<ul style="list-style-type: none"> • HIV/AIDS, TB, Malaria and other diseases; • child health; • human resources for health; and • access to essential drugs with local production of medicines and linking with South America and India.

EQUINET work on ART expansion, fair financing reinforce, feed into and use the work on HRH, while the work on trade and health locates HRH issues within wider policy context and pressures. In this, as shown in Figure 3, EQUINET provides resources for research, training, policy dialogue, policy analysis and support for the development and implementation of policy.

More information can be found about EQUINET at the website at www.equinet africa.org. The site has a searchable bibliography, and all publications are in a fully-searchable database on the site.

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



Dotty Dikwayo of the SADC Network of Nurses told a story: “A fisherman was fishing and he caught a big fish and threw it back into the sea, and he got another big fish and also threw that back into the sea, then he tried again and got nothing and went away. When asked why he threw those big fish away, he said he didn’t have a big enough pot to cook the fish.” She said that we are not like that: we will not quit or be discouraged, we are EQUINETers and non-quitters. She gave recognition to and thanked everyone for their contribution, and urged delegates to give recognition to all others with whom they worked.

Appendix 1: List of participants

	NAME	E-MAIL	ORGANISATION/ COUNTRY
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Appendix 2: Programme

REGIONAL MEETING ON EQUITY IN THE DISTRIBUTION OF HEALTH PERSONNEL IN SOUTHERN AFRICA August 18th to 20th 2005, Sunnyside Hotel Johannesburg, South Africa

Friday August 19th		
9am	Opening and welcome Introduction to the meeting and delegates	
9.30am	Panel: Policy perspectives, priorities and key goals on HRH From the health worker At country level At regional level At continental level	Chair: Dr. Percy Mahlati NEHAWU (J van den Berg) Namibia Ministry of Health (M. Pendukeni), ECSA (S Shongwe) WHO (M. Awases)
11.00am	Tea/Coffee Break	
11.30am	EQUINET HRH research findings Context and Overview Country level findings SA, Malawi, Namibia, Zimbabwe Overall findings and policy issues; Regional policy priorities, space and capacities	Chair: Hon Chebundo A. Ntuli Y. Dambisya, O. Mudyarabikwa, S. Ipinge, A. Muula L. Gilson
1pm	Lunch	
2pm	Plenary discussion: Issues from the mornings presentations - structured discussion on key areas: Introduction to working groups	Facilitator: Uta Lehman
3pm	Tea	
3.15pm	Working Groups:	
4.15pm	Feedback from the groups and discussion	Chair: L Nashixwa (Namibian MoH)
Saturday August 20th		
8.30am	Reflections on the previous day: summary of future directions and institutional actors	
9.15am	Policy perspectives and actions by <ul style="list-style-type: none"> • Health civil society • Researchers in recipient countries • Regional institutions • International agencies 	Chair: Hon S. Njikelana SATUCC (M Kachima) Canada (R Labonte) SADC (E Malekia) SIDA (P Eriksson), IOM (L Joensson/B Rijks), PHR (E Friedman)
10.15am	Plenary Discussion Introduction to working groups	
10.45am	Tea/Coffee	
11.15am	Working groups on strategies, areas of work and institutional actors for	

	<ul style="list-style-type: none"> • Country level work and support • Regional level work and co-ordination • International interaction and engagement • Information and advocacy 	
12.15am	Feedback from the Groups and discussion	Chair: I. Makwiza
1.00pm	Lunch	
2.00pm	Summary of key areas of follow up work. Discussion	A Ntuli
2.40pm	Overview of EQUINET mechanisms for follow up and support	R. Loewenson
3.pm	Closing Remarks	D Dhikwayo