

EQUITY IN THE DISTRIBUTION OF HEALTH PERSONNEL

REGIONAL RESEARCH REVIEW MEETING REPORT

**JOHANNESBURG, SOUTH AFRICA
April 15th to 17th 2004**



Southern African Regional Network
on Equity in Health (EQUINET)
in co-operation with
Health Systems Trust South Africa (HST)



With support from SIDA

Executive Summary

Since 2003, EQUINET and HST have implemented a longer term programme of work that has carried out a wider review of the literature on the distribution and migration of health personnel in the region and a regional research programme aimed at building analytic capacity, evidence and policy engagement around the issue. EQUINET and HST collaborated with a consortium of institutions in southern Africa and internationally, known as the Human Resources for Health (HRH) Network, in order to link this southern African programme of work with wider international work on the equitable distribution of health personnel in southern Africa. In January 2004 a call for research proposals was made within a framework set out from the literature and policy review. The proposals were reviewed and a number of these selected for participation in a regional meeting. Between 15 and 17 April 2004, the Health Systems Trust and EQUINET organised the regional meeting in Johannesburg, South Africa, bringing together researchers and stakeholders from southern and western African, Canada, the UK, USA and Australia.

The meeting objectives were to:

- ◆ Present and discuss evidence to date and to identify key areas of focus for an Equinet Research programme on equity in the distribution of health personnel in Southern Africa.
- ◆ Work with Researchers to strengthen their proposed areas of work and define the follow up research programme.
- ◆ Agree on the time and activity frameworks for the follow up programme of work and its links to other activities of HRH.
- ◆ Contribute to the development of a shared South-North advocacy strategy geared to maximizing the collective impact of the work.

Presentations from HST, Australia, the UK, Canada and USA outlined the policy and analytical framework underpinning research activities of this theme. Theoretical issues underlying methodologies for HR monitoring, mapping migration, undertaking policy analysis and advocacy were presented. Country level proposals were presented, work-shopped and developed and on the basis of this an analytical framework for this theme work was refined. The HRH theme will undertake work in three key areas:

- ◆ **The development of Equitable Human Resource Policy**, with an emphasis on internal distribution of health personnel.
- ◆ **The development of Ethical Human Resource Policy**, focusing on issues of International Migration with emphasis on researching and providing evidence about “what makes health personnel stay”.
- ◆ **The impact of the HIV/AIDS epidemic upon the distribution of health personnel**, and what are the opportunities and challenges to strengthen health system.

Core data will be collected at country level and analysed regionally to provide an evidenced based context for the research.

1. Introduction

The Southern African Regional Network on Equity in Health has since 1998 been exploring the issue of equity in the distribution of personnel. Initial work was implemented in 1999 to examine the factors affecting the distribution of health personnel in the region, particularly noting the role of health personnel associations in the development and implementation of equity oriented policies.

Since 2003, EQUINET and HST have implemented a longer term programme of work that has carried out a wider review of the literature on the distribution and migration of health personnel in the region and a regional research programme aimed at building analytic capacity, evidence and policy engagement around the issue. EQUINET and HST collaborated with a consortium of institutions in southern Africa and internationally, known as the Human Resources for Health (HRH) Network, in order to link this southern African programme of work with wider international work on the equitable distribution of health personnel in southern Africa.

The programme of work seeks to promote the equitable distribution of health personnel in southern Africa through:

- ♦ Exploring and reviewing relevant policy tools for enhancing health equity in personnel distribution in southern Africa
- ♦ Analysing and identifying mechanisms for strengthening governance arrangements and industrial relations systems for managing negotiations and policy interactions health professional associations and health unions and state authorities on health personnel issues
- ♦ Facilitating and informing dialogue on policy options for dealing with attrition of health personnel from southern Africa to selected high income countries.

The work will:

- ♦ Outline the major dimensions of (in)equity in the distribution of health personnel within southern Africa and between southern Africa and countries that are major recipients of southern African health personnel (eg UK, Australia and Canada)
- ♦ Obtain and analyse determinants of the above dimensions of (in)equity in health personnel, including policy or planning shortfalls that lead to push, pull, return and retention in both sending and receiving levels of health systems and countries.
- ♦ Explore possible and current policy options and perspectives of government, patients, civil society, health providers and health professional associations of the barriers to achieving more equitable practice in health personnel distribution
- ♦ Explore differences between SADC countries and internationally in the dimensions, determinants of and responses to (in)equity in health personnel distribution, drawing also from experiences South-East Asia, Pacific, West Africa, East Africa, where available.
- ♦ Facilitate discussion and review of the findings to promote policy convergence, policy dialogue and to strengthen policy action within southern African countries, within SADC and in countries that employ southern African health personnel
- ♦ Build a critical mass of skills, networking and information dissemination on issues of equity in health personnel within southern Africa

In January 2004 a call for research proposals was made within a framework set out from the literature and policy review. The proposals were reviewed and a number of these selected for participation in a regional meeting. Between 15 and 17 April 2004, the Health Systems Trust and EQUINET organised the regional meeting in Johannesburg, South Africa, bringing together

researchers and stakeholders from southern and western African, Canada, the UK, USA and Australia. This meeting brought together researchers from within the SADC Region with researchers from the hub countries (Australia, UK and Canada) and resource people having specialist expertise in various HR and allied fields.

Aims

This meeting comprised an important milestone in the work programme and was designed to:

- ♦ Refine the HRH network’s research programme for Southern Africa
- ♦ Provide an opportunity to strengthen research proposals submitted in response for the Equinet call for expressions of interest
- ♦ Build and augment the HRH networks concrete action plan
- ♦ Provide a platform for exchange and debate about HRH research and action being undertaken in recipient countries, in particular the UK, Canada, Australia and the US
- ♦ Contribute to the development of a shared South-North advocacy strategy geared to maximising the collective impact of the work

The work of Equinet and HST is located within the broader framework of social justice. Equity is essentially about fairness, and implies that the most vulnerable and needy groups within a society require access to greater resources than those communities that are more robust. In relation to health such an approach is intended to improve the health of the most vulnerable at a faster rate than those whose health status is “better”, thereby reducing the gap.

The work of the HRH theme will be strengthened through identifying and building on the links and synchronicities between this theme and the work of other EQUINET themes, including the work on AIDS; Trade; Governance; Human Rights; and Resource Allocation.

2. Background

2.1 EQUINET work on Equity in health

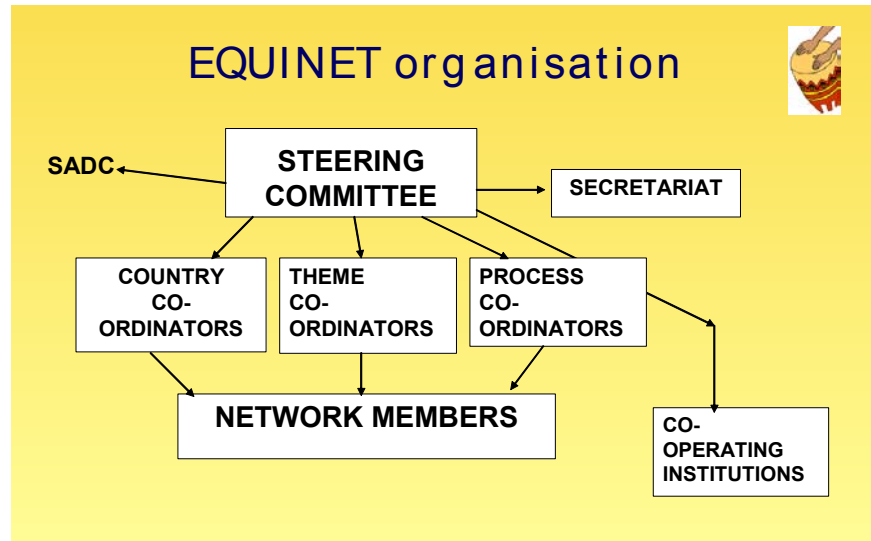
Rene Loewenson TARSC presented an overview of EQUINETs organisation, mechanisms and resources. The network aims to promote and realize shared values of equity and social justice in health. As a network formed by professionals, civil society members, policy makers, state officials and others within the region, EQUINET works through existing institutions in southern and east Africa. It supports the building of a perspective and knowledge on equity in priority theme areas. It does this through the provision of research grants and studies, including multi-country studies, of training, skills development and mentoring, of publications, through meetings and forums for dialogue, and through its newsletter and website. EQUINET supports equity actors and equity oriented social action, and their networking through information tools, issue forums, exchange visits, country level equity networks and alliances with parliaments and civil society. The evidence produced is used for policy engagement, to support SADC policies, to promote good practice and build skills. EQUINET has built skills in policy analysis to strengthen the research to policy link.

EQUINET work covers theme areas identified as priorities for health equity in the region, including

- ♦ Macroeconomic policy, trade and health
- ♦ Health rights as a tool for health equity
- ♦ Health sector responses to HIV/AIDS
- ♦ Food security, nutrition and essential services for health

- ◆ Governance, equity and health
- ◆ Fair financing and equitable resource allocation
- ◆ Equity in Human resources for health
- ◆ Monitoring equity in health

Through the country networks, we support country actors and keep them informed of regional processes, opportunities and work. The organizational structure of EQUINET reflects these areas of work, in themes, processes and at country level, with co-ordinating institutions in each who participate in the governance mechanism of EQUINET, the steering committee and who direct its work. The programme defined by the steering committee is implemented by the secretariat, who do this through supporting, resourcing and networking the institutional co-ordinators. It is an open and flexible structure and has grown and changed as the work being done and the institutions co-ordinating the work have changed.



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The updated EQUINET website (www.equinet africa.org) aims to:

- ◆ provide an information, research and policy resource to all those working on health equity in and beyond southern Africa,
- ◆ explore the potentials of information and communication technology in promoting health equity.

The site provides databases on equity in health materials, and how to search and access the information. The searchable databases contain research reports, policy briefings, latest publications and an annotated bibliography organized into thematic sections. EQUINET News enables those denied access to the web to still receive content, to know what is being produced and to disseminate reports, debates and information on actions.

2.2 The theme work on Equity in the Distribution of Health Personnel

Antoinette Ntuli, HST, indicated that there is a growing recognition that any health system cannot function adequately without a skilled human resources foundation. Deteriorating socio-economic conditions in Africa, increasing migration of HRH, and the absence of adequate strategies in both developed and developing countries to produce and retain adequate supplies of appropriately trained health personnel highlight the urgent need to reverse the Human Resource drain from health systems, and especially public health systems, in Southern Africa.

The migration of skilled professionals from poor to rich countries is severely limiting the ability of countries to provide even basic health services and infrastructure and has limited the ability of health workers to combat the HIV/AIDS epidemic and achieve any substantial progress towards the millennium development goals.

On a global scale, the overall impact of the “brain drain” has contributed to the widening gap between rich and poor countries and the increasing external dependence of the developing world. The slow pace of efforts to stabilise the migration of human resources, growing protectionism and reduced capital flows to developing countries in an increasingly hostile environment have all operated to slow the pace of recovery. Increasingly, the consequences of the “brain drain” in relation to the ethics of national policies, which allow rich countries to recruit the most qualified health professionals, at no cost, are being questioned. The partial responsibility of African governments for the current crisis is also coming under the microscope.

Inequity in distribution of personnel on the African continent is reflected in an absolute shortage of personnel to population for key skilled health personnel, and a maldistribution of personnel along three different axes, between

- ♦ public and private health sectors
- ♦ urban and rural areas
- ♦ tertiary and primary levels of the health system

31 countries in Africa do not meet the ‘Health for All’ standard of a minimum of one doctor per 5000 people. In the 1980s, the doctor: population ratio was 1:10 800 in sub-Saharan Africa, 1:1400 in all developing countries and 1:300 in industrialised countries. In the 1990s the doctor: population ratio in Malawi, Mozambique and Tanzania was 1:30 000 or more and in Angola, Lesotho, Zambia and the Democratic Republic of Congo this ratio stood at 1:20 000. Although Africa has a better supply of nurses, it still lags behind other regions of the world. In the 1980s, the nurse: population ratio in Africa was 1:2100, compared to 1:1700 persons in all developing countries and 1:170 in industrialised countries. Almost 50% of the doctors trained in Africa leave to work abroad. Work by Padarath et al, points to migration flows that follow a hierarchy of wealth resulting in a global conveyor belt of health personnel moving from the bottom to the top and thus increasing inequity.

Increasing shortages of trained health workers in rich countries coupled with aggressive recruitment strategies to meet their labour needs has turned many developing countries into exporters of health staff. There is some evidence of poor planning by developed countries. For example, the United States will require 1 million additional nurses within the next ten years to meet its shortfall. In the United Kingdom, a quarter of their nurses will be over the age of 60 years by 2010. An estimated 31% of the UK healthcare workforce is from other countries. About 20% of the medical workforce in Canada, Australia and the United States is made up of international medical graduates. Approximately, 25% of Canadian hospital based physicians are foreign (OECD). In Australia, doctors recruited to work in areas of need or rural areas has increased from 667 in 1993 to 2 900 in 2002. There are currently, over 600 South African doctors working in New Zealand, the cost to the country is estimated to be R600 million. The estimated cost of training a GP in the SADC Region is \$US60 000, this translates into a reverse subsidy from developing countries worth \$500 million per annum for health personnel alone. UNCTAD estimates that rich countries are saving US\$ 184 000 in training costs per professional and that the United States saved US\$3.86 billion as a result of importing 21 000 Nigerian doctors.

Factors influencing HRH distribution and flows

Endogenous and exogenous push and pull factors influence flows of health personnel. Endogenous push factors include poor levels of remuneration and salaries, lack of job satisfaction, work associated risks including crime and HIV/AIDS, lack of opportunities for further education and career development, frustration with civil service and industrial relations

systems that are overly bureaucratic and policy responses such as Community Service that are perceived to be unfair or undesirable. Pull factors include the converse of push factors above as well as mechanistic and flawed developed country staff forecasting needs and recipient country or institution recruitment (that is sometimes aggressive). Exogenous Push and Pull Factors reflect the broader socio-economic conditions and include poverty, unemployment, quality of life and crime, lack of business and economic opportunities, war, civil conflict and political repression, lack of education opportunities for children.

Push and pull factors are augmented by financial and non-financial stick and stay factors. Stick factors include high levels of morale and being able to effectively deliver high quality care; being valued; appropriate supervision; rewards and incentives that result in increases in status, salaries, and training opportunities; social values such as social and cultural ties and barriers to migration for example reluctance to re-locate and language difficulties. Stay factors that have to be overcome if migrants are to return to their country of origin include the development of new social and cultural bonds, reluctance to disrupt of children's education and new lifestyle patterns and lack of awareness of job opportunities in the individual's country of origin.

Undersupply of health personnel in developing countries results from underproduction, increased demand for healthcare, high attrition rates as a result of HIV/AIDS and migration that is made easy by training that prepares personnel for 'western settings'. The quality and output of training institutions is under threat from Structural Adjustment Programmes which not only reduced money for health but also education, including training institutions. Many of the push and pull factors impacting on health personnel are also affecting academic staff and migration is likewise taking its toll on training institutions. Additionally, there is some evidence of reduction in funding for training as demands for healthcare increase. Production of HRH is also affected by barriers to entry such as poor quality of education and high costs of training fees.

A resurgence of international activism and deteriorating health outcomes in poor countries have brought the migration of health personnel to the forefront of the international agenda. In 2002, the 55th World Health Assembly proposed that all countries participate in ethical recruitment and distribution of skilled health professionals to counter the human resource crisis in poor countries and the World Health Organisation (WHO) has initiated a database of "Human Resources for Health Policies" which focuses on policies that have had a positive impact on providing equitable, balanced health workforces.

The African Union has declared 2004 the "Year for Development of Human Resources with Special Focus on Health Workers", this is an attempt to persuade stakeholders to accept their responsibility for ethical recruitment and the achievement of an equitable health care balance.

Whilst, aggressive recruitment of health personnel by rich countries continues, some attempts have been made by recipient countries to limit the impact of migration. The United Kingdom has introduced codes of conduct on International Recruitment, and has introduced immigration restrictions in receiving countries. Restricting the use of expatriate technical co-operation has also been introduced. The Commonwealth has introduced a voluntary code of practice for the international recruitment of health workers, in an attempt to balance the needs of source and recipient countries.

Despite these efforts however, it is unlikely that rich countries reliance upon foreign based health professionals will diminish in the foreseeable future.

Policy Responses

Antoinette outlined the range of policy responses to this situation as below:

Production of Health Personnel

- ◆ National Personnel Accounts to track blocks, inequities and gaps is often missing,
- ◆ Strengthen efforts that can match personnel to workloads and resources or to burden of disease
- ◆ Some evidence of reorientation of curricula and there is potential to increase numbers through training
- ◆ Upstream, potential for improving secondary education and downstream, measures that emphasise a career in medicine as a vocation
- ◆ Creation of specific health qualifications, and cadres of workers with skills appropriate to needs of country, eg Malawi's 'Medical Assistants', and Tanzania's 'Medical Licentiates'

To strengthen deployment and retention of public health personnel

- ◆ Appropriate recruitment - eg from rural areas
- ◆ Decentralisation of location of training institutions
- ◆ Providing continuing medical education for rural doctors using distance learning methods
- ◆ Incentives both financial and non-financial
- ◆ Bonding, for example Community Service and bursary schemes/loans
- ◆ Overcoming 'bureaucracy' of civil service
- ◆ Upstream measures to improve infrastructure, health facilities and supplies of medicines
- ◆ Enable HPs with HIV to work for as long as possible

For reducing migration out of SADC

- ◆ Codes of conduct on International Recruitment (UK)
- ◆ Immigration restrictions in receiving countries including temporary work permits
- ◆ Restricting use of expatriate technical co-operation
- ◆ Commonwealth Code of Practice for international recruitment of health workers that is intended to balance needs of both source and recipient countries.

Mitigating the Impact of Brain Drain

- ◆ Compensation in the form of a 'brain drain tax'
- ◆ Programmes to channel remittances to development
- ◆ Facilitating return of skilled migrants
- ◆ Making use of Brain Gain through utilisation of skills via knowledge networks

3. Developing the Research Agenda

3.1 Research questions from the proposals submitted

From the call for proposals to undertake research within the Region put out by EQUINET and HST, 10 proposals were shortlisted. These proposals fell into three broad areas:

- ◆ Production and Distribution of HRH
- ◆ Migration of HRH
- ◆ Impact of HIV/AIDS on Human Resources

PRODUCTION AND DISTRIBUTION

Researcher	Aims And Objectives
Yoswa Dambisya, South Africa	Aim To establish the distribution of pharmacists trained at the University of the North, and the factors responsible for their choices in terms of sector and location of place of work.

	<p>Objectives</p> <ul style="list-style-type: none"> • Trace the whereabouts of all UNIN pharmacy graduates in terms of place and sector of work. • Investigate the factors that influenced the distribution/location of UNIN pharmacy graduates to their present stations. • Assess how satisfied/happy UNIN pharmacy graduates are with their present situation (in terms of location, sector, income levels). • Assess the relative contribution of various factors to the choices made by UNIN pharmacy graduates. • Solicit suggestions for improvement in areas such as recruitment of students for pharmacy training, allocation of pharmacy graduates for internship, community service and after community service posting, and postgraduate training. • Initiate and encourage the involvement of UNIN pharmacy graduates in the programmes' activities.
Joseph Chilongani Tanzania	<p>Aim The main objective of the proposed study is to assess the distribution of human resources personnel in the health delivery system in Tanzania and to identify factors associated with that distribution.</p> <p>Objectives</p> <ul style="list-style-type: none"> • To describe the distribution of human resource personnel in the health delivery system in Tanzania • To identify factors associated with the distribution of human resource personnel in the health delivery system in Tanzania • To identify factors associated with movement of health personnel between rural and urban, private and public, primary and tertiary levels of the health delivery system in Tanzania
Adamson Muula, Malawi	<p>Aim To determine the coping mechanism of health professionals in Malawi.</p> <p>Objectives</p> <ul style="list-style-type: none"> • To determine the sources of income for health professionals in Malawi • To determine working practices of health professionals in Malawi that may influence their retention in the country • To determine attitudes of health professionals towards various forms of out of formal employment incomes • To contribute to local, national and international debates on the issues of health human resources
Steve Reid, South Africa	<p>Aim To evaluate the educational factors that influence the choice of rural or urban sites of practice of health professionals in South Africa.</p> <p>Hypotheses</p> <ul style="list-style-type: none"> • Choice of practice site is influenced by educational factors to a lesser extent than other factors. • Of the educational factors that influence the choice of practice site, the most significant is the length of time of the exposure to rural practice as an undergraduate.
Oliver Mudyarabikwa,	<p>Aim To provide public sector planners with the underlying causes for the</p>

Zimbabwe	<p>maldistribution of public sector health workers, to influence them to reconsider indicators for efficiency in health human resources management.</p> <p>Objectives</p> <ul style="list-style-type: none"> • Outline the major Health Human Resource policies prevailing in the country • Identify and quantify the size of key stakeholders contributing health human resources and therefore “subsidizing” the public sector. • Outline approaches used to determine health human resources requirements in the public sector. • Identify the Standard Staffing Patterns used by the MoH&CW for each level of health facility in the country. • Review the Health Human Resources Audit for the key and critical health worker categories, quantifying filled and vacant posts. • Assess the geographical distribution of health workers in terms of rural or urban location in relation to population concentration. • Identify the major staffing and distribution gaps against the set standards. • Identify and review the public sector strategies employed to mitigate the staffing and distribution imbalances, indicating their respective effectiveness.
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MIGRATION

Zanele Mhlongo, Swaziland	<p>Aim The overall purpose of the study is to generate information that policy makers can use as a springboard for deciding on policy to curb brain drain.</p> <p>Objectives</p> <ul style="list-style-type: none"> • Determine causes of nurses’ emigration to other countries • Identify strategies to alleviate and curtail brain drain of professional staff in health.
Scholastika lipinge, Namibia	<p>Aims To explore and describe the perceptions of the health professionals with regard to the current condition of services that might have an influence on the movements of health professionals in Namibia.</p> <p>Objectives</p> <ul style="list-style-type: none"> • To describe the perceptions of the health professionals regarding the current conditions of services in Namibia • To identify and describe the strength and shortcomings of the condition of services in Namibia • To make appropriate recommendations as related to the improvements of the condition of service
Abdool Kurremun, Mauritius	<p>Objectives</p> <ul style="list-style-type: none"> ♦ To explore, Review and harmonise, where relevant, policy tools for enhancing health equity in personnel distribution in Southern Africa. ♦ To Strengthen mechanisms for managing the policy interactions between health professional associations and health unions and state

	<p>securities on health personnel issues.</p> <ul style="list-style-type: none"> ◆ To Facilitate and inform dialogue on policy options for dealing with the attrition of health personnel from Mauritius to selected high income countries, including the United Kingdom, Australia and Canada. ◆ To elicit the opinions of nurses on different factors affecting the motivational aspect of their duties. ◆ To identify the motivating and demotivating factors and their causes. ◆ To use the analysis as a basis for making recommendations to upgrade their performance and satisfaction. ◆ To promote the best possible standards of health around the country. ◆ To discourage activities which could harm any country's health care system. ◆ To ensure that the working conditions and educational opportunities in the country are sufficient to the Nursing personnel in areas of work. ◆ To assess the impacts of brain drain on equity and performance of health services. ◆ To ascertain and describe indicators reflecting the consequences of the drain on the health sector. ◆ To explore and describe the factors contributing to the movement and migration of Nursing Personnel and assess its impact on equity and performance of health services. ◆ To assess the distribution of Nurses in the health delivery system in Mauritius. ◆ To assess policies to address the consequences of the brain drain, including existing and proposed policies and policies not currently debated. ◆ To identify the vacant and occupied posts of the Nursing services in Mauritius. ◆ To identify the Nursing Personnel distribution inequities by comparing where they are based. ◆ To identify the strengths and weaknesses of the Nurses after training and for replacement. ◆ To identify key stake holders augmenting training and distribution of Nursing personnel in the country. ◆ To solicit suggestions for improvement in areas such as recruitment of students and for further training.
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IMPACT OF HIV/AIDS

<p>Soraya Elloker, South Africa</p>	<p>Aim To inform policy implementation on treatment access in south Africa, particularly with respect to the equity dimensions.</p> <p>Objectives</p> <ul style="list-style-type: none"> ◆ To identify the implications for health workers of proposals for expanded treatment access through the Municipal services, particularly within primary care and district services, and whether this would be placing extra motivation for workers who are already contemplating leaving the public health sector. ◆ To find out the endogenous reasons why primary health workers are
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	<p>leaving the public health service and what steps might be taken to reverse this trend both from a policy and operational level. We seek to determine how new proposals for ART access will exacerbate or reverse factors driving attrition from public health service.</p> <ul style="list-style-type: none"> ◆ To identify measures to be included in implementing treatment access policies that reinforce health worker retention, including protection of health worker risk and rights within the process.
<p>Robert Molebatsi, Botswana</p>	<p>Objectives</p> <ul style="list-style-type: none"> ● To get an inventory of traditional practitioners registered and those in partnership with Ministry of Health in the collaboration and cooperation initiatives. ● To find out how the potential contribution of traditional medicine can be harnessed. ● Using case studies of HIV/AIDS and TB, and psychological problems, how has the role of these two practices been harnessed? ● Observe how dialogue between the two systems has been promoted and note the success and problems areas. ● What programmes, practices and provisions are in place to foster mutual respect and cooperation between the two systems? ● To what extent has research in traditional herbal medicine been carried out?

3.2 Refining the Research

Group discussions with participants comprising a mix of researchers and resource people explored

- a. what core issues the studies should include and
- b. key features of the study design with regard to methods and the population to be studied

The Core Issues to be explored included:

- Stakeholders attitudes to migration. Possible stakeholders include HR/personnel departments; Unions and Professional Associations; Training Institutions; Registering Bodies; Government reps including politicians and civil servants; Communities and Patients; SDAC and Commonwealth Secretariat.
- Understanding of factors that encourage people to stay
- What do source countries feel that developed countries should do (restitution, partnerships, ethical recruitment?)
- Public discourse around HR flows
- Document experiences of people who have migrated (Why people have moved; what is their experience; what can be learned from the diaspora, do people see migration as easy?)
- Working conditions in source countries
- Definitions of retention (satisfied at work) and return (what would encourage people to return?)
- Mechanisms for sharing information
- How has what health workers are doing changed in light of the HIV pandemic?
- What needs to change to ensure equitable access?
- What kind of support is required for health workers to provide equitable and quality health care services?

- The role of Trade Unions, professional organisations and statutory bodies

It was agreed that the Study Design should

- Use participatory approaches
- Use methods to suit the research design, including stakeholder analysis; and a mix of qualitative and quantitative (although primarily descriptive rather than statistical analysis) research; and policy and document review.
- Target a mix of study populations, including exiting students; mixture of professionals; professional associations. Communities may be an additional resource.

4. Resource inputs

Presentations were given on five areas of relevance to HRH and HRH research including financing issues, research methodology, collecting HRH data and information, mapping migration, policy analysis and advocacy.

4.1 International and National Financial Issues

Eric Friedman, Physicians for Human Rights USA, outlined issues relating to financing that needed to be taken into account in assessing HRH policies, including

- Salaries, bonuses, and benefits are 60-80% of health sector's recurrent costs.
- Low compensation is a major, but not the only factor in the brain drain affecting public health sector losses. Issues include:
 - How best to design compensation programs? What will they cost?
 - How many tasks can community health workers perform? What is required for their success (training, compensation, supervision)?
 - How to design short work programs in wealthy countries?
 - Where could local health professionals replace foreign expatriates and consultants?
 - Higher compensation to local health professionals, less to foreign expatriates and consultants?

He cited some Success stories, such as

Ghana's Additional Duty Hours Allowance (ADHA) which from initial reports has reduced the brain drain, circumvents the civil service salary structure (overtime and performance-based payments are promising strategies). *It also providing cars; will build affording housing Kenya doctors' salary increases which doubled public sector doctors salaries and from anecdotal reports led to doctors returning to the public sector from private sector Other Initiatives, such as* South Africa, Mauritania measures to increase rural salaries, bonuses; Development of mid-level cadres of health professionals (community health nurses, medical assistants – Malawi); Community health workers for specific tasks (ARV treatment monitors; Nepalese women and acute respiratory disease) and provision of short stints of paid service abroad.

He noted that despite the Abuja Declaration (2001) of allocating at least 15% of annual government budget to the improvement of the health sector", actual Health sector spending was below this in Africa in almost all countries. Various estimates have been calculated for the cost of financing a minimum health care package:

- WHO Commission (2001): \$34 per capita
- Arhin-Tenkorang and Buckle (2001): \$45 per capita
- IMF (2001): \$36 per capita

Actual health spending in reality is at

- <\$10 per capita public health spending in many African countries
- In 48 least developed countries, \$11 per capita health spending from government, donor, and out-of-pocket (1997) (WHO Commission report)

He noted that states have legal obligation to “take steps . . . to the maximum of [their] available resources, with a view to achieving progressively the full realization of the rights recognized” (International Covenant on Economic, Social and Cultural Rights). Governments should be held to their obligations through increased domestic commitment on health spending, including compensation, for sustainability

On ODA, he noted that donors are very reluctant to fund recurrent costs and overall health systems development (particularly salaries). Workshops take place of salary support, pre-service education. In Malawi, donor spending on workshops and other in-service training equivalent to 50% of salary for all 9,500 health workers. Meanwhile, the nursing school in Malawi closed for lack of funds. WHO Commission on Macroeconomics and Health estimates \$6 billion for health (now \$2-3 billion additional because of AIDS and Global Fund). The Commission estimates donors must spend \$22 billion/year by 2007 and \$31 billion/year by 2015 to enable delivery of essential health package. He proposed

- Using the Global Fund for staff compensation, at the least for AIDS, Tb, and malaria scale-up. However sustainability is an issue and the Global Fund wants to know how salaries will be sustained after proposal period is over
- Promoting Debt relief, as Sub-Saharan African countries spend about \$14.5 billion per year servicing their debts.

He also noted that IMF influences have resulted in restrictions/freezes on hiring and compensation in health sector, reported inability to accept \$ for AIDS, health spending. Ghana's ADHA to health workers and other civil service wages reportedly significant factor in breaking IMF 2002 budget targets. As a result \$147 million in loans held back. Uganda (finance ministry) almost refused \$52 million Global Fund grant as it has stringent public sector hiring restrictions and a freeze or near freeze on health worker recruitment. The Clinton Foundation had to negotiate with IMF to reduce health sector employment restrictions in Mozambique. In Kenya health worker/public sector hiring restrictions has led to over 4,000 unemployed nurses. In Zambia a program of housing allowances for civil servants caused the country to exceed target of public sector wages. To meet the target, a salary freeze was introduced, housing allowances reduced, and no new civil servants (including health workers) were employed for 1 ½ years

His **recommendations** were for

- IMF/World Bank statement/policy of no punitive actions for increased health/education spending, wages, personnel (or explicit support for these increases!)
- Exclude health/education sectors from various spending ceilings
- On-going dialogue mechanism
- Possible progress
- World Bank planning dialogue with all stakeholders to examine nature and impact of restrictions; goals including eliminating harmful misinformation
- Process could last several years – we need interim measures
- Advocate for World Bank/IMF statement calling for immediate moratorium on health/education wage, hiring restrictions

He also proposed relatively inexpensive HRH capacity-building measures

- HR management capacity-building in health ministry

- HR management capacity-building at facility level
- Devolve tasks to nurses and other health personnel
- Explore potential uses of community health workers
- Ensure medical/nursing schools are open and have sufficient trainers
- Treatment literacy and encourage HIV testing for health care workers
- Psychosocial support for health care workers
- Community service requirement for health professionals

He proposed that the Global Fund be used for salaries to fill the gap until more sustained, higher government (and donor) funding becomes available. Governments should be pressed to meet their 15% pledge. There should be a call for an immediate moratorium on health sector wage, hiring freezes, supported by measures to provide for New cadres, devolve responsibilities, and better HR management.

4.2. HRH Data & Information

Dr. Dela Dovlo, an HR Consultant, outlined issues regarding HRH data and its management. He noted th

- Demand & Supply,
- Utility/Productivity /Quality
- Attrition/Loss (What Type & What Category?; How Many; Where Located; What services delivered; Scope of Service; Service Outputs/Health “production” Skill Ratios/Mixes

“Right numbers & types, in right places, in right combinations; at right cost; doing the right thing;

The key data needs are

- Personal Characteristics: Gender, Age profile, Qualifications, Experience/Years of service, Background/origins?
- Historical Data & Future Trends

Sources of HRH Data are

- Employers – Govt; Private Sector; NGOs, Self Employed;
- Regulators – Professional Councils/Boards
- Unions/Professional Associations. (groups)
- Educators/Training Institutions: Registration Database; Employment/Payroll Database
- Surveys, Census, Membership/Student rolls

He raised some Practical Issues related to Data that implied looking further at data to obtain :

- Annual Staff levels & Trends eg; New Employment (new Graduates; Foreign graduates, returnees)
 - Sub-Categories/Specialties
 - Mid-Level Staff
- Numbers leaving service annually – (Retirees, Resignations, Public to Private and versa; deaths; early retirements; into non-health professions)
- Service Activity Data (Workload, Distribution calculation & comparisons)
- Public-Private Distribution (Age, Gender, urban-rural, dual practice, NGO, Para State, Corporate etc)
- Rural-Urban Distribution (Age, Gender, Private/Public)
- Primary, Secondary and Tertiary distribution (A,G)
- Unemployed Health Workers

- Loss/Attrition Data?

He noted that the Traditional Sector seems non-existent in data terms due to difficulties of typology and categorization), and also noted the need for inter-country comparability – on cadre types; nomenclature variations; different training backgrounds or entry qualifications. He proposed that indicators include

- Vacancies rates for professionals in public health services (Staff norms?)
- Expatriate employment rates
- Resignations rates (Health professionals compared with professionals from other Public Services)
- Salary levels compared to the Cost of Living Index(Purchase Parity)
- Comparison of Specialist/ Generalist vacancy rates Lecturers/ Trainers in the health professions
- Service benefit Costs for Health Workers
- Organizational culture - “?Bureaucracy index” (eg; Delays in recruitments).
- Trends in Average Age of Specialists/Postgrad. Staff.
- Trend in Doctor & Nurse : Population ratios
- Unemployment rates (graduates, other Technical staff)
- Trainee Return Rates from External Courses
- No. of Health Workers registered to migrate - (eg; “Good Standing” “Verification”, J-1 visa clearance rates)

4.3 Mapping Migration:

Dr. Kwadwo Mensah, an HR Consultant noted that most people define *international* migration as the movement of people from one country to another to take up employment, to establish residence or to seek refuge from persecution, either temporarily or permanently. It is estimated that in 2000 almost 175 million people, or 2.9% of the world's population, were living outside their country of birth, (UN Populations Division Populations Database). Medical practitioners and nurses represent a small proportion of this number (but the loss of health human resources for developing countries can mean that the capacity of the health system to deliver health care equitably is compromised).

Most countries collect some data on migration in the following categories, although there is little consistency between countries on how these definitions are applied

- Permanent settlers - legally admitted immigrants who are expected to settle in the country
- Temporary migrant workers - remain in the receiving country for finite periods as set out in an individual work contract or service contract made with an agency.
- Temporary professional transients - professional or skilled workers who move from one country to another, often with international firms.
- Asylum seekers
- Externally displaced persons - not refugees but have valid reasons for fleeing their country of origin (such as famine or war).

There is also the undocumented labour migrants - those who do not have a legal status

While it may be possible to say how many workers have left the health system, it may not be possible to know where they went or to trace them. So who are the migrants we want to map? To ensure accuracy and comparability of migration statistics, efforts should be made to harmonize definitions of migration.

The usual Sources of Data include

- Administration registers - can provide data on all migrant flows (often limited to urban areas or public sector)
- Migration visa/working permit/border statistics
- Censuses/Surveys
- Professional association records
- Regulatory body records
- Health Service records

There are challenges to mapping, including for those working in health sector but changed profession; no longer working in health sector or moved on to another country. To overcome these it is necessary to

- Use as many records as are available to crosscheck data
- Collect primary information using classmates, relations as key informants
- Use as many records as are available to crosscheck data
- Collect primary information using classmates, relations as key informants

4.4 Policy Analysis

Dr. Erwin Erasmus, CHP. presented an outline of policy analysis, noting that it draws on a number of academic disciplines. Policy is central to the organisation and functioning of the health system. Policy Analysis provides a more comprehensive attempt to take account of processes, factors that influence policy and its implementation¹.

He outlined the policy analysis triangle shown in the Figure overleaf.

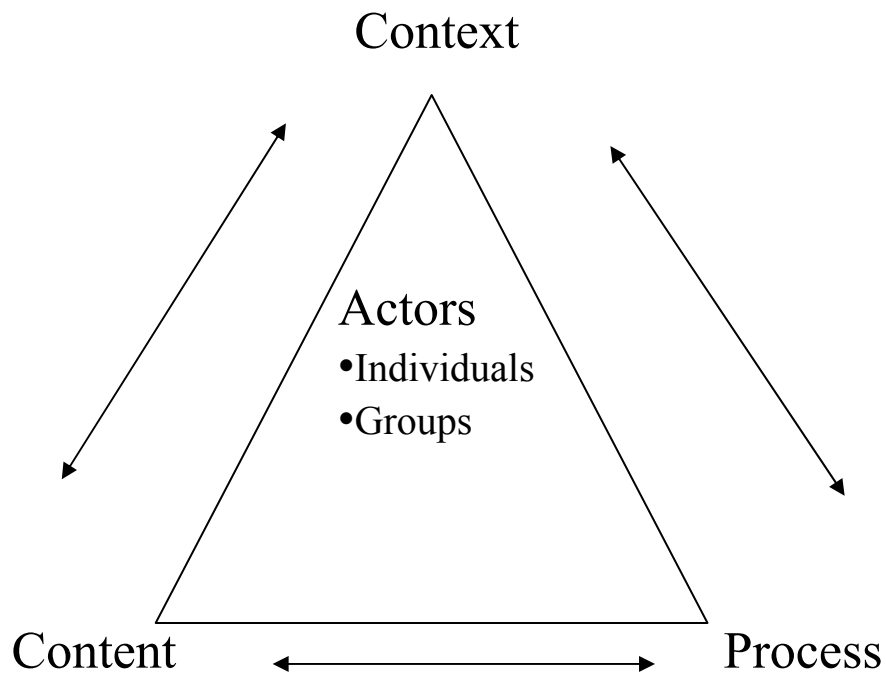
He raised questions that researchers may wish to consider if they are developing proposals that incorporate a component of policy analysis:

- Does the proposal reflect the complexity and range of actors and processes that combine to impact on the specific policy issue being addressed?
- Are the necessary links between these actors and processes being made in the proposal?

¹ He provided readings on policy analysis, including Walt, G. & Gilson, L. (1994) Reforming the health sector: the central role of policy analysis. Health Policy and Planning, 9(4), 353-370.

- Hill, M. (1997) The Policy Process in the Modern State. Prentice Hall, London.
- Grindle, M.S. & Thomas, J.W. (1991) Public Choices and Policy Change: The Political Economy of Reform in Developing Countries. The Johns Hopkins Press, Baltimore
- Crosby, B. (1991) 'Stakeholder Analysis: A Vital Tool for Strategic Managers' in Technical Notes, USAID's Implementing Policy Change Project, No. 2.
- Gustaffson, D. & Ingle, M. (1992) 'Policy Characteristics Analysis' in Technical Notes, August 1992, USAID's Implementing Policy Change Project, No. 3.

The Policy Analysis Triangle



(Walt & Gilson, 1994)

4.5 Advocacy

Mike Rowson, Medact, indicated the needs for advocacy as

- Measurable goals
- Extensive knowledge of who you are trying to reach and what moves them
- Compelling messages that connect with your target audience

One person cannot face the system alone indicating the importance of networking. What then are the compelling messages in HRH? The areas raised were

- Cost control
- Rational planning
- Expansion of under funded systems
- Caring relationships; trust
- Giving back – aid flows
- Collaboration and partnership, Don't stress conflict?

In the UK advocacy they aim to give the target a number: "something that looks like data", and to open up the policy discussion. However they need southern experience and understanding, the south to raise issues simultaneously in each country and coalitions around agreed measured on international migration.

5. Refining the Analytical Framework

In the second set of parallel working groups participants discussed their proposals in light of the methods and resource inputs. These discussions led to the development of a refined analytical framework to guide the regional research.

Analytical Framework

- a. **The development of equitable human resource policy**, with an emphasis on internal distribution of health personnel. The analytical frame work developed to facilitate this defines the health system as an integrated system in which both traditional and allopathic practitioners have a significant role to play. It requires analysis of the demands on, and needs of, the health system, especially at district and PHC level; what this implies for production of health personnel; and a mapping of current practices, roles and types of health personnel, their distribution and workload.

Health System: integrated comprising both traditional and allopathic (Western, scientific) and incorporates Public/Private mix need to addressed inside flows
Health System Demands /Needs (especially at District and PHC level) and what this implies for distribution and production
Mapping in Relation to Current Practices: including roles and types of distribution workloads to give insight into what is happening in terms of how people are distributed, and their workload?
Policy Analysis: What are the enablers and disablers and where do we have leverage?
Management: What tools and capacity are available

- b. **The development of Ethical Human Resource Policy**, focusing on issues of International Migration. The key emphasis of work in this area will be on researching and providing evidence about “what makes health personnel stay”, i.e. what are the main factors impacting on retention. We will be aiming to gather a spectrum of comparative information with a strong focus on qualitative factors. The analytical framework encompasses:

National Policy and Practice: in health sector and beyond health what are the enabling and disabling factors
International and bi-lateral policy and practice: in health sector and beyond health what are the enabling and disabling factors
Policy Advocacy: Identification of relevant policy advocacy processes with a view to ensuring information will get used; and identification of actions required to encourage governments to take on board research findings

- c. **Understanding and responding to the impact of the HIV/AIDS epidemic upon the distribution of health personnel**, (and what are the opportunities and challenges to strengthen health system). The analytic framework is on strengthening health systems in order to best provide ART, with a focus on

District level and PHC. Issues to be explored include: HR roles, concerns issues /perceptions, HR demands; work environments; HR Capacities; Support options and current policy / HR strengthens union/governance roles.

- d. ***Building a regional analysis and policy engagement from country evidence:*** Country level research proposals will be supplemented by the collection of the following core data which will be analysed regionally. This will include

Characteristics of the Health System

- % of GDP in health sector
- Private/Public Mix –shares of health expenditure public and private, indicators of inequality in private and public expenditure
- Rural/Urban Divide
- Basic Organization of health services
- Population Health – priority health problems, morbidity and mortality indicators
- Poverty levels and distribution

Brief Profile of Human Resources

- Key sources of data, their Use and Quality
- Private and Public distribution of HRH by category
- Rural and Urban distribution of HRH by category
- Human Resources share of the Public Health Budget
- Major internal and external flows of HRH by category
- Major Shifts in Personnel

Policy Profile

- Human Resources Policy (internal/external and stay and return factors)
- Agreements in Key Areas
- Policy Implementation Gaps
- Policy Institutions (who makes policy, where and with what policy processes)

Wider Policy Determinants

- GATS commitments and Bilateral Agreements
- Medium Term Expenditure Framework (MTEF) and International Monetary Fund (IMF)
- Other (qualitative)

AIDS and Antiretrovirals (ART's)

- Describe specific migratory measures
- HRH policies, programmes and issues for ART expansion

6. The Way Forward

Following the workshop researchers will refine their proposals and resubmit them. Each proposal will be reviewed by one of the resource people who had attended the meeting. It was proposed that all participants participate in the collection of core data and include in their proposals holding country level stakeholder meetings to share the findings once they have been analysed regionally. The sum of the work will be brought together at a Regional Meeting to be held in mid 2005.

Appendix 1 Programme

Wednesday April 14th	Participants arrive; informal supper	
Thursday April 15th		
8.00 am	Breakfast	
9.00 am	Introduction to the meeting and to delegates	A. Ntuli
9.30am	Overview of EQUINET, its priority areas of work and resources	R. Loewenson
10.00am	Discussion	
10.20am	Tea/coffee break	
10.50am	Introduction to the analytic and policy issues: Policy objectives and priority areas of work in: SADC UK Australia Canada Discussion	Chair: R. Loewenson A. Ntuli M. Rowson S. Arkles T. Schrecker
12.30pm	Lunch	
2.00pm	Working group 1: Parallel sessions on key areas of work: Research/policy questions, objectives 1: Migration of personnel 2. Internal distribution of personnel 3: AIDS, traditional sector and other	Facilitators: K. Mensah D. Dovlo M. Ntuli
3.30pm	Tea	
3.45m	Presentation and plenary discussion of working groups	Facilitators: R. Loewenson and A. Ntuli
5.00pm	Legal and trade issues affecting HRH	Chair: M. Masaiganah R. Tayob
5.30pm	Day ends	
7.00pm	HRH Meeting Private Dinner	
Friday April 16th		
8.30am	National and international financing issues affecting HRH	Chair: R. Mdlalose E. Friedman
9.00am	Methods issues: (15 minute presentations) Policy analysis Data collection on HRH Policy mapping for advocacy Mapping migration Discussion	E. Erasmus D. Dovlo M. Rowson K. Mensah
10.30am	Tea/Coffee	
11.30am	Working group 2: Parallel sessions on key areas of work: Methods, indicators, analytic categories 1: Migration of personnel	

	2. Internal distribution of personnel 3: AIDS, trad sector and other	
1.00pm	Lunch	
2.00pm	Presentation and plenary discussion of working groups Discussion	Facilitated by R. Loewenson and A. Ntuli
3.15pm	Tea	
3.45pm	The view from the coalface – a healthworker's perspective	Chair: M. Ntuli D. Dikwayo
4.15pm	Early closing and time for individual work on proposals.	
Saturday April 17th		
8.00am	Breakfast	
9.00am	Overall framework of the HRH programme: Questions, research, policy and capacity work, processes and time frames Discussion	A. Ntuli and R. Loewenson
10.00am	Tea/Coffee	
10.30am	Presentation and discussion of proposals 1: Migration of personnel 2. Internal distribution of personnel 3: AIDS, trad sector and other Discussion	Chair: S. Reid and A. Muula
12.00pm	Follow up issues: administrative issues, the June Conference, publications and other	R. Loewenson A. Ntuli
12.30pm	Final words Feedback from the community Feedback from the health workers Feedback from authorities Closing	M Masaiganah S Elloker R. Mdlalose
1.00pm	Lunch	

Appendix 2 Participants List

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Appendix 3

UK, Australia and Canada (Hub Countries) Research: Summary of Research Objectives and Activities

1. UK (Medact)

- Major recipient of health professionals from poorer countries
- Despite a policy of “ethical recruitment”
- Questions
 - How can we properly assess the costs of health professional migration
 - How can we balance the rights of communities and health workers within a right-based framework

Paper on costs – and solutions

- ♦ Why do people come to the UK?
- ♦ Why is “ethical recruitment” failing?
- ♦ What can be put in its place?
 - Restitution
 - Partnership
 - Emphasis on UK training enough of its own health professionals

Addressing broader systems issues

- Financial pressures on poor country health systems immense
- Need to argue much more strongly for “expansive” health policy
- But also need to address the issue of **how** money flows through systems, and the role of the private sector
- **We do have a strong case!**

2 Australia

This project has five clear and specific aims.

1. To examine how regional policies at Commonwealth, state and regional levels have influenced the international migration of developing country health professionals.
2. To analyze data of developing country skilled health professional migration into Australia.
3. To ascertain stakeholder feedback on key areas of possible policy development in this area.
4. To appraise policy options for adoption at international commonwealth, state and regional levels.
5. To synthesize these analyses into a report recommending a set of preferred policy options and outlining areas for further research and analysis.
6. These aims will be achieved through the following framework:

Policy Review

- Analysis of Commonwealth/state/regional policies that have influenced migration choices of skilled health professionals.
- Analysis of Australian policy responses to initiatives of developing country governments on migration of skilled health professionals.

- *Data analysis* Analysis of existing published and unpublished data sources on skilled health professionals migrating to Australia.
- *Stakeholder Assessment* Interviews to take place with key stakeholders within Australia. Interviews to deal with: (i) Existing recruitment policies and practices, (ii) Applicability of voluntary codes (e.g. Commonwealth Code) of ethical recruitment, (iii) Definitions of what constitutes 'recruitment', (iv) Initial statements of new policy options for dealing with the question of ethical recruitment from developing countries including Sub-Saharan African and Asia-Pacific regions.
- *Policy Option Appraisal* A review of potential policy options for dealing with the key issue of implementing equity-orientated policies for migration of health professionals from Sub-Saharan Africa. This review should consider the implications of national commitments to existing multilateral policies and should take into account positions of international and national organizations
- *Policy Recommendations* Findings of the four above activities will form the basis of a preliminary report that seeks to outline a set of recommended policy options.

3. Canada

Key Research Questions:

- What factors are most important in determining the migration choices of health professionals immigrating to Canada from SSA? Have aspects of Canadian public policy implicitly or explicitly encouraged such migration?
- Which factors are most, and least, amenable to change through Canadian public policy?
- What are the financial benefits to Canada from the immigration of health professionals from SSA? Do available data permit comparisons to be drawn between the value of these benefits, the value of losses to immigrant health professionals' countries of origin, and Canadian official development assistance (ODA) to health?
- Are losses to SSA offset by transfers from Canada? (E.g. remittances from émigré health professionals, contributions by émigrés returning to SSA ('brain recirculation') temporarily or permanently, improvements in Canada's ability to provide scientific and technical assistance for health systems in the developing world)
- How will current General Agreement on Trade in Services (GATS) negotiations affect the ability of national governments to adopt policies aimed at promoting equity in HHR planning? How will they affect health personnel flows in and from SSA?

Methodology and research activities

1. Analysis of existing published and unpublished data sources (a) on health professionals immigrating to Canada (b) on economic losses to immigrant health professionals' countries of origin, remittance flows, economic gains to Canada in the form of training cost savings, and immigrant health professionals' contribution to Canadian scientific and technical capacity in international health.
2. Historical review, using published and unpublished ('grey literature') sources, of (a) federal, provincial, and regional policies related to immigration and

domestic HHR planning, (b) Canadian policy responses to initiatives by SSA governments on migration of health professionals; (c) policies adopted by organizations of health care professionals and managers and other key stakeholders with respect to the equity dimensions of international recruitment of health professionals.

3. Policy analysis of federal-provincial-territorial implications of national commitments to equity-oriented unilateral or multilateral policies affecting immigration of health professionals from developing countries.
4. Policy analysis and ongoing monitoring of implications of GATS commitments to liberalized trade in services for ability of governments to implement equity-oriented policy measures affecting migration choices of health professionals. .
5. Descriptive review of policy measures that have been proposed or implemented to address issues of global equity in distribution of HHR.
6. Focus groups in which both health professionals who have left SSA and those who have stayed will be asked to share the reasons for their choices.
7. Interviews with a purposive sample of key Canadian informants addressing questions related to existing recruitment policies and practices; determinants of migration decisions; and feasibility and desirability of policy options.
8. Interviews with a convenience sample of physicians and nurses who have immigrated to Canada from SSA.