

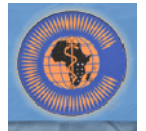
Health worker retention and migration in east and southern Africa

Regional Meeting report

March 17th to 19th
Arusha, Tanzania



Regional Network for Equity In Health In East And Southern Africa (EQUINET)
in co-operation with
the East, Central and Southern African Health Community (ECSA-HC)



with
**Health Systems Trust (HST) South Africa,
University of Namibia, Namibia**



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Report by
Training and Research Support Center

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1.BACKGROUND

The Regional Network For Equity In Health In East And Southern Africa (EQUINET), through Health Systems Trust (HST) South Africa and University of Namibia, Namibia in co-operation with the Regional Health Secretariat East, Central and Southern Africa (ECSA-HC) in March 2007 held a regional meeting in Arusha Tanzania drawing in researchers, country programme managers, health worker associations regional and international agency personnel and other relevant stakeholders to develop the work under the joint EQUINET / ECSA-HC programme on health worker migration and retention. The meeting was scheduled to take place after the 2007 ECSA Regional Health Ministers Meeting. A reference group of regional and international expertise was established to provide technical input to the programme. Ministries of health were approached in 2006 to identify focal points for the programme and a call was put out in late 2006 for researchers to submit concept notes for work on migration. The delegates for the meeting were drawn from the reference group, country focal points and researchers and other related organisations working on health worker migration and retention. The delegate list is shown in Appendix 2.

The EQUINET-ECSA-HC programme in 2007-8 is supporting empirical research on the costs and benefits of health worker migration within and beyond east and southern Africa (ESA); and supporting evaluation of the effectiveness of current policies and agreements to manage these costs and benefits. This work is co-ordinated by Health Systems Trust South Africa. The programme is further supporting work with country teams to support monitoring and evaluation and operational research to inform policy development and strengthen management and evaluation of incentives for retention of health workers, particularly non financial incentives. This work is co-ordinated by University of Namibia, Namibia. Both programmes are working with the EQUINET steering committee and the ECSA Technical Working Group on Human Resources for Health.

As background to the regional meeting three papers were prepared by EQUINET/ECSA-HC:

- i. a literature review on non financial incentives for health worker retention in ESA
- ii. a literature review on methods and evidence on costs and benefits of health worker migration in ESA
- iii. an analysis of current policies for management of health worker migration in ESA

The meeting aimed to:

- i. Present evidence from literature review, Ministries of health and other stakeholders on priority issues and methods for implementing and monitoring non financial incentives for health worker retention in east and southern Africa and identify research priorities and methods and methods for supporting monitoring on health worker retention
- ii. Present evidence from literature review, Ministries of health and other stakeholders on priority research issues and methods for analysis of costs and benefits of health worker migration in east and southern Africa and identify research priorities and methods on mapping the costs and benefits of health worker migration
- iii. Identify the institutional arrangements and focal points for co-ordinating and implementing follow up work in the EQUINET/ ECSA-HC programme

The programme is shown in Appendix 1.

The regional meeting provided a forum to review country experiences on health worker retention and migration, and to collectively establish the parameters for the follow up work programme. Thanks is given to the ECSA-HC secretariat, the EQUINET secretariat, HST and University of Namibia for their roles in organizing the meeting, to TARSC for production of the meeting report and to SIDA (Sweden) for financial support for the meeting).

This report is organised in three major sections.

- The first presents the regional context for work on migration and retention, as outlined in presentations by EQUINET, ECSA-HC, SADC, WHO, and other regional partners.
- The second presents the overview of the current situation with respect to health worker retention and migration, integrating evidence from background papers and country experiences.
- The final section summarises the discussions held on follow up work on migration and retention.

2. THE REGIONAL CONTEXT FOR WORK ON HEALTH WORKER MIGRATION AND RETENTION

2.1 The East, Central and Southern Africa (ECSA) Health Community

Helen Lugina ECSA –HC presented the Resolutions of the 42nd Regional Health Ministers Conference (RHMC) in relation to Human Resources For Health as a basis for the programme of work in ECSA.

**East, Central and Southern African Health Community
42nd Regional Health Minister's Conference 6-11 February 2006
Resolutions of the 42nd Regional Health Minister's Conference
RHMC/42/R4 Human Resources for Health**

Noting that several recommendations made during previous RHMCs continue to be pertinent human resources issues that need full implementation and periodic evaluation;

Acknowledging that HIV and AIDS pandemic adversely impacts on human resource and quality health care;

Recognizing that adequate human resource is critical for the effective implementation of HIV/AIDS intervention;

Recognizing that out-migration of scarce health professionals from the ECSA region is a growing problem which continues to deplete the existing health care workforce;

Recognizing that without accurate, current data for human resource policies, planning and management meaningful development in the region is difficult;

The 42nd Regional Health Ministers conference urges member states to:

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

In follow up to these ECSA-HC has been working on national systems of continuing professional development that promote on-the- job and team-based training; developing a system for tracking continuing professional development; developing

and strengthening innovative mechanisms for staff recruitment based on norms that are regularly reviewed. ECSA-HC has noted that most countries in the region have established career path and related measures, some countries have instituted mechanisms for innovative recruitment, e.g. use of retired health workers and extending retirement age and that most countries have established career path, HR management systems, salary top-ups and allowances, while some have improved health worker access to ART. A few countries have established systems where continuing professional development contributes to credits for renewal of license to practice.

However there is less information on how all the non-financial incentives in general are managed, and a lack of systematic mechanisms for continuing professional development. The work done to date suggests that there is need

- For systems for tracking professional development to identify lessons
- to document better practices on innovative recruitment methods to learn from these
- For more information on how effective codes, protocols and agreements are in managing migration
- For regional documentation and review of salaries in the region and how they match to the cost of living and other social needs.

The ECSA-HC Secretariat is thus currently carrying out programmes of work to address these issues,

- To support member countries in conducting appropriate research on health workers e.g. in retention, effects of out-migration, work-load studies and to promote evidenced based best practices
- To facilitate the development of human resource information systems in member states
- To support the development of a common position on the ethical recruitment of health workers and compensation for outmigration
- With EQUINET to review and assess non-financial incentives for retention and the costs, benefits of and effectiveness of measures for management of migration
- With MOH-Kenya, USAID a study on workforce competences and facility assessment for safe deliveries
- With WHO, World Bank and Capacity Project, ECSA-HC co-sponsored and conducted the first meeting of the Africa Health Workforce Observatory held in Arusha in 2006

2.2 Southern African Development community (SADC)

Lebogang Lebese: (SADC-Botswana) outlined the SADC institutional and legal framework for work on health workers, particularly noting the SADC protocol of health, 1999; the SADC human resources strategic plan 2006 – 2019 and the policy guidelines on attraction and retention of health professionals in the SADC region.

SADC is implementing its protocol on health in relation to health workers through a situational analysis on the magnitude of brain drain, prevailing conditions of service and working environment, implementing the strategies and policies and monitoring. This has led to development and implementation policies and strategies for retention of health personnel and improvement of their salaries; development of a regional qualification framework on health by 2007; identification, establishment and development of centres of specialisation by 2009 and facilitation of continuous training through exchange programmes and attachments. SADC has set targets for the production and retention of required health workers in the region between 2010 and 2020.

SADC identifies the major challenges in relation to health workers as

- Migration of health professionals within countries, in the region and internationally
- Mismatch between supply of and demand for health workers
- Poor workforce planning capacity
- Privatization of public health sector
- Effects of HIV and AIDS on health workers

As a policy response SADC is working on policy guidelines for

- Sharing of research tools and harmonization of key indicators;
- Measuring and managing the health worker supply and demand challenges;
- Addressing migration of health professionals; and
- Attracting skilled SADC nationals.

SADC Ministers have reiterated the position that recruitment of health professionals within the region be undertaken through mutual agreements within Member States and through exchange programmes to promote skills circulation in the region. There should be a mechanism to ensure the return of health professionals to their home countries upon completion of their training. Ministers urged Member States to enter into agreements to recruit health professionals within the framework of the SADC Protocol on Health.

The SADC Ministers meeting has called for annual reporting on this strategic plan and on the policy guidelines, particularly in relation to the packages for attracting, recruiting and retaining health professionals, workplace HIV and AIDS policies and programmes for health workers, data on the magnitude of the brain drain and effective information management systems for planning, managing and monitoring HRH, including tracking health professionals on completion of training outside their countries. Towards harmonising approaches SADC has developed a concept paper on brain drain and skills circulation within the context of the implementation of the SADC Human Resources Strategic Plan.

2.3 EQUINET

EQUINET is a network of professionals, civil society members, policy makers, state officials in east and southern Africa that aims to advance and support health equity and social justice based on shared values. It is a forum for dialogue, building knowledge, perspective, learning and critical analysis, and for sharing information and experience and networks people to overcome isolation, promote exchange and co-operation and build strategic alliances using bottom-up approaches.

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair'

Equity in health implies directing more resources for health to those with greater health need

Equity in health means having the power to influence decisions over how resources for health are shared and allocated

EQUINET is involved in a range of areas to advance equity and some of the current work involves: -

- Building people-led, people-centered health systems that organize, empower, value and entitle people;
- Promoting increased fair, sustainable and equitable financing for health
- Ensuring adequate, well-trained, equitably distributed and motivated health workers;

- Informing equitable and health systems strengthening roll out of ART, and
- Advocating fair global, economic and trade policy with national flexibility to protect health

EQUINET co-ordinates this work through country, theme and process co-ordinators in different countries and institutions of the region (see www.equinet africa.org).

The context for EQUINET work on health workers is the wider regional equity analysis in east and southern Africa. An analysis being compiled in 2007 (to be published in August 2007) tells a story of opportunities for health, policies for universal access to health care and inequalities in access to the resources to achieve these opportunities. This demands health systems that are able to

- Meet and protect rights to health for all in society (universally)
- Invest in and resource accessible, frontline comprehensive services that effectively address the major problems people face
- Direct resources towards those with greatest health need and protect against poverty
- Raise resources from those able to pay (progressive financing, with cross subsidy).

Lessons learned from ART roll out on enhancing outreach and equity show that while money and drugs are important, successful roll out is also a consequence of the strength and integration of district health systems, one part of which is the availability of adequate, trained and supported health workers.

EQUINET is organizing evidence on how the region can and is responding to these challenges, such as through the way health systems are financed, the management of economic and trade policies, the organization of community and public roles in health and the organization of and value given to health workers. Drawing on research and review work implemented in 2005/6 and planning and review meetings held with country and regional level personnel, EQUINET is focusing on policies and measures for enhancing, managing and monitoring incentives for health worker retention, especially non financial incentives, and on the costs and benefits of migration and the extent to which current policies, codes and agreements manage costs and enhance benefits. This work is being implemented in co-operation with ECSA-HC, and in collaboration with SADC, IOM and WHO and other institutions involved in health worker migration and retention, with support from SIDA.

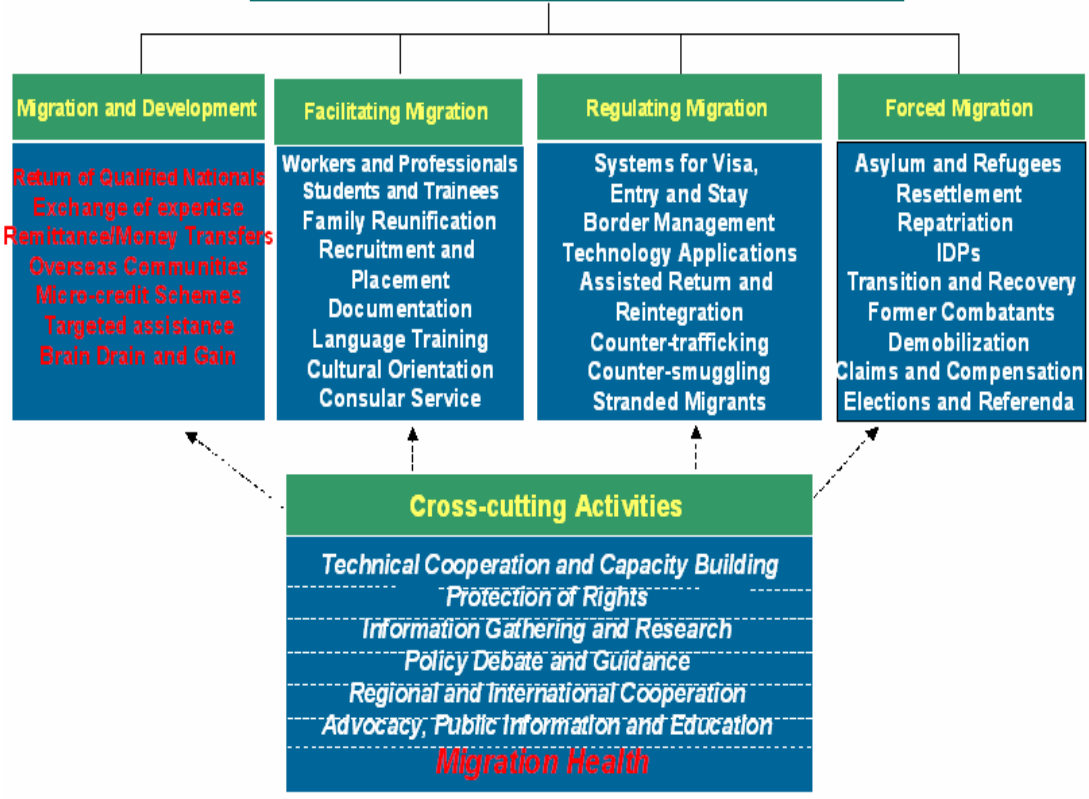
2.4 International Organisation on Migration

Dr. Davide Mosca: IOM International Organization for Migration outlined the importance for migration management of shaping clear and comprehensive policies, laws and administrative arrangements to ensure that population movements occur to the mutual benefit of migrants, society and governments.

This implies developing comprehensive/harmonized labour, migration, and health human resources management policies; reliable, accessible, usable databases able to monitoring the impact of migration and ethical codes, including on health service delivery. It also means taking affirmative strategies, such as support of exchange programs; training and education plans and harnessing the Diaspora. (See figure overleaf).



MANAGING MIGRATION MAIN AREAS



IOM has two major return Programmes for Highly Skilled Professionals

- Return and Reintegration of Qualified African Nationals (RQAN), initiated in 1983 within the context of the Lomé II, III, & IV Conventions, facilitating the return of over 2,000 highly skilled and experienced African nationals to both public and private sector jobs in 41 countries in Africa and assisting 2,565 fellowship students through EC funded programmes; and identifying suitable candidates among Diaspora communities to fill vacant positions to address identified gaps in key socio-economic sectors of the countries of origin
- Migration for Development in Africa (MIDA) launched in 2001 in Gabon to facilitate the transfer of skills and resources of the African Diaspora to countries of origin through temporary, long-term, or virtual return. The OAU Lusaka Summit in July 2001 commissioned IOM to initiate activities that would enable member countries to match the skills and resources available in host countries with shortcomings in human resource supply identified by governments in countries of origin

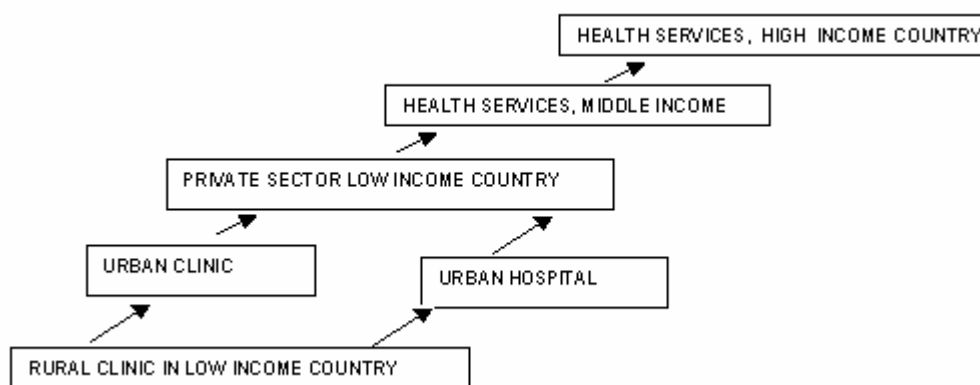
IOM also has a partnership with the East African Community since 2006 to promote cooperation on developing health programmes and projects to enhance the health of migrants as well as address gaps and impacts in health service delivery associated with migration. This works through a Regional Committee of Experts, regional workshops and commissioned research in Kenya, Tanzania, and Uganda on the health of migrants and the migration of HRH. A Conference is proposed in Nairobi in July 2007.

IOM has partnered with the International Labour Organization (ILO) and the World Health Organization (WHO) to explore opportunities, and challenges and brainstorm practical approaches and innovative solutions relating to the mobility of health care workers. From this IOM, ILO, and WHO are collaborating to provide technical assistance to governments; IOM, in partnership with other stakeholders, is collaborating in the establishment of national observatories to track/monitor the global migration of health workers and in the Global Health Workforce Alliance. IOM is creating online platforms to facilitate information exchange and a database of health workforce resources in Diasporas.

This work raises the importance of multisectoral in-country dialogue, country ownership and stewardship in managing migration of health workers, through country specific, tailored approaches. There is need to build synergies, pooling of resources, cooperation and merging of various initiatives, donors support and to involve the Diaspora in moving from brain-drain to brain-gain.

2.5 A summary of the regional context

Current evidence suggests that with some exceptions, health systems in ESA are generally under-staffed and exhibit maldistribution of health workers. Under these conditions health workers become de-motivated and less productive. The situation has been aggravated by AIDS, further depleted the health workforce even in the context of increased demands on health systems. Outflows from public sector and rural areas of ESA countries of key personnel is a loss in public investments. When these workers go to high income areas and countries this is a subsidy from poor to rich as shown below.



Responding to this situation takes political and strategic leadership working in a multisectoral framework to build and resource comprehensive plans for effective health workforces. While there is greater international recognition of these issues, and commitment to act on them, debates and contestations that surround policy options within countries and internationally (such as over bonding and compensation) pose difficulties in setting and implementing policy. Global and international funds have only slowly begun to realign to the recurrent needs of health worker financing, after decades of structural adjustment related cuts in public personnel and wages. This calls for strategic management, and monitoring and evaluation approaches to share good practice within the region.

There is now strong policy recognition and there are many options being implemented within the region to address the issue. While not amenable to “quick fixes”, experience indicates that various measures that reverse real wage declines, that provide incentives for career paths, working conditions and social conditions of

health workers can lead to flows back into the public sector and into priority levels of the health system. Incentives work better than coercive measures and efforts to build pull factors that outweigh push factors are likely to have greatest sustainability. Equally there are approaches that can address international migration, make it a matter of public agreement between countries rather than unplanned private flows, and ensure that it is done fairly. This meeting builds on existing work within the region and intends to identify concrete options and follow up work to strengthen positive action.

3.OVERVIEW OF RETENTION AND MIGRATION

3.1 Incentives for Health worker retention

Yoswa M. Dambisya-University of Limpopo South Africa presented a summary of the background paper commissioned by EQUINET and ECSA-HC on health worker retention strategies in ESA. This paper reviewed the actions ESA countries are taking on health worker retention, and the potentials, impacts and constraints to these actions.

The presentation reviewed both financial incentives, such as salaries, allowances, top-ups, bonuses, rewards, pensions, loans; dual practice, under-the-table payments; per diems, insurance, fellowships, tuition. It also examined the non-financial incentives. These can be internal or external and both motivate an individual's degree of willingness to exert and maintain an effort towards organizational goals. They include self-efficiency, valence and expectations while non financial external incentives include Supervision, recognition, rewards, prizes, training & career paths, working conditions, access to treatment and care.

The review findings suggest that there is much information on the problem, some information on financial incentives but less information documented on non-financial incentives. Very little is documented on how incentives are managed and monitored as well as on impact and success factors. Incentives being applied in the region include salary top-ups, allowances, dual practice, per diems, sitting allowances. The non-financial Incentives being applied include higher training, scholarships/bursaries ± bonding, research opportunities, skills enhancement; housing, electrification, staff transport, childcare facilities, food and improved facilities & equipment, general conditions of service and workplace security. Some countries are also improving their HR Management systems through strategic planning, open appraisal systems, and supervision and providing for health worker access to ART and medical care.

Incentives are designed to attract or retain. Little has, however, been documented on monitoring and evaluation of incentives, and their impacts are not well assessed. The review suggests that there are gaps to be filled in documentation of actions and learning from experiences to develop a common strategic approach to health worker retention in ESA countries. The current evidence does however suggest that there are some success stories in

- meeting immediate needs through top ups, allowances
- combining financial and non-financial incentives
- targeting recruitment, training and bonding:
- Using incentives to attract health workers from private to public sector
- Financing incentives through SWAPS and budget support, including through external resources.

The final review report will be finalized and produced in May 2007.

In the discussion, delegates noted that a focus on financial incentives in African countries is not sustainable and that health workers themselves seek wider rewards, such as electrification, housing and decent working conditions. Non-financial incentives are something that ESA governments can do. This means that we need to be clear which ones have a greater effect of retaining our health labour force. We also need to understand the context within which incentives work. Those that work for some categories to address international migration may be different to those that address rural urban imbalances. Nurses and doctors are not the only professions in the health workforce, and we should not forget other important health workers. Not talking about them or putting as much attention to them can suggest that they are of less importance, yet its clear that these people should work together if we are to limit workloads and if we are to have quality health delivery systems. Of particular importance are the PHC services and health workers. .

Delegates felt that opportunities for further training were amongst the most attractive non financial incentives, such as through sponsorship for graduate and undergraduate training. Other experiences of incentives were exchanged, including transport allowances, subsidised loans to buy cars, staff welfare centres for health workers, and a health worker health insurance scheme.

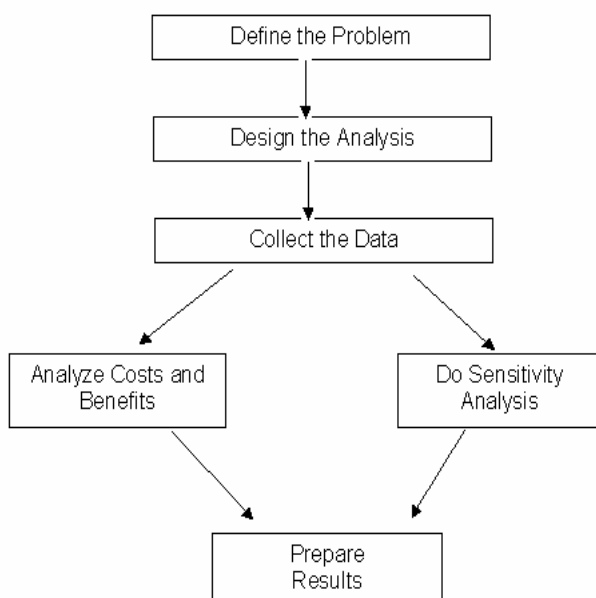
3.2 Protocols for managing migration and their impact

Catherine Pagett HST: South Africa reported on a Review of Codes and Protocols for the management of health worker migration commissioned by EQUINET and ECSA-HC. A range of instruments were reviewed, including multi-lateral agreements, codes of practice, bilateral agreements, and position statements. The paper identified that while there are a number of policies for ethical recruitment, few deal with issues of reparations, support for retention and production, and transfer of resources to address factors motivating migration. Also there are weak monitoring and enforcement systems for most of the policies so that they are still weakly applied with little sanction for breach. The agreements in the region are of note as mechanisms exist through SADC and bilateral agreements to manage migration affirmatively and evaluate their effectiveness.

It was agreed that the issues raised in the paper were key research areas for follow up, including exploring gaps; documenting successful implementation of codes or policies; and putting in place systems for monitoring, implementation or sanctions on agreements..

3.3. Methods for assessment of costs and benefits of migration:

R Robinson North South Institute- Canada presented a flow diagram depicting the major steps in performing a Cost Benefit Analysis (CBA) of health professionals' migration.



In defining the problem it is important to define from whose perspective the issue is being explored, the

- Migrant health professionals; population of recipient country and population of source country (global)

- Migrant health professionals and population of source country (social)
- Population of source country only (social)
- Population of host country only (social)
- Migrant health professionals only (private)

Clarifying this will make-work easier when carrying out a Cost and Benefit Analysis.

Defining costs and benefits should be the first step in designing the analysis and identifying the measurement of the relevant costs. Some of the measurements suggested included direct and indirect monetary and non-monetary costs to the health system, health workers and to the society. Benefits identified include direct monetary and non-monetary benefits to the health system; the health workers and the society.

Data on this could be time-series data, cross sectional data and qualitative information for specific relevant variables. Sources include national Census, International organizations, Regional and sub-regional organizations, Government Ministries, Hospitals and clinics, Universities and nursing schools, Medical associations, Physicians, and nurses' associations, Government officials, Health sector managers and administrators, Immigrant networks, organizations/associations and other relevant institutions

A sensitivity analysis is done for several economic and non-economic factors that influence the structure of costs and benefits associated with the migration of health professionals. Measurement of the costs and benefits is subject to imperfections due to compromised data quality and a multiplicity of distortions. The uncertainty that characterizes the data/information on which the analysis is based suggests the caution with which the results should be accepted.

There are constraints in doing a cost benefit analysis of health worker migration

- Limited data on numbers in migration and on costs and benefits (quantity and quality)
- Problems with measurement of historical, opportunity cost data, and with measurement of externalities
- Measuring real or nominal monetary values and the rate at which costs are discounted

In the discussion participants observed that remittances are an important indicator of the benefits of migration, their huge potential for supporting development and poverty reduction having captured the attention of governments and development agencies alike. However, while remittances can enable developing countries to repay foreign debt and improve their creditworthiness, they cannot be a replacement for development aid.

There is need to encourage the formation of Diaspora committees. These committees can start small and in the long run ESA countries may benefit from them. Thus means that attitudes towards our trained labour force in the Diaspora should change, so that those who want to contribute back to their countries are not rejected and can contribute to development strategies by transferring skills and investing in local economies. Delegates felt that those in the diaspora should be appreciative of the harsh conditions in countries for those remaining and not demand unfair excessive preferences from the health systems, undervaluing those who stayed.

Participants at the meeting agreed that there should be a standardised way of calculating costs of training a health worker. As there was no current consensus on this it should be an area of follow up research.

It was felt, however, that costs of migration outweighed the benefits and that this means that the policy focus should be on valuing and retaining the existing health workforce. While there is a need for investment in training, this needs to be done with measures to support health workers. For example measures are needed to encourage women to enter health professions and accommodate their needs through flexible work arrangements and leadership career tracks adapted to family life. Governments should include plans for how health workers will collaborate with staff in other sectors, such as transport and education sectors, to maximize the efficiency of scarce resources and to build partnerships between patients and health workers.

4.COUNTRY EXPERIENCES OF RETENTION AND MIGRATION

Countries made inputs within sessions on migration and retention. (Not all countries present made presentations). The presentations that were made are briefly summarized below.

4.1 Botswana:

Gaongalelwe .Seetasewa , Ministry of Health Botswana gave a brief overview of the human resources for health situation in that country, especially in relation to doctors and nurses, where there is a problem of out migration, especially to overseas countries. In the case of doctors the country relies more on expatriates, for instance recently the Ministry recruited a group from Nigeria and a few from Ethiopia. Problems of recruitment and retention are further affected by the lack of a local medical school to train health workers nationally, since nowadays some young doctors are not willing to come back home after completion of their studies.

4.2 Kenya:

Dr Francis Kimani: Human Resource for Health in Kenya gave a brief summary of the human resources for Health in Kenya and the health system. He outlined the Kenya HRH Strategic Plan that emphasises an equitable distribution of health workers and human resource development, which builds capacity for health. The plan strengthens performance management for health workers. He highlighted the reasons for attrition of health workers in Kenya, included early retirement, illnesses and deaths, dismissal form service, resignation and ending of contract. He pointed to the need for effective data management on human resources, and to making clear the terms and condition for health workers.

4.3 Lesotho:

John Nkonyana, of the Human Resource department in the MOHSW outlined the human resource challenge in Lesotho. Vacancy rates range from 15-20% with most of the vacant posts being those of support staff. Rates also need to be reassessed in the light of HIV and decentralization requirements, with relevant incentives for each level. Despite efforts by the Ministry to review and reorganize structures to determine the critical needs in light of changing roles brought about by decentralization, the impact on the supply of health workers has been slow due in part to the time taken to recruit and apply changes, given the wider sectoral co-ordination needed. The Ministry has expanded the training of nursing assistants and reintroduced nurse clinician course in response to immediate needs for scaling up HIV and AIDS, prevention, care and support. While welcome, the scale does not yet meet the size of the problem and training remains a priority to meet nurse shortages. Further training

needs to be linked to remuneration and working condition incentives. HR in Lesotho remains a challenge and an area of focus for the 2007/08.

4.4 Mauritius

Dhanunjeye Gaoneadry- Ministry of health and Quality life reported that Mauritius has taken an intergraded approach to health planning. In place, is a staff welfare policy, continual upgrading of health centers to maintain quality service, sick leave, medical tourism with tax free incentives, and specialists are allowed private practise. There is enough recognition of trained person and international agencies have come into Mauritius to build schools. The first medical school was set up in 2000 and many doctors prior to this were trained externally, such as in East Europe.

4.5 Swaziland

Sibusisiwe Sibandze-Ministry of Health and Social Welfare noted that in Swaziland, government ministries review at the beginning of the financial year possible interventions for retention and implement what they feel is feasible in collaboration with other sectors. There are other challenges that countries face in addressing issues of incentives, such as how to justify and treat health workers differently to other civil servants. He also pointed to challenges of ensuring that training and creation of posts are harmonized, through harmonizing training plans with human resource plans.

4.6 Uganda

Rachel Birungi Asiimwe: Ministry of Health briefly summarised the Ugandan experience, highlighting the need to understand costs associated with incentives and that they should come as a package already budgeted for in the financing for health system so that costs associated with the HRH plan are projected and met. She suggested that non-financial incentives and improvements to structural conditions were the approach that best fits most ESA countries. Health workers based in remote areas of Uganda, despite lack of financial incentives and hard working conditions, frequently exhibited a high level of motivation to perform well. This motivation can be traced to good leadership and supportive management, among other factors. Her analysis suggests that certain non-financial incentives can have a beneficial effect on motivation, even under adverse conditions of insufficient pay and equipment, understaffing. There is need to address “how” to develop incentive structures. She noted that incentives must be designed to get value for investment, and to harmonise training plans with human resource plans and jobs.

Finally she recommended that discussions centre around the benefits of migration, as most energy has already been exerted on costs of migration, and that the focus should now be on action.

4.6 Zambia

Florence R Sichundu: Ministry of Health-Zambia highlighted that Zambia is currently facing an increased rate of disease burden accompanied by high attrition of critical human resources for health due to deaths and resignations threatening the ability of health systems to deliver effective care. She outlined the Human Resource interventions that the Government of Zambia has and is implementing to address migration of health workers. The Human Resources Strategic Plan covering 2006 to 2010 has been developed and is currently in operation. The Government of Zambia has provided additional budgetary support for this plan, including for recruitment and retention of critical health workers.

The Zambia Health worker retention scheme is expanding from coverage of doctors contracted for rural areas to include tutors, nurses and paramedical staff serving in

rural and remote districts. The scheme provides various retention incentives, including non financial incentives such as career development and housing. Flexible contracts are used to allow health workers who have reached retirement age but willing to work to continue service. While the scheme places resource and planning demands, in 2006 alone the health workforce increased from 23 000 to 51 000.

Incentives are targeted to critical shortage areas like rural remote areas, and builds on district level initiatives. Some Hospitals with nurse training schools have used bonding or districts scholarships to retain locals after training as well as strengthening in-service education for existing health workers

In discussions on the presentation further challenges to such HR schemes were noted in relation to salary differentials between public and private health personnel; and health worker fear of exposure to HIV. It was further noted that such schemes demand and can build further trust between authorities and health workers for their implementation, and that this can be built through signals such as comprehensive orientation programmes, language preparation, mentoring, educational support and career progression particularly in rural areas. It was noted by delegates in the discussion that the constraints to and success factors for incentive systems are often affected by broader contextual factors and that HR management covers a complex and interrelated system, where specific measures aimed at one group can impact on the entire system.

4.7 Zimbabwe:

Jane Mudyara Human Resources Department Ministry of Health and Child Welfare, Aillet Mukono Parliament, Moses Chimbari NUST- Migration of health workers outlined the Zimbabwe context and work. Trends and statistics of out migration of health workers in Zimbabwe indicate a drop in out migration in 2005 to 2007, although with still high levels, considering the expense and time to train the workforce. Migration is internal, regional and international, with public to private, public/private to regional and international movement. The main push factors for rural to urban migration include limited educational opportunities for children, lack of opportunities for locums, poor transport, limited health facilities, professional isolation, inadequate safe water and sanitation. Retention strategies have been put in place to deal with these, including rural allowances, relocation support for spouses and strategies to equip rural health facilities. There is also a provision of suitable living environment, improvements in road networks as well as educational allowances and low interest loans. Push factors for public to private sector include lower remuneration, poor allowances, no rewards for high performances, no provision of compensation for extra work, lack of recognition vis a vis academic qualifications, bureaucracy in appointments promotions and procurement, burnout from vacant posts and many others. Efforts for retention include a regular review of salaries and allowances, housing and transport allowances, rewarding of high performers, reduction of bureaucracy by decentralizing responsibilities and authority and management training. The push factors for migration to other countries combine the above factors. The retention strategies that have been put in place include study opportunities to those who have served government for two years or more, bonding, provision of incentive schemes (the introduction of new vehicle purchase scheme for critical members of staff), provision of institutional accommodation (loans adequate to construct or buy basic house and the provision of an adequate reliable public transport), top up salaries and provision of holiday allowances. The strategies to manage migration also include

- Creation of health service board (HSB) (focusing on health workers)

- Training policy like the PCN- over 95% rural health centers should be run by a qualified nurse and bonding
- Recruitment of; expatriate staff and retirees on one-year renewable contracts
- Aggressive advocacy to increase the health budget and
- Improvement of working conditions.

Delegates noted the difficult economic context for these strategies. It was further suggested that communities can contribute greatly to valuing health workers, such as through non-financial incentives such as building doctors houses to retain health workers in their communities.

The discussions on the country experiences raised a number of issues:

- Training is an important strategy but needs to be closely linked to incentive strategies for non financial incentives that governments and local communities can contribute to and that health workers see as important.
- Attention should be given to migration within countries and within the region as this is also an important factor affecting availability of health workers in key health services. It is not possible to stem migration through coercive measures and ways need to be sought to encourage retention and tap any benefits from migration, while minimizing costs. We need to explore the current experience and impact of Diaspora committees. Which countries have existing Diaspora committees and what have they done so far?
- There are still no standardized approaches to calculating key costs, such as the costs of training a health worker; the costs of health worker skills. These issues should be resolved at regional level for a common approach
- There is need to examine using evidence from HMIS the impact of codes and agreements.
- In assessing what incentives to apply, countries need to not only decide on the design of the incentives, but strategically manage processes for their introduction and for sustaining them, as well as for exit strategies for them. As all incentives cost it is important to identify these costs, and to explore the role of institutional mechanisms like 'health service boards' and financing mechanisms like SWAPS in enabling incentives strategies.
- Evidence from the region can support the development of guidelines for training and development for retention within Ministries of Health in ESA for retention, and for harmonizing training with human resources plans.

5. FOLLOW UP PROGRAMME OF WORK

As shown in the programme in Appendix 1, delegates went into parallel working groups at different stages of the meeting to design and plan the regional programme of follow up work. The report presents this in a consolidated manner, but the sessions involved working groups and report back on

- Setting priorities for research or monitoring
- Identifying evidence, data sources and methods to address these priorities
- Identifying institutional roles and work-plans to take the work forward

5.1 Operational research and policy monitoring on health worker migration

The context raised earlier was noted and within this the need for monitoring of current policies and for developing standardized common Indicators to assess the

costs and benefits of migration. The barriers to policy development and negotiation on migration include absence of valid systematic evidence and knowledge gaps. The absence of agreed, firm evidence weakens the political momentum, especially in a context that is complex and multifactorial with inequalities in power and resources between different actors internationally.

Areas of research focus include

- Factors leading to migration in different countries and for different forms of migration
- Impact of migration on key areas of health systems establishing clear indicators and benchmarks that can be used across the region
- Effectiveness of current measures and policies for managing migration and reasons for failure or limits to current measures
- Agreed indicators for monitoring and reporting on effectiveness of policies.
- The implications of migration for achievement of national goals and for the achievement of the MDGs

This takes note of the need for tools and agreed indicators that have been validated on the total cost for training a health professional (from primary to tertiary and in service); and on costs and benefits within and beyond health systems and on the distribution of these costs between households, communities, state and private sector. It also notes the need for other agreed regional benchmarks, such as of ideal health worker standards within countries.

Some of the specific areas of priority focus were further explored.

What are the ideal country-specific HRH inventories and where are the gaps?

- le How many workers do we have and how many do we need?
- Needs to assess standards based on population ratios; distribution of workers based on country-specific needs; and a minimum package per unit
- Data Sources are Health Institutions, Health Ministry
- Bias and error may arise in gaps between reported and actual numbers, indicating a need for verification of a sample of evidence
- There may also be high costs and logistic difficulties in gathering evidence, particularly given the “informal” nature of many transfers

The priority work identified was to determine the effectiveness of the policy interventions made by African governments to manage costs and benefits of the migration of health professionals

Specific Objectives were

- To determine the costs of training a health professional (doctors, nurses and others) and the required costs given the ideal and real inventories for human resources for health in African countries.
- To carry out a cumulative cost/ benefit analysis on migration.
- To develop valid indicators and gather evidence for a database to monitor the policies being used to manage the migration of health professionals within the region and internationally

Data Sources include: Training Institutions, Government Ministries, Private Sector, Faith-based Institutions and national statistics. It would be important to move from ad hoc surveys to developing agreed consensus data sets that could be tracked within countries and compared across countries. The tools for collection may include assessment of registers and routine data and surveys, with measures for validating or assessing the reliability of data.

It was proposed that a Multi-Level Systems approach is needed for this analysis, from International, Regional, National and Sectoral levels. The analysis would need to not only measure economic and health worker indicators, but also social parameters including social effects such as leadership and human security, and institutional dimensions.

5.2 Operational research and monitoring on health worker retention

A number of current approaches to monitoring retention incentives were noted, including

- measurement of achievements against targets,
- monitoring patient satisfaction and complaints
- Annual performance appraisal
- quarterly consultations with employees by management teams;
- meetings of a human resources technical group
- Monthly high level management meetings

The information is used to determine areas that need action and to review HRH plans. The feedback has also been used to amend restrictive laws or take other measures to encourage return and retention. Monitoring is also used to identify gaps in or adjustments needed to current incentives.

At regional level, ECSA-HC is working with WHO, Capacity project and the World Bank. HR data is integrated into overall HR systems, and the Health workforce observatory is a system that supports monitoring and evaluation of migration and retention.

There are however barriers and information gaps:

- Feedback and information flow is often incomplete or not comprehensive or systematic, takes longer than it should to be used due to procedural formalities and there are not always the management capacity or resources in place to make the suggested adjustments
- In some cases schemes are introduced without thorough prior review and research due to circumstances, making it more difficult to withdraw or reorient incentives

Generally countries want to know how effective and how sustainable current incentive schemes are and to have clearer guidelines for introducing and managing such schemes. There is an interest in exchanging experience across ESA countries. While noting the specificity of country context, it was proposed that there is scope to develop general guidelines on options for introducing and managing non financial incentives. Countries were also concerned to put in place and have guidelines for the tolls and parameters for monitoring retention schemes, exploring the effectiveness of those in place and exchanging experience on how to deal with the shortfalls.

There is need to develop guidelines that will be used to support priority areas of planning, the guidelines for retention should cover Availability of human resources within countries, Standardization of guidelines, objectives and outcomes, timeframes, outcome and performance indicators, sustainability of incentive schemes. Each country should develop own guidelines- that will be harmonized with regional or international guidelines to consolidate more input. For Sustainability of incentive schemes, governments should take full responsibility in funding the incentive

schemes. The ministers meeting in April 2007 should be used to drive and push these suggestions so that they can be adopted.

Countries thus proposed as a first step to implement a more systematic assessment of the non-financial incentives at country level, and assessment of their impact in order to identify

- The type of non financial incentives being applied in countries
- Possible indicators and approaches to monitoring of non financial incentives
- Guidelines for introduction and management of non financial incentives for retention
- Examples of successful practice for regional exchange

The information limitations highlighted in the migration group were also raised as issues in this group. Secondary or reported evidence cannot always be relied on and there is need for physical monitoring and 'manual checks' of evidence.

The evidence would thus come from a mix of methods:

- key informant interviews: (workers representatives, trade unions, HR managers, Professional bodies, trainers)
- Desk reviews/document analysis
- Analysis of the health management information system
- Staff establishment evidence bases on priority needs
- Field work to map incentives and establishments and to make direct checks to verify secondary evidence

The sources for such evidence include

- Inter-sectoral committees, eg skills Retention committees, public service Commission
- Health institutions, eg Ministries of Health, Health Service board
- HRH Managers, Professional bodies, Trade unions- bipartite or tripartite, Trainers of health workers, Health workers, HR Consultants
- Parliament portfolio committees and Development partners
- Annual reports- Ministry, Board/Commission and other key stakeholders
- Documents from international partners (SADC protocols)
- Strategic plans and Resolutions from meetings -Ministry, Board/Commission and other key stakeholders

It would be important for evidence to feed back into country level intersectoral planning groups and into the WHO observatories at country level and the ECSA-HC regional observatory so that there is a platform to share experiences and identify operational research.

It was agreed that countries would provide feedback on the proposed work to their seniors, and that once agreed would form a core team, finalise their proposed work in April and the full study protocols by end May. A technical review team at regional level will give technical analysis and peer review support of this work. Once country work is agreed on and resourced then the work will be implemented, and a proposed time frame of June to November for country level work, and January – May 2008 for regional level exchange, and country guidelines development was suggested. A follow up regional meeting to review country findings could thus be held in early 2008.

5.3 Summary

The follow up work will thus focus on two major areas,

- On migration, the development of a concept paper on brain drain and skills circulation within the context of the SADC Human Resources Strategic Plan, leading to analysis of costs and benefits of migration and the effectiveness of current policies and measures for managing these.
- On retention, mapping and then monitoring the effectiveness of the policies and strategies for retention of health personnel, particularly non financial incentive schemes, to identify guidelines for the use and management of such incentives
- In both migration and retention, identification of routine monitoring parameters and tools and organization of data to better manage and monitor policies for retention and migration

It was proposed that the work have direct relevance to and feed into country retention strategies and policy development on migration, and support the strategic management capacities for this through tools, identified core indicators, guidelines and information exchange. Online platforms can also be used for information exchange where useful. An email list exists for easy communication and can be used to share ideas and country experiences. There is for example an existing mailing list on health worker issues in ESA at 'HR-list@equinetafrica.org'.

The meeting delegates will share the outcomes of the meeting with their respective institutions. Co-ordination of the migration work will be through ECSA-HC and EQUINET (HST with support from the Secretariat) and of the retention .group through ECSA-HC and EQUINET (University of Namibia with support from the Secretariat).

Finally it was noted that the scale of and demand for this work is high and EQUINET was encouraged to expand research resources and work in these areas to address this demand.

6. CLOSING

The meeting delegates appreciated the meeting, which they felt offered an opportunity to share and understand regional perspectives on health worker migration and retention. Researchers present at the meeting hoped to use the information gained in their research and programme work in the different countries in ESA. Delegates thanked EQUINET (and the network institutions HST, University of Namibia and TARSC) and ECSA-HC for the unlimited support throughout the meeting. Delegates agreed that the objectives of the meeting were met and that the working groups were quite informative especially in designing shaping up future work. Delegates were wished safe travel and promised follow up on their proposed plans.

Appendix I. Meeting Agenda

Regional policy and research meeting on Health worker migration and retention in east and southern Africa March 17th to 19th Arusha, Tanzania

DAY ONE – SATURDAY 17 MARCH 2007

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
OPENING AND INTRODUCTIONS			
900-945	Opening remarks	Welcome Introduction to objectives and process of the workshop Delegate introduction	ECSA-HC EQUINET
945-1045	Introduction to EQUINET and its work on health workers	Overview of EQUINET, its work; the theme work on health worker and the current EQUINET / ECSA-HC programme on retention and migration Discussion	EQUINET
1045-1115	TEA/COFFEE		
OVERVIEW OF RETENTION			
1115-1205	Incentives for health worker retention	Presentation of review of the literature on incentives for retention of health workers in ESA, Methods used, Issues arising Discussion	Yoswa Dambisya U North SA
1205-100	Country experiences of Incentives for health worker retention	Brief country inputs on successful examples and major challenges in designing and implementation of non financial incentives for health worker retention Discussion on issues raised	Country delegates
1.00pm	LUNCH		
OVERVIEW OF MIGRATION			
2.15-3.15	Health worker migration	Presentation of review of protocols on migration and their impact Presentation of review of literature on costs and benefits of migration, findings, methods and issues Discussion	C Paggett HST R Robinson North South Institute
3.15-4.15	Country experiences of managing health worker migration	Brief country inputs on identified costs and benefits and challenges in managing migration Discussion on issues raised	Country delegates
4.00-415	TEA/COFFEE		
PROGRAMME OF WORK:			
4.15-5.15	Parallel working groups on retention and migration	Introduce the working groups Set up the parallel Working groups Group 1: Priority issues for operational research and areas for monitoring on improved design and management of incentives for health worker retention Group 2: Scoping of operational research and areas for policy monitoring on managing health worker migration	EQUINET

DAY TWO—SUNDAY 18 MARCH 2007

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
8am-845am	Administration	Administration and country meetings	EQUINET
PROGRAMME OF WORK:			
845-915	Recap of day one	Recap of issues raised, knowledge gaps and areas of policy, research, programme work identified	EQUINET
915-1015	Feedback and discussion on working groups	Report of working group sessions (10 min per group, 15 min discussion) General discussion on the areas of focus for the follow up programme in each area	
1015-1045	TEA/COFFEE		
METHODS FOR FOLLOW UP WORK: Chair L Lebesse SADC			
1045-1215	<i>Parallel Session 1</i> Methods for analysing and monitoring retention Incentives	Presentation on approaches, methods and constraints in OR and monitoring Discussion including how methods issues apply in specific country level contexts	Y Dambisya, Capacity project
1045-1215	<i>Parallel Session 2</i> Methods for carrying out cost benefit analysis on and policy monitoring on migration	Presentation on approaches, methods and constraints R Robinson Discussion including on country level contexts	R Robinson, Facilitated by
1215-1pm	Feedback and discussion on parallel sessions	Report of parallel sessions Methods proposed Problems / issues arising from country contexts to address Approaches to addressing problems	
1.00pm	LUNCH		
PROTOCOLS AND PLANS FOR FOLLOW UP WORK			
2.15-4.00	Parallel working groups on retention and migration	Introduce the working groups Set up the parallel Working groups Group 1: Protocols, steps and potential country partners for operational research and areas for monitoring on improved design and management of incentives for health worker retention Group 2: Protocols, steps and potential country partners for operational research and areas for policy monitoring on managing health worker migration	H Lugina
4.00-415	TEA/COFFEE		
THE REGIONAL POLICY AND PROGRAMME CONTEXT			
4.15-5.30	Regional panel	Policies and programmes for health worker migration and retention in SADC Implementing the 42 nd RHMC resolutions on health workers IOM: Managing Migration Trade union perspectives and work programmes EQUINET Regional equity analysis: policy and discussion points on health workers Discussion	SADC ECSA-HC IOM PSI EQUINET

DAY THREE–MONDAY 19 MARCH 2007

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
PROTOCOLS AND PLANS FOR FOLLOW UP WORK			
800-915	Country meetings	Administration and country meetings	
915-1045	Feedback and discussion on working groups	Report of working group sessions (15 min per group, 30 min discussion)	
1015	TEA/COFFEE		
INSTITUTIONAL MECHANISMS			
1045-1215	<i>Parallel Session 1</i> Plan of work for analysing and monitoring retention Incentives	Presentation from countries proposing to do work in this area on country level focal point, researchers, institutional mechanisms, time frames, national mechanisms for review and policy forums to feed into General discussion on next steps	
1045-1215	<i>Parallel Session 2</i> Plan of work for cost benefit analysis on and policy monitoring on migration	Presentation from countries proposing to do work in this area on country level focal point, researchers, institutional mechanisms, time frames, national mechanisms for review and policy forums to feed into General discussion on next steps	
12.15-1pm	Feedback and discussion on parallel sessions	Report of parallel sessions General discussion on co-ordination, time frames, resources and reporting	
1.00pm	LUNCH		
CONSOLIDATION			
2.15-3.00	Consolidation of areas of focus and follow up work	Summary presentation of key agreed areas for follow up work on retention and migration <ul style="list-style-type: none"> ◆ Areas of focus ◆ Expected inputs to policy or programmes ◆ Country participation ◆ Institutional, co-ordination and reporting mechanisms ◆ Resources Discussion, amendments and adoption	EQUINET/ ECSA-HC
3.00-3.15	Closing	Closing remarks	EQUINET/ ECSA-HC

Appendix II. Delegates List

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