



IOM International Organization for Migration
OIM Organisation Internationale pur les Migrations
OIM Organización Internacional para las Migraciones

HEALTH WORKER MIGRATION IN SOUTH AND SOUTHERN AFRICA: Literature Review

INTERNATIONAL ORGANIZATION FOR MIGRATION
PRETORIA

**Pretoria, South Africa
October 2007**

Researcher Gayatri Singh (University of Witwatersrand, South Africa)
Technical and Editorial Advisors Liselott Verduijn and Reiko Matsuyama, (IOM Pretoria)

3 SECTION 1

MIGRATION FLOWS, PATTERNS & IMPACTS OF HEALTH WORKER MIGRATION IN SOUTHERN AND SOUTH AFRICA

1.1 Sources of Data and Scope of the Study	3
1.2 Migration Flows and Patterns of Skilled Workers	3
1.2.1 Southern Africa - Health Worker Migration Patterns	4
1.2.2 South Africa – Regional Importer and Net Global Exporter of Health Workers	7
1.2.3 Other Trends in Health Worker Migration in Southern Africa	11
1.3 Impact of Health Worker Migration	11
1.3.1 Impact on Sub-Saharan and Southern Africa	12
1.3.2 Impact on South Africa	14
1.3.3 Other Impacts	16

18 SECTION 2

CAUSES OF HEALTH WORKER MIGRATION

2.1 Economic Factors	18
2.1 Working Conditions for Health Personnel in the Era of HIV and AIDS	20
2.2 Human Resource Management	21
2.2.1 Lack of Equitable Distribution and Reform	21
2.2.2 Education Opportunities, Training and Professional Development	22
2.3 Living Conditions	23
2.4 Other Enabling Factors	23
2.4.1 Increased Demand for Health Services and Health Personnel in Developed Countries	24
2.4.2 Increased Ease of Access to Overseas Employment Opportunities	24

25 SECTION 3

RETENTION ORIENTED RESPONSES TO HEALTH WORKER MIGRATION

3.1 Economic factors in retention of health workers:	25
3.2 Addressing Working Conditions	26
3.3 Human resource management	28
3.3.1 Enhancing Equitable Distribution of Health Professionals	28
3.3.2 Organisational Reform in Health Systems	29
3.3.3 Opportunities for Training and Professional Development	30

33	SECTION 4	
	MANAGING MIGRATION: POLICIES, LEGISLATIVE FRAMEWORKS & PROGRAMMES PERTAINING TO THE INTERNATIONAL MIGRATION OF HEALTH WORKERS	
	4.1 International Responses	34
	4.1.1 International Organisations	34
	4.1.2 International Trade Agreements	37
	4.1.3 Multi-Stakeholder Initiatives	38
	4.2 Regional Responses	40
	4.2.1 Continental	40
	4.2.2 Sub-Regional	41
	4.3 Bilateral Donor Responses and Bilateral Agreements	42
	4.3.1 Department for International Development (DFID)	42
	4.3.2 U.S. Agency for International Development	43
	4.3.3 President's Emergency Plan for AIDS Relief (PEPFAR)	44
	4.3.4 Bilateral Agreements and Medical Exchange	45
	4.4 Other Initiatives	45
	4.4.1 South African Network of Skills Abroad (SANSA)	45
	4.4.2 The Placement Project	46
	4.4.3 Rural Health Initiative (RHI)	46
	4.5 Frameworks on Ethical Recruitment and the Rights of Migrant Workers	47
	4.5.1 The Commonwealth Secretariat	47
	4.5.2 WHO Code of Practice on the Ethical Recruitment of Health Workers	48
	4.5.3 International Council of Nursing and the International Confederation of Midwives	48
	4.5.4 Melbourne Manifesto: A Code of Practice for the International Recruitment of Health Professionals	48
	4.5.5 UK National Health Service (NHS) Code of Practice on Ethical Recruitment of Healthcare Professionals	49
	4.5.6 South Africa's Voluntary Prohibition on SADC Recruitment	50
	4.5.7 A Best Practice Example of Source Country Migration Management: The Philippines Migration Promotion and Protection Programme	50
	4.5.8 United Nations (UN) International Human Rights Instruments	51
	4.5.9 International Labour Organization (ILO) Conventions Relating to Migrant Workers	51
53	SECTION 5	
	CONCLUSION	
56	ANNEX 1	
	LIST OF SELECTED LITERATURE	

SECTION 1

MIGRATION FLOWS, PATTERNS & IMPACTS OF HEALTH WORKER MIGRATION IN SOUTHERN AND SOUTH AFRICA

This section analyzes the available data on flows and trends in health worker migration from southern and South Africa, as well as the impact of migration flows in the context of southern Africa's human resource crisis in healthcare.

1.1 SOURCES OF DATA AND SCOPE OF THE STUDY

Prior to any analysis, it should be acknowledged that data on migration flows is often incomplete and inconsistent across countries. Migration data is compiled from a diverse and disparate range of sources – population censuses; sample surveys; occupational and administrative registers; border-point statistics; and visa, permit and residence applications – and is used for a variety of purposes. Variation in data collection instruments and mechanisms themselves, as well as cross-country variation in data collection policies often results in significant information gaps and incongruent information. While immigration data is often detailed, few countries effectively monitor the emigration of their population. A further obstacle is that many health workers either do not work in health care upon arrival in the destination country or they work informally or at lower job levels and are, thus, not easily traceable through medical registers. All of these factors undermine the external validity of the data and often result in underestimations of actual migration. While acknowledging these limitations, however, the magnitude and diversity of existing data on migration patterns and trends to and from South and southern Africa allows for reliable comparison and analysis.¹ This section uses the most updated and relevant data available in academic journals, databases, policy reports and newspaper articles and forms the backdrop of the rest of the report.

1.2 MIGRATION FLOWS AND PATTERNS OF SKILLED WORKERS

The migration of highly-educated, skilled workers from the world's poorest economies to the wealthiest is neither a new phenomenon nor one that has waned in the last half century.² Throughout sub-Saharan Africa, the loss of highly-skilled emigrants, educated at the tertiary level, has persisted for decades and risen at a particularly staggering rate in recent years. From 1960 to 1975, sub-Saharan Africa averaged a loss of 1,500 skilled emigrants per year. By the 1980s, the number had jumped to approximately 8,000; and by the 1990s, the most conservative of estimates argued the loss of 20,000 highly qualified emigrants per year.³

Largely driven by economic factors,⁴ skilled labour overwhelmingly emigrates to a handful of wealthy industrialized countries. As a

result, nearly 50% of all skilled migrants reside in the United States today; Canada and Australia draw a combined 20% of skilled labour; and the United Kingdom, Germany and France benefit from 15% of the world's skilled migration.⁵ In total, 85% of global skilled labour migrants work and live in only six countries.⁶ While skilled labour migration is a problem for countries in all regions, African countries are shown to exhibit the highest proportion of migration and labour loss with an average skilled migration rate of 10.5%, as compared to Asia at 3% and North America at 5.5%.⁷

The loss of health workers, as a subset of high-skilled labour emigrants, to high-income countries has been particularly explosive both in the magnitude and escalating rate of migration in recent decades due to domestic shortages of trained health workers and growing demand on healthcare systems in Organization for Economic Co-operation and Development (OECD) countries (see Section 2.5.1).⁸ As a result, the impact of health worker migration on sending countries has come under increased scrutiny and become a subject of heated debate in recent years. Despite extensive analysis and discussion, the impact and implications of health worker migration remain unclear, if not disputed.

The following sections examine the extent of such migration, the patterns of migration flows and address some of the issues being debated with respect to the impact.

1.2.1 Southern Africa - Health Worker Migration Patterns

Analysis of health worker migration to the United Kingdom in recent years highlights the magnitude and nature of this global phenomenon. Between 2000 and 2004, nearly 40,000 foreign nurses registered to work in the United Kingdom according to the government's official statistics. While nurses were drawn from a range of countries, the loss of nurses from sub-Saharan African countries was particularly severe. In the four year span, South Africa lost 6,028 nurses to the U.K.; Zimbabwe lost 1,561; Nigeria lost 1,496; Ghana lost 660; Zambia lost 444; Kenya lost 386; Botswana lost 226 and Malawi lost 192.⁹ Beyond the substantial flow of nurses, it is estimated that more than 13,300 physicians from sub-Saharan Africa were already

1. Diallo K (2004). Data on the migration of health workers: sources, uses and challenges. *Bulletin of the World Health Organization*, 82(8): 604-606.
 2. Bueno de Mesquita J Gordon M (2005). *The international migration of health workers: a human rights analysis*. London, Medact/British Medical Association.
 3. Ibid.
 4. The factors creating the impetus to migrate are discussed in Section 2.

5. Docquier F Marfouk A (2006). International migration by education attainment, 1990-2000. In Caglar O et al. (Eds). *International migration, remittances & the brain drain*. New York, The World Bank/Palgrave Macmillan, pp. 168, 187.

6. Ibid.

7. Ibid., p. 172-173.

8. The OECD is a group of thirty member countries. The United Kingdom, United States, Canada, Australia, New Zealand and France constitute the largest destination countries for southern African health worker migration within its membership.

9. Carvel J (2004). Nil by mouth. *London, The Guardian*, 27 August, <http://society.guardian.co.uk/NHSstaff/story/0,,1292102,00.html>, Accessed 20 February 2007.

registered and working in the U.K. by this time.¹⁰

Table 1: Overseas Trained Nurses Registered Per Annum in the U.K. (Bach 2006. p. 9)

COUNTRY	1998/99	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05
India	30	96	289	994	1 830	3 073	3 690
Philippines	52	1 052	3 396	7 235	5 593	4 438	2 521
Australia	1 335	1 209	1 046	1 342	920	1 326	981
South Africa	599	1 460	1 088	2 114	1 368	1 689	933
Nigeria	179	208	347	432	509	511	466
West Indies	221	425	261	248	208	397	352
Zimbabwe	52	221	382	473	485	391	311
New Zealand	527	461	393	443	282	348	289
Ghana	40	74	140	195	251	354	272
Pakistan	3	13	44	207	172	140	205
Zambia	15	40	88	183	133	169	162
US	139	168	147	122	88	141	105
Mauritius	6	15	41	62	59	95	102
Kenya	19	29	50	155	152	146	99
Botswana	4	-	87	100	39	90	91
Canada	196	130	89	79	52	89	88
Nepal					21	43	73
Swaziland						81	69
China							60
Malawi	1	15	45	75	57	64	52
Others						637	495
Total	3 621	5 945	8 403	15 064	12 730	14 122	11 416

10. Clemens M Pettersson G (2006). Medical leave: a new database of health professional emigration from Africa - working paper no. 95. Washington, Centre for Global Development, p. 12.

Source NMC (2005)

Listed by most numerous country applicants in 2004 - 05

Evidence further highlights the relative magnitude of migration flows and health worker loss from southern Africa. While Zambia had an estimated 1,600 doctors in the 1980s, only 400 remained by 2002. Similarly, of the 1,200 doctors trained in Zimbabwe in the 1990s, only 360 were practicing in the country in 2003.¹¹

Destination country data provides even more detailed information on the flows of health workers. Based on data from national registers in seven of the primary destination countries for sub-Saharan African nurses and physicians, Clemens & Pettersson¹² generated

a database of health professional emigration. The magnitude of physician emigration from southern African countries to the United Kingdom, United States, Canada, Australia and Portugal highlights the overwhelming concentration of these migration flows to only a handful of destination countries. Yet, within this concentration of migration flows, the database magnifies the significant variation between countries (see Table 2)

This database shows that United Kingdom is the predominant destination country for most southern African-born physicians. Doctors born in Mozambique, however, overwhelmingly immigrate to Portugal and physicians born in Lesotho, Namibia, Swaziland and Zimbabwe are more likely to immigrate to South Africa than anywhere else.

The magnitude of variation in emigration rates between countries in the region is another striking characteristic of the database.

11. Huddart J Picazo O (2003). The health sector human resource crisis in Africa: an issues paper. Washington, Academy for Educational Development (AED), <http://www.aed.org/ToolsandPublications/upload/healthsector.pdf>, Accessed 19 February 2007, p. 11.

12. Clemens M et al., op.cit.

SECTION 1

With 530 registered doctors practicing in Botswana, the 68 Botswana-born physicians registered abroad results in an emigration rate of 11%. With a physician emigration rate over 30% in Lesotho and Namibia, it rises to over 50% in Malawi, Tanzania and Zambia, and 75% in Mozambique. As such, South Africa, Swaziland and Botswana are the only countries in southern Africa with a physician emigration rate below the average for sub-Saharan Africa.

Table 2: African-Born Physicians Registered to Work in Primary Destination Countries
(Adapted to list SADC countries from Clemens, M. & G. Pettersson 2006)

	RECEIVING COUNTRIES									
	Domestic Workforce	UK	USA	France	Canada	Australia	Portugal	South Africa	Total Abroad	% Working Abroad
Botswana	530	28	10	0	0	3	0	26	68	11%
Lesotho	114	8	0	0	0	0	0	49	57	33%
Malawi	200	191	40	0	0	10	2	48	293	59%
Mozambique	435	16	20	0	10	3	1,218	61	1,334	75%
Namibia	466	37	15	0	30	9	0	291	382	45%
South Africa	27,551	3,509	1,950	16	1,545	1,111	61	X	7,363	21%
Swaziland	133	4	4	0	0	0	1	44	53	28%
Tanzania	1,264	743	270	4	240	54	1	40	1,356	52%
Zambia	670	465	130	0	40	39	3	203	883	57%
Zimbabwe	1,530	553	235	0	55	97	12	643	1,602	51%
Sub-Saharan Africa	96,405	13,350	8,558	4,199	2,800	1,596	3,847	1,434	36,653	28%

Beyond the magnitude of migration flows as documented in medical registers, the intent to migrate is a significant factor worth analysis. A six country study coordinated by the World Health Organization investigated health workers' intentions to migrate.¹³ Of the respondents, 26.1% in Uganda, 37.9% in Senegal, 49.3% in Cameroon, 58.3% in South Africa, 61.6% in Ghana, and 68.0% in Zimbabwe indicated their intention to migrate. Of those intending to migrate, approximately 2% in Cameroon, Senegal and South Africa and 20% in Uganda and Zimbabwe intended to migrate to another African country. The overwhelming majority, however, intended to migrate to OECD countries.¹⁴ A similar survey of 1,200 South African doctors completing their year of community service found that 43% intended to work abroad.¹⁵ While the intention to migrate does not directly translate into actual migration, it is a strong proximate indicator of the favourability of international migration among health workers.

1.2.2 South Africa – Regional Importer and Net Global Exporter of Health Workers

South Africa provides a distinct case study as it is both a significant recipient, as well as source, country of migration flows regionally and internationally.¹⁶ The country suffers from a substantial skilled labour drain as the rate of emigration over the last decade exceeded the rate of immigration by a factor of four. Furthermore, the drain on South Africa's skilled labour supply has rapidly increased in recent years as the emigration rate is now six times larger than the immigration rate. This worsening condition, however, is the result of a significant drop in immigration and not a rise in emigrant outflow (see Figures 1 & 2)

13. Awases M Nyoni J Gbary A Chatora R (2003). Migration of health professionals in six countries: a synthesis report. Geneva, World Health Organization Regional Office for Africa (WHO/AFRO).

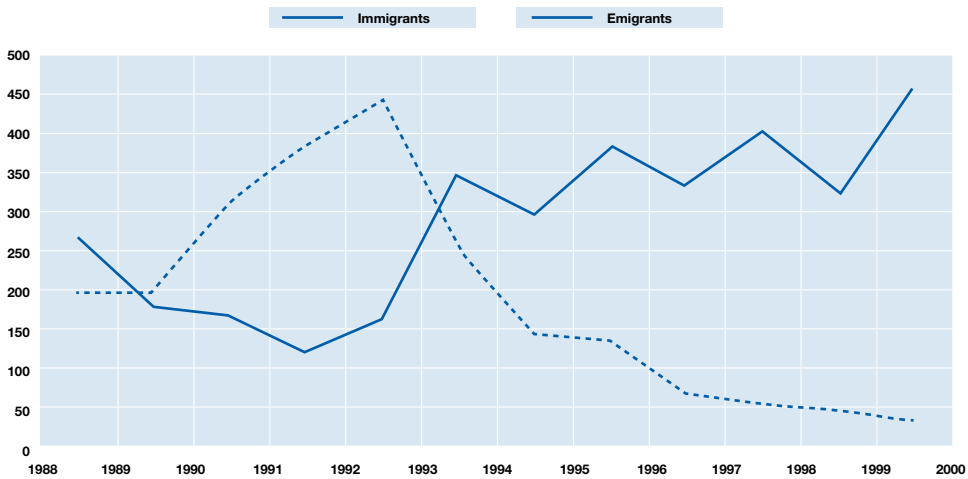
14. Ibid.

15. Reid S (2002). Community service for health professionals. South African Health Review 2002. Durban, Health Systems Trust.

16. Bhorat H Meyer J Mlatsheni C (2002). Skilled labour migration from developing countries: study on South and southern Africa - international migration paper no. 52. Geneva, International Labour Organization, p. 14.; and Hamilton K Yau K (2004). The global tug-of-war for health care workers. Washington, Migration Policy Institute, <http://www.migrationinformation.org/Feature/display.cfm?id=271>, Accessed 22 February 2007.

Figure 1: Migration Flows of Health Professional in South Africa, 1988-2000 (Source Dumont & Meyer 2004. p. 123)

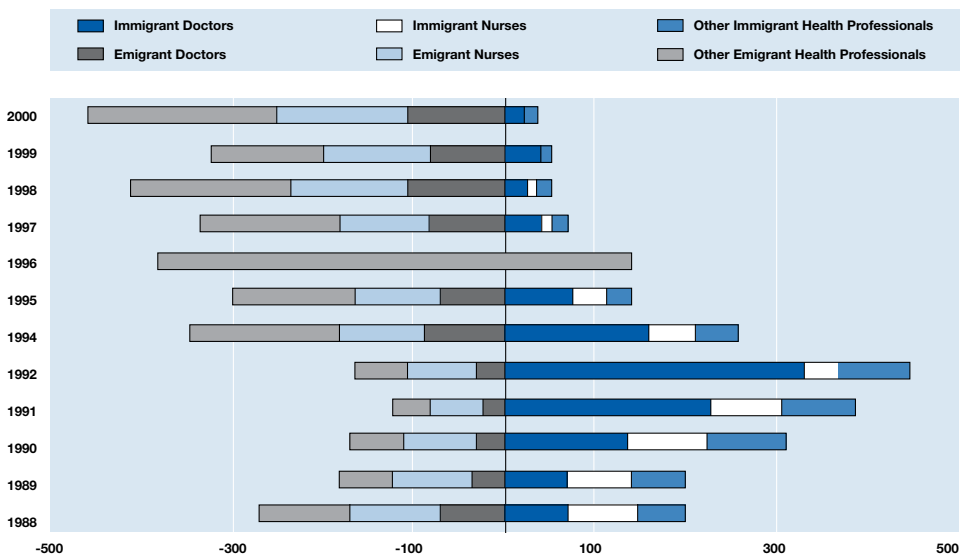
Chart III.4 Migration flows of health professionals in South Africa, 1998 - 2000 (official data)



Source: Doherty and Joffe, 2003

Figure 2: Migration Flows of Health Professionals in South Africa by Categories, 1988-2000 (Source: Dumont & Meyer 2004. p. 123)

Chart III.5 Migration flows of health professionals in South Africa by categories, 1998 - 2000 (official data)



Source: Doherty and Joffe, 2003

As most low and middle-income developing countries are effectively only source countries of skilled health labour for the more advanced industrial economies, South Africa's experience as both source and recipient country is unique.¹⁷ Particularly striking is the fact that the country's patterns of health worker migration mirror the broader tendencies of general skilled labour migration in and out of South Africa.

While there exists an overwhelming dearth of reliable skilled labour migration data for the African continent generally or the Southern Africa Development Community (SADC) more specifically, a large body of anecdotal evidence and a number of disparate studies highlight the regional flow of skilled labour and trained health professionals into South Africa. Survey sampling, for example, has shown that 41% of skilled foreign labour in South Africa is drawn from the labour supply of other countries in Africa, and that 18% comes directly from other SADC countries.¹⁸

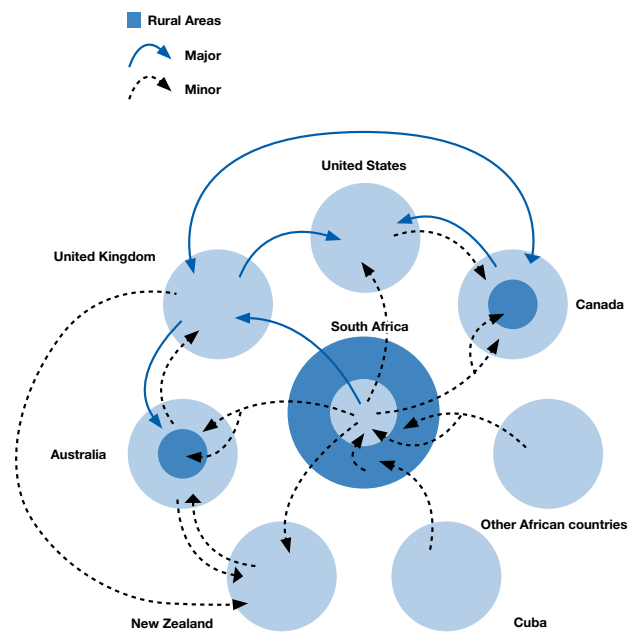
Zimbabwe is a particularly important, albeit controversial, source of immigrants to South Africa owing to the country's acute political, economic and social upheaval in recent decades.¹⁹ A survey identifying more than 22,000 skilled Zimbabwean immigrants working in South Africa, found the majority held bachelors degrees, approximately 20% had obtained a masters degree and 5% had completed a Ph.D.²⁰ While the numbers underestimate the true magnitude of skilled immigration from Zimbabwe, the data provides a semblance of scale. Interestingly, the country's health sector has suffered the most as a result of skilled labour migration as a large proportion of the professionals identified as fleeing Zimbabwe are doctors, nurses and educators.²¹

It is estimated that nearly one-in-four doctors in South Africa is a non-citizen.²² In this regard, Lesotho's experience as a labour source for South Africa is worth noting. Historically, the Basotho were drawn to unskilled labour professions in South Africa's mines and industrial sector. While emigration to South Africa waned through the mid 1990s as a result of strong growth rates and employment opportunities in Lesotho, a resurgence of skilled employment opportunities in post-Apartheid South Africa resulting from shortages of properly qualified local black candidates has led to the impetus of renewed labour loss for Lesotho. Attracted by higher pay and better working conditions, Lesotho's nurses often migrate

to South Africa to supply the country's domestic demand.²³

Despite the gains of minor regional and international immigration inflows, South Africa continues to lose a substantially larger proportion of its skilled labour supply as global emigration rates from the country exceed immigration by a factor of six.²⁴ Although distinct in its potential ability to draw significant levels of skilled labour from countries with lower remunerative salaries and inferior working conditions, South Africa's experience of net medical labour loss is comparable to that of most developing economies. More than 75% of skilled emigrating South African emigrants relocate in only five countries: the United Kingdom, the United States, Australia, Canada, and New Zealand (see Figure 3 below).²⁵

Figure 3: Main Channels of Out- and In-Migration for South



Source: Adapted from Dumont and Meyer 2004

Africa (Source: Joint Learning Initiative 2004. p.104)

For South Africa, the loss is severe as an estimated 30% to 50% of all medical school graduates emigrate to the U.K. or U.S. every year.²⁶ Over the last 35 years, it is estimated that 45% of the University of the Witwatersrand's medical graduates have left the country to practice.²⁷ For recipient countries, the migration flow is critical to healthcare service delivery as more than 6% of the total healthcare workforce in the U.K. and 10% of Canadian

17. Hamilton K et al., op.cit.

18. McDonald D Crush J (2002). Destinations unknown: perspectives on the brain drain in southern Africa. Cape Town, Southern Africa Migration Project, p. 13.

19. Bhorat H et al., op.cit., p.18

20. OCHA (2003). Zimbabwe: focus on the extent of the brain drain. New York, United Nations Office for the Coordination of Humanitarian Affairs (OCHA), http://www.irinnews.org/report.asp?ReportID=35578&SelectRegion=Southern_Africa, Accessed 18 February 2007.

21. Ibid.

22. Padarath A Chamberlain C McCoy D Ntuli A Rowson M Loewenson R Thompson C (2003). Health personnel in southern Africa: confronting maldistribution and brain drain - Equinet Discussion Paper No. 3. Johannesburg, Regional Network for Equity in Health in Southern Africa(EQUINET)/Health Systems Trust.

23. Bhorat H et al., op.cit., p. 18

24. *ibid.*, p. 14.

25. *ibid.*, p. 15.

26. Carvel (2004), op.cit.

27. Ndulu B (2002). Human capital flight: stratification, globalization, and the challenges to tertiary education. Unpublished Paper.

physicians are South African.²⁸

High emigration rates for trained nurses from South Africa mirror the flight of doctors and general practitioners. The U.K.'s National Health Service, alone, registered 6,028 South African nurses between 2000 and 2004.²⁹ These numbers are particularly profound as the average annual loss of nurses to the United Kingdom of 1,500 per year persists despite the implementation of specific regulations designed to prevent the recruitment and drain of health workers from South Africa.³⁰ According to the Democratic Nurses Association of South Africa (DENOSA), a South African nursing union, more than 300 nurses emigrate out of the country every month.³¹

1.2.3 Other Trends in Health Worker Migration in Southern Africa

One of the key challenges facing the health systems in southern and sub-Saharan Africa is the unequal distribution of health workers over the public and the private sector and rural and urban geographies. Resulting from the internal movement of health

workers, it is particularly pronounced in South Africa. In 1998, 52.7% of all general practitioners, 57% of professional nurses and 76% of all specialists worked in the country's private sector, despite the private health sector catering to the needs of less than 20% of the population.³² Urban/rural inequities in distribution are equally emphasized with the urbanized provinces of Gauteng and the Western Cape averaging 180 doctors per 100,000 people – two to three times higher than the national average – and the largely rural Eastern Cape and Northern provinces maintaining 34 and 21 doctors per 100,000, respectively – three to four times less than the national average. Additionally, over 80% of nurses and 88% of physicians work in urban areas, despite only 54% of South Africa's population being located in urban settings.³³

Inequity in distribution of health workers has been further documented in Malawi, Zambia and Zimbabwe (see Table 4). As the data highlights, less than 20% of the health workforce in each

28. Padarath A et al., op.cit., pp. 16-17.

29. Carvel (2004), op.cit.

30. Bueno de Mesquita J et al., op.cit.; and Carvel (2004), op.cit.; and Hamilton K et al., op.cit.

31. Padarath A et al., op.cit., pp. 16-17

32. Dumont J Meyer J (2004). The International Mobility of Health Professionals: An Evaluation and Analysis Based on the Case of South Africa. Trends in International Migration – SOPEMI 3rd Ed. Paris, Organization for Economic Co-Operation and Development (OECD), p. 122.

33. *ibid.*

Table 4: Distribution of Professional Health Staff – Late 1990s (Source: Huddart 2003)

COUNTRIES	CENTRAL & PROVINCIAL HOSPITALS	RURAL HEALTH CENTRES	OTHERS (CENTRAL HQ, ETC)
Malawi	54%	16%	30%
Zambia	41%	19%	40%
Zimbabwe	51%	5%	44%

of the three countries is located in rural health facilities.³⁴

Beyond inequity in the distribution of health workers, the provision of health care in Zimbabwe is further influenced by inequity in funding between its public and private health sectors. Zimbabwe's public health sector provides subsidies to the private health sector. Aimed at growing the private sector's capacity to provide health care, the financial benefits of the subsidies overwhelmingly benefit a handful of private practice owners and health financiers.³⁵

1.3 IMPACT OF HEALTH WORKER MIGRATION

Healthcare is fundamentally a labour-intensive, client-oriented

service sector based on skilled human resources.³⁶ As the health worker is the foundational component of the healthcare system, the impact of skilled labour loss on the health sector of low and middle-income source countries is profound.³⁷

Faced with health personnel shortages and high levels of distributional inequity within limited labour supplies (see Table 4), the loss of medical professionals at current rates radically diminishes often already sub-standard service delivery.³⁸ The loss of health professionals increases the workload on remaining, and often already overburdened, medical personnel; reduces the level of support and supervision of experienced supervisors and colleagues; and directly limits the quality and quantity of

34. Huddart J et al., op.cit.

35. Mudyarabikwa O (2000). An examination of public sector subsidies to the private health sector: a Zimbabwe case study. Johannesburg, Regional Network for Equity in Health in Southern Africa (EQUINET), pp. 17, 22-23.

36. Martineau T Decker K Bundred P (2002). Briefing note on international migration of health professionals: levelling the playing field for developing country.

37. Padarath A et al., op.cit., p.5

38. *Ibid.*

healthcare service provision.³⁹ The emigration of health workers, thus, dramatically weakens failing healthcare systems, and for personnel-strained programs and facilities, the loss of even a few key staff can be enough to permanently close a specialized treatment centre, a rural maternity health program or an AIDS clinic.⁴⁰

Beyond the added strain on remaining health workers and the diminished capacity of the health care system, the economic loss for a developing country is massive. The sunk costs of public investment in primary and secondary education, lost contributions to taxes and GDP, unrealized revenue generation and the subsequent costs of rising illness and mortality resulting from healthcare staffing shortages and the substitution of less qualified replacements, among other costs results from the emigration of individual health workers.⁴¹

1.3.1 Impact on Sub-Saharan and Southern Africa

According to the World Health Organization, sub-Saharan Africa is home to only 11% of the world population, but is afflicted by an overwhelming 24% of the global disease burden and maintains a mere 3% of the world's trained health professionals.⁴² Suffering from the worst healthcare infrastructure and lowest availability of health workers of any region of the world, 36 of 47 sub-Saharan African countries fail to meet the World Health Organization's minimum standard of one doctor for every 5,000 people.⁴³ In this environment, the impact of skilled labour emigration on primary healthcare delivery and critical efforts to effectively respond to HIV and AIDS, Tuberculosis, Malaria and other diseases are crippling.

The health personnel to population ratio provides a relative indicator of the human resources available in the health sector of specific countries. In Sub-Saharan Africa, there are on average 17.1 physicians per 100,000 people. Broad variation exists, however, between countries. While South Africa has 77 physicians per 100,000 people, Tanzania, Malawi, Mozambique and Lesotho range from 2 to 5 physicians per 100,000 people. Botswana, Namibia and South Africa are the only countries in southern Africa with a higher physician to population ratio than the sub-Saharan African average. When analyzed against the available health personnel in destination countries, however, the magnitude of health personnel shortages in southern Africa are

strikingly apparent. In the United States, there are 256 physicians for every 100,000 people. There are 230 physicians for every 100,000 in the United Kingdom; 337 per 100,000 in France; 247 per 100,000 in Australia, 214 per 100,000 in Canada, and 342 physicians per 100,000 people in Portugal.⁴⁴

Table 5: Health Personnel to Population Ratios in Southern Africa

HEALTH PERSONNEL TO POPULATION RATIO		
*PER 100,000 PEOPLE		
	Physicians	Nurses
Botswana	40	265
Lesotho	5	62
Malawi	2	59
Mozambique	3	21
Namibia	30	306
South Africa	77	408
Swaziland	16	424
Tanzania	2	30
Zambia	12	113.1
Zimbabwe	16	128.7
Sub-Saharan African	17.1	87.4

Source: WHO Global Health Atlas 2007 (2001-2004 Data)

While nurse shortages persist throughout southern Africa at a comparable scale, the inter-country variation within sub-Saharan Africa is less severe. In contrast to the region's physician to population ratios, only four countries – Lesotho, Malawi, Mozambique and Tanzania – in southern Africa have a lower nurse to population ratio than the average for sub-Saharan Africa.⁴⁵

Regardless of the country, the loss of skilled health workers is pronounced given the generalized shortages of health personnel throughout southern and sub-Saharan Africa. Zimbabwe's experience poignantly highlights this reality. In 2001, Zimbabwe had over 2000 vacant nursing posts nationally.⁴⁶ 382 nurses migrated from Zimbabwe to the United Kingdom that same year. While this increased the United Kingdom nursing stock by a mere 0.1 percent, the loss to Zimbabwe's nursing stock was proportionally 40 times greater.⁴⁷

While emigration data is limited and inconsistent in its reporting across countries, a number of disparate findings serve to outline the magnitude of the problem in Sub-Saharan African, as well as to highlight the distinct nature of the healthcare crisis within these countries.

39. Dovlo D (2003). The brain drain and retention of health professionals in Africa. Accra, Regional Training Conference on Improving Tertiary Education in Sub-Saharan Africa., 23-15 September, p. 5.; and JLI (2004). Human resources for health: overcoming the crisis. Cambridge, Joint Learning Initiative (JLI) Fellows of Harvard College, pp. 14-15.

40. Carvel (2004), op.cit.; and Hamilton K et al., op.cit.

41. Nayak S (1996). International migration of physicians: need for new policy directions. Bonn, VIIIth General Conference Proceedings of the European Association of Development Research & Training Institutes, p. 3.

42. OCHA (2006). Health worker migration – can it be stemmed?. New York, United Nations Office for the Coordination of Humanitarian Affairs (OCHA), http://www.irinnews.org/report.asp?ReportID=52694 &SelectRegion=Southern_Africa, Accessed 20 February 2007.

43. Bueno de Mesquita J et al., op.cit.

44. WHO (2007). Global health Atlas. Geneva, World Health Organization (WHO), <http://www.globalatlas.who.int>, Accessed 20 February.

45. Ibid.

46. INR (2001). International perspectives: advancing nursing in Zimbabwe. International Nursing Review, 48(2): 74.

47. JLI, op.cit., p.104.

Ghana, today, faces widespread vacancies throughout its national healthcare system – with nearly three-quarters of specialist posts empty – as a result of an estimated 60% of domestically-trained medical school graduates having left the country in the 1980s and 1990s to practice medicine elsewhere.⁴⁸ Zimbabwe similarly struggles to maintain a failing healthcare system crippled by massive skilled labour flight owing to the country's protracted economic and political crisis. It is estimated that more than 80% of the doctors, nurses, physical therapists and medical specialists trained in Zimbabwe since independence in 1980 have now emigrated out of the country.⁴⁹ Symptomatic evidence of this devastating labour outflow, many pharmacies throughout the country have now closed as a result of the loss of trained pharmacists and chemists.⁵⁰

Malawi offers a varied perspective as the country does not suffer from conflict or political tension, but rather severe under-development and a grossly inadequate institutional and infrastructural foundation. With only four central hospitals, 266 trained physicians and 510 primary healthcare facilities in a country of nearly 12 million, Malawi suffers from one of the worst healthcare infrastructures in the world and one of the largest shortages of trained health workers, with a doctor-to-patient ratio of nearly 1:46,000.⁵¹ Beyond the shortage of trained health professionals, most of the country's community health centres lack piped water, communication facilities, properly trained personnel, adequate supplies of drugs, and medical equipment.⁵² Despite the annual training of hundreds of nurses at the Kumuzu College of Nursing, little progress has been made in the country in recent decades as most nurses emigrate in search of higher pay and better working conditions. Highlighting this phenomenon, a survey of health workers found that of thirty registered nurses at one operational hospital, twenty-six planned to leave the country in order to work elsewhere. Further, as a result of high emigration rates and AIDS-related deaths, it was found that only one of the country's twenty-four surgeon posts, a mere 9.3% of specialist postings and only 28% of nursing positions were filled in 2003 in the country, a massive drop from 47% in 1998.⁵³ It should, thus, be no surprise that only 52% of births are attended by skilled health personnel in Malawi; the infant and maternal mortality rates are among the highest in Sub-Saharan Africa; and Malawi maintains one of the lowest life expectancy rates in the world.⁵⁴

The country of Swaziland, afflicted with the highest AIDS prevalence rate in the world, offers a striking comparison. An estimated three hundred nurses in the country died of AIDS-related complications between 2003 and 2005. Over this same period, a mere 200 new nurses were trained in the country, of which 150 emigrated to Europe in search of better working conditions and higher pay.⁵⁵

The loss of limited health workers both diminishes the quality of care and significantly limits the provision of all services to the population in need, whether routine immunizations and tuberculosis treatment or specialized ARV counselling and more advanced services. The specialized skills and human capital of the medically-trained labour supply is, for the poorest and least developed of these countries, singularly critical to salvage crumbling and resource-poor healthcare systems. The recruitment and migration of health workers from the countries where they are needed most, thus, threatens developing nations not only with stagnation, but substantial deterioration in the wake of rising projected global and domestic healthcare needs in the decades to come.

1.3.2 Impact on South Africa

The net loss of health personnel as a result of emigration from South Africa would not constitute a significant threat to the country's healthcare and economy if there did not already exist an overwhelming shortage of general and specialized health personnel. Straining the country's ability to address the high burden of disease and significantly limiting the economy's productive capacity, personnel shortages persist throughout all regions of South Africa, particularly in rural and disadvantaged communities. In 2003, an assessment by the World Health Organization found that more than 60% of South African healthcare institutions struggled to replace nurses lost as a result of emigration. With more than 4,000 vacancies for general practitioners and upwards of 32,000 nursing vacancies throughout the country, the severity of the problem is profound. For the millions dependent on the critical services of the country's under-staffed healthcare system, the impact is devastating.⁵⁶

While the diminished quality and availability of general medical treatment is the most common symptom of emigration, personnel shortages are particularly damaging to the provision of specialized healthcare in the country as well. The quality and availability of mental healthcare, in particular, has suffered. In 2003, only 91 psychiatrists operated in the public health sector nationally, resulting in a patient to doctor ratio of 70,000:1 in the psychological healthcare field. Psychological healthcare services in South Africa are obscenely overextended and subsequently unobtainable, as a result, for hundreds of thousands desperately

48. Dovlo (2004), *op.cit.*, p. 5; Dumont J et al., *op.cit.*, p. 122

49. Bueno de Mesquita J et al., *op.cit.*

50. Hamilton K et al., *op.cit.*

51. WHO (2007), *op.cit.*; and Benson T (2002). Malawi: an atlas of social statistics. Washington, International Food Policy Research Institute (IFPRI), http://www.ifpri.org/pubs/cp/malawiatlas/malawiatlas_04.pdf, Accessed 19 February 2007, p. 41.; and UNDP (2005). Malawi human development report 2005. New York, United Nations Development Program (UNDP), <http://www.undp.org/mw/reports/FinalNHDR%20feb%2013.pdf>, Accessed 19 February 2007, p. 10.

52. UN (2001). Common country assessment of Malawi. Lilongwe, United Nations (UN), http://www.undg.org/documents/1676-Malawi_CCA_-_Malawi_2001.pdf, Accessed 19 February 2007, p. 28.

53. Hamilton K et al., *op.cit.*

54. UN, *op.cit.*, pp. 30-32; and UNDP, *op.cit.*, p. 10

55. Boseley S (2005). UK agencies still hiring poorest nations' nurses – loophole undermining Africa's fight against AIDS. London, The Guardian, 20 December, <http://www.guardian.co.uk/frontpage/story/0,16518,1671243,00.html>, Accessed 22 March 2007.

56. Hamilton K et al., *op.cit.*

in need. With nearly one in seven South Africans suffering from a diagnosable mental illness, most in the country remain undiagnosed and never receive proper treatment.⁵⁷

Beyond diminished service delivery and accessibility, the loss of critical health workers in South Africa has resulted in the closure of several facilities and termination of many critical health programs. One of the most poignant examples of the devastating effects of skilled labour loss and medical out-migration on healthcare in South Africa occurred in 2000. The Centre for Spinal Injuries in Boxburg, South Africa is a specialized referral medical centre servicing the specialized healthcare needs of the entire region. The Centre's two anaesthesiologists were simultaneously recruited to work in a Spinal Injuries Unit in Canada. Despite the critical importance of its consultative, operational and rehabilitative services, the spinal injury centre, like so many other facilities and programs throughout the country, closed on account of its inability to replace a few key staff members.⁵⁸

The prevalence of health worker vacancies, perhaps more than any other indicator, highlights the impact of health worker migration in South Africa. In 2003, the South African Department of Health projected 4,222 unfilled vacancies for physicians and a further 32,734 unfilled vacancies for nurses nationally. The Chris Hani Baragwanath public hospital, alone, had credits available but were unable to hire the 950 nurses it needed, to supplement the existing nursing staff of 1,100, and 18 pharmacist vacancies remained, leaving the hospital's 17 active pharmacists grossly understaffed.⁵⁹ The sheer prevalence and magnitude of health worker vacancies in South Africa is apparent in that more than 20% of the public health sector posts were vacant in seven of the nine South African provinces, and as many as 67% of the posts in northern rural Mpumalanga province were vacant in 2003.⁶⁰

1.3.3 Other Impacts

1.3.3.1 Impact on migrant health workers

Little work has gone into investigating the conditions of health workers in the destination country. While it is generally assumed that health workers undertake the move to a more developed country in order to better their quality of life, this may not always be the case. In recent years the working conditions of internationally recruited nurses and physicians, their career advancement, and discrimination faced at work (including salary scales) has come under scrutiny.⁶¹ A report by the Royal College of Nursing (RCN) found that overseas nurses felt a lack of recognition for their skills and previous work experience,

discrimination due to their foreign training and undermining of their capabilities on the basis of their foreign training.⁶² Along with this, emigrant health workers may also feel the effects of being separated from familial networks and coping in an alien environment and such discriminatory treatment may further increase psychological stress.

1.3.3.2 Impact on health workers in the sending country

Another visible negative impact can be seen on health workers that remain in the sending country. The depletion of human resources from the health sector brings additional burden of treatment and care on those who choose not to leave or are unable to leave. Importantly, due to the existing shortage of health workers, there is little time for health workers to engage in professional advancement activities such as attending conferences and professional meetings in order to exchange information and skills.⁶³ Bach cites Xaba and Phillips work indicating that nurses in many countries, including South Africa, are frustrated and envious of those going overseas as they struggle to cope with the lack of human resources.⁶⁴ Moreover, constant exodus of trained doctors and nurses also create a void in terms of experience within the health care that is crucial for the smooth day-to-day functioning and the health system's ability to plan and deliver education and training for its health workforce.⁶⁵ Finally, this may lead to seeking donor funded assistance from foreign specialists who, while a valuable resource, may not be familiar with the local systems and may create more reliance on external support.⁶⁶

1.2.3.3 Positive impact

Some of the negative impact may be mitigated if African nationals in the diasporas maintain links with their country of origin and send remittances home.⁶⁷ A recent IOM study shows that the Zimbabwean economy, for example, is increasingly supported by remittances received from Zimbabweans living abroad.⁶⁸ Relatively stable flows of remittances could play an important role in mitigating current account problems, particularly those stemming from volatile capital flight trends. During the 1980s international remittances covered 80 percent of the current account deficit in Botswana and constituted more than half of Lesotho's foreign exchange earnings.⁶⁹ In Lesotho in the 1990s, Basotho mine workers' remittances from South Africa accounted for as much as 67 percent of the GDP.⁷⁰

57. Keeton C (2003). Brain drain shrinks mental care. Johannesburg, The Sunday Times, 24 August, <http://www.hst.org.za/news/20030828>, Accessed 20 February 2007.

58. Martineau T et al., op.cit., p. 10.

59. Dumont J et al., op.cit. p. 22

60. Anso T (2004). Where are all our doctors going?. Johannesburg, The Star, 29 July.

61. Bach S (2006). International mobility of health professionals – brain drain or brain exchange?. Helsinki, World Institute for Development Economics Research (WIDER) United Nations University (UNU).

62. Buchan J Seccombe I (2004). Fragile future? a review of the UK nursing labour market in 2003. London, Royal College of Nursing (RCN).

63. Awases M et al., op.cit.

64. Xaba J Phillips G (2001). Understanding nurse emigration: final report. Cape Town, Trade Union Research Project (TURP), p. 6.

65. Bach (2006), op.cit.

66. *ibid.*

67. Vertovec S (2002). Transnational networks and skilled labour migration. Ladenburg, Conference on Migration, 14-15 February.

68. Bloch A (2005). The development potential of Zimbabweans in the diaspora: a survey of Zimbabweans living in the UK and South Africa. Geneva, International Organisation for Migration (IOM).

69. De Haan A (2000). Migrants, livelihood and rights: the relevance of migration in development policies. London, Department for International Development (DFID).

70. Business in Africa (2006). Beating poverty through the black market, News piece dated: 2006-06-14.

However, there is little systematic evidence of the extent of benefit derived from remittances in the SADC region, specifically related to emigrant health workers. The bulk of remittances are often used for consumption, most often of basic necessities, but in some cases of luxury goods. These funds are used only secondarily for investment in human capital (education or health). Hence the money sent often only benefits individuals, families, and households, rather than the public health care or educational systems.⁷¹ Communal or collective remittances are typically invested in community improvements, but make up only a tiny fraction of total remittances. This suggests that significant increases in remittance flows may not necessarily lead directly to lasting changes in receiving economies.

71. Martineau T et al., op.cit.

SECTION 2

CAUSES OF HEALTH WORKER MIGRATION

The framework for analyzing reasons for skills emigration most commonly uses the dichotomous categories of 'push' and 'pull' factors. On the whole, 'push' factors highlight the negative aspects of the circumstances faced by professionals' in the home country, while 'pull' factors represent the positive conditions (expected or prevalent) in the destination country. However, neither of these categories is mutually exclusive. Rather, they can be best seen as representing two sides of the same coin. To this mix of push and pull factors should be added another category of enabling factors that act as catalysts for emigration of health workers or play a guiding role in the choice of destination, aid the ease of transition etc. For example, because of high migration costs, potential migrants need to have access to financial means to migrate. As a result doctors and nurses from richer African countries are more likely to leave than poorer ones.⁷² One reason for this is that economic development in the sending country is likely to assist potential emigrants overcome fixed costs associated with making a move overseas.⁷³ Furthermore, existing Diaspora networks in the country of destination facilitate migration and direct migration flows by providing the necessary information, contacts to find work, and a social environment. In addition, international agreements facilitate the flows of migration to and from certain sending and receiving countries. Hence, migration should also be analyzed in terms of geopolitical influences and transnational communities and networks rather

72. Clemens M (2006). Do visas kill? The effects of African health professional emigration. Centre for Global Development Working Paper.

73. Hatton T J and Williamson J G (2005). What fundamentals drive world migration? in Borjas G J and Crisp J eds., *Poverty, International Migration and Asylum*. New York. Palgrave Macmillan pp. 15-38.

than only in terms of the individualistic calculations of migrants.⁷⁴ This section lays out the causes of health professional migration under four different headings that incorporate push, pull and enabling factors.

2.1 ECONOMIC FACTORS

The opportunities for better earnings remain a key factor in health workers propensity to migrate. This constitutes both a push and a pull factor due to wage differentials between countries. World Health Report 2006 cites 'better remuneration' as the most likely reason to leave in South Africa, Uganda and Zimbabwe (see Figure 4). Amongst doctors and nurses in Ghana, low salaries were invariably mentioned as a primary motivation for migration.⁷⁵ Wages in Sub-Saharan African countries are frequently highly insufficient and public sector health wages can drop sharply during economic crises.⁷⁶ In addition, due to salary compression in many African countries the differences in wages between lower and higher rank health workers have decreased. The incentive to specialize is therefore weaker. In line with the international trend, better wage opportunities are also a key reason for the rural-urban migration of health workers, along with better working and living conditions (as discussed in the following sections).

74. Portes A (2001). Introduction: the debates and significance of immigrant transnationalism., in *Global Networks*, Vol 1 (3), pp 181-194; Faist, T (1999) *Transnationalism in International Migration: Implication for the Study of Citizenship and Culture*. Paper to the ESRC Transnational Communities Programme Seminar, Faculty of Anthropology and Geography, University of Oxford, WPTC August 1999. www.transcomm.ox.ac.uk/working%20papers/faist.pdf.

75. Mensah K MacKintosh M and Henry L (2005). *The Skills Drain of Health Professionals from the Developing World: a framework for Policy Formulation*. London: Medact.

76. Alkire S Chen L (2004). "Medical exceptionalism" in international migration: should doctors and nurses be treated differently? Draft paper prepared for the workshop "Global Migration Regimes", Institute of Future Studies, Stockholm. 9 June 2004. <http://www.globalhealthtrust.org/doc/JLI%20WG%20Paper%207-3.doc>

Wages are also often in stark contrast with the work pressures and occupational risks that health workers face (see section 2.2 below).⁷⁷ Benefits such as remuneration for overtime, night duty allowances, specialisation allowances, adequate accommodation, travel or car allowances, and subsidised meals that might compensate for longer working hours are often not adequately provided.⁷⁸ Vujicic et al suggest that wage differentials between source and destination country can be in the order of 3-25 times with very large wage differentials within southern Africa, for example, between Zambia and South Africa.⁷⁹ Even if an individual feels that they earn enough to meet their existing financial needs, they may cite other reasons such as long term security for children and families, lack of ability to purchase property at the current wage etc. as factors that motivate them to migrate in search of better opportunities.⁸⁰ But if the cost of living and purchasing power parities in the destination countries are factored in, especially when the destination is a country with high costs of living like UK, these differentials may eventually be smaller. However, this is not necessarily factored into the decision making process of a potential migrant. On a survey carried out by the Southern African Migration Project (SAMP) to assess the emigration potential of final year students in six SADC countries, three most important reasons (in order of importance) for leaving their home countries came up consistently across the nations: level of income, ability to find a job, and cost of living.⁸¹ Interestingly, only Zimbabwean respondents ranked the cost of living first.

Economic reasons to migrate are not only related to higher wage but also to the lack of absorptive power in the public health sector of many sub Saharan countries. In 1999, International Monetary Fund (IMF) and World Bank initiated national poverty reduction strategies for low income countries, intrinsically intertwined with economic policies. The implementation of these strategies is mandatory for the countries to qualify for debt relief under the Heavily Indebted Poor Country initiative. In theory this seems reasonable but the conditions associated with such strategies place ceiling limits on medium term expenditure that prevent these nations from increasing allocations on social expenditure such as healthcare budget, salaries of public sector health personnel etc., thus hampering many incentive associated retention strategies.⁸² The Clinton Foundation faced such restrictions while trying to increase the level of health worker employment in Mozambique as part of an initiative to respond to HIV/AIDS. While the Clinton Foundation was eventually able to negotiate a temporary reduction in restrictions on health sector employment with the IMF, this issue highlighted the counter productive nature of these policies that should be aimed at socio-economic transformation.⁸³ This is likely to become an especially pertinent issue to health sector reform in sub-Saharan Africa as governments attempt to institute worker retention strategies or strengthen HIV/AIDS initiatives. The organisation Physicians for Human Rights (PHR) has also noted similar problems in Kenya, Uganda, and Zambia etc.

77. Huddart J et al., op. cit.

78. Physicians for Human Rights (PHR) (2004). An action plan to prevent brain drain: Building equitable health systems in Africa; Padarath A et al., op.cit.

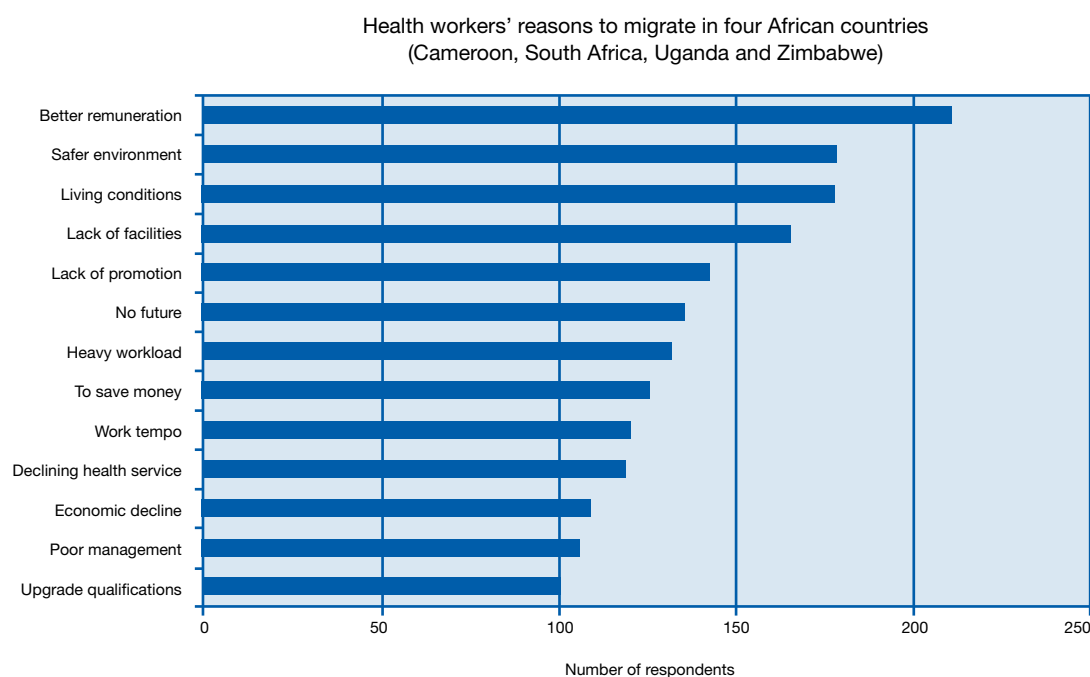
79. Vujicic, M., P. Zurn, K. Diallo, and M. Dal Poz (2004). 'The Role of Wages in the Migration of Health Care Professionals from Developing Countries', *Human Resources for Health* 2(3). <http://www.human-resources-health.com/content/2/1/3>

80. Bach S, op. cit.

81. Crush J Pendleton W and Tevera D S (2005). Degrees of Uncertainty: Students and the Brain Drain in Southern Africa, Migration Policy Series 35, Southern African Migration Project.

82. Bach S, op. cit.

83. PHR, op. cit. p. 80

Figure 4: Health workers' reasons to migrate in four African countries. Source: World Health Report 2006.

2.1 WORKING CONDITIONS FOR HEALTH PERSONNEL IN THE ERA OF HIV AND AIDS

Poor working conditions for health workers in sub-Saharan Africa constitute a significant push factor for migration. Lack of proper equipment and medical supplies often prevents health professionals from fulfilling their tasks. This invariably results in ineffective care for patients and frustration among health workers with their jobs.⁸⁴ This is especially the case in rural areas where staff and resource shortages are far more acute. Healthcare workers often face occupational risks due to the lack of safety materials such as gloves and gowns, and from handling non-sterile injecting equipment or accidental exposure to blood or blood products.⁸⁵ This is especially dangerous where health workers in sub-Saharan Africa have to work in conditions and places where HIV and other infectious diseases are highly prevalent.⁸⁶

The impact of HIV and AIDS on the health workforce is yet to be fully understood. Not only is the burden of disease increasing the workload on an already understaffed system in southern Africa, but it also has a direct impact on health workers by increasing AIDS related morbidity and mortality among this group. For instance, research in South Africa revealed that almost 16% of health care workers both in public and private sectors in Free State, Mpumalanga, KwaZulu-Natal and North-West were found

to be living with HIV.⁸⁷ Projections for 2010 made by Kober and Van Damme in Swaziland based on 2004 data available show that “both emigration and attrition due to HIV/AIDS pose a serious double threat for Swaziland’s health system, which, if not effectively tackled, would mean the loss of more than 330, or 44%, of the nursing workforce in the public sector up to 2010.”⁸⁸ This, in turn, creates further strain on the health care system in the form of absenteeism, reduced productivity and a more stressed workforce.

As a result of such factors, many health workers are not able to deal with the difficulties they encounter in their work environment. Moreover, lower-level health care workers and nurses occasionally experience both verbal and physical abuse, exploitation, gender discrimination, and lack of recognition for their experience and expertise⁸⁹, adding to the already existing occupational stress factors. In most health institutions care and counselling for health workers are not available. There is also little acknowledgement of individual problems that could arise due to difficult working conditions⁹⁰, such as inadequate day care facilities for the children of health workers working overtime.⁹¹

84. PHR, op. cit.; Awases M, op. cit.

85. Tawfik L Kinoti S N (2003). The impact of HIV/AIDS on health systems and the health workforce in Sub-Saharan Africa. USAID, Bureau for Africa, Office of Sustainable Development.

86. PHR op. cit.; Awases M, op. cit.

87. Shisana O Hall E Maluleke K R Stoker D J Schwabe C Colvin M (2003). The impact of HIV/AIDS on the health sector: National survey of health personnel, ambulatory and hospitalised patients and health facilities, 2002. Human sciences research council (HSRC).

88. Kober K., and Van Damme, W. (2007). Public sector nurses in Swaziland: can the downturn be reversed? *Human Resources for Health* 2006, 4:1. p. 7.

89. Bach S (2003). International migration of health workers: labour and social issues. Geneva, International Labour Organization (ILO); Awases M op. cit.

90. PHR op. cit.; Awases M op. cit.

91. Liese B Blanchet N Dussault G (2003). The Human Resource Crisis in Health Services in sub-Saharan Africa. Background Paper, The World Bank.

2.2 HUMAN RESOURCE MANAGEMENT

Along with the inadequate working conditions, poor human resource management practices remain a powerful constraint on the effectiveness of the public health sector, contributing to out-migration.⁹²

2.2.1 Lack of Equitable Distribution and Reform

The lack of management of human resources in health in southern Africa is now beginning to be noticed as a barrier to the retention of health workers. Public health systems in this region have received inconsistent planning and coordination, often leading to a maldistribution of already scarce resources. The most apparent form of skewed distribution of healthcare workers and resources is in the differences between urban and rural areas. Government spending often focuses more on health care institutions in urban areas, creating access problems for rural populations. However, maldistribution also takes place in skills, specialization, and gender of health professionals. A poor skills mix may mean that highly trained health professionals do work that could also be done by relatively less trained professionals. The gender imbalances in health care institutions usually result in a preponderance of males in skilled, specialized professions, and a preponderance of females in the nursing profession.⁹³ Also, insufficient numbers of new jobs are created every year and there is a limited capacity to absorb qualified persons within public health systems.⁹⁴ In recent years, many countries have made progress in developing national policies around effective human resource management. However, the implementation, monitoring and evaluation of these policies have been slower and more difficult. While the policies may be worthy, the implementers often lack funding to address issues like remuneration and retention adequately.⁹⁵ Coupled with this are the barriers posed by slow government bureaucracies and highly centralized management systems that involve several bottlenecks in decision making process.⁹⁶

2.2.2 Education Opportunities, Training and Professional Development

SAMP's 2003 Potential Skills Base Survey of students from six SADC countries showed that emigration potential of graduating students was the highest in the sectors of health, teaching and commerce.⁹⁷ While wages, living and working conditions dominated the responses, the 'prospects for professional advancement' fared almost as important as other reasons cited.

Authors such as Huddart have argued that under-funding in the training of medical, nursing, and related professions often results in low numbers and/or poor quality of graduates and could thus be an impetus for graduating students looking for further educational opportunities abroad.⁹⁸ Similarly, inadequate research possibilities, along with a lack of access to up-to-date information in the professional realm, leads many young African physicians to attend further graduate medical education programs abroad where they become attracted to medical practice conditions not available in their own countries. For those left behind, similar conditions cause frustration and lowering of morale among the health professionals.⁹⁹ Lack of proper training also means that the young physicians lack the ability to deal with medical situations that they have not been trained to deal with, further causing individual stress and a generally low level of healthcare.

The PHR cite results from interviews carried out by Hagopian in Ghana and Nigeria to demonstrate how some medical schools on the African continent inculcate a culture of 'medical migration' among their graduating students.¹⁰⁰ Students learn from their professors and peers about the benefits of emigration and often role model on professors who have previously emigrated. Training and practicing abroad is considered a signifier of success and prestige that is often also endorsed by the management of medical schools. Educational institutions that successfully export graduates are seen as demonstrating their quality and competitiveness by improving the attractiveness for potential students seeking international opportunities.¹⁰¹ Needless to say, this presents a real loss to the sending country in terms of knowledge base, experience and economic investment in terms of the tax payers' money.¹⁰² However, there is also a likelihood that the young professionals may leave to gain international experience but come back to contribute to the health systems in an even more significant manner. A more systematic review of such dynamics needs to be undertaken.

Finally, due to the overwhelming burden of disease on health systems, health care workers in southern Africa do not get enough opportunities to continue training and education once they are employed. This leads to a lack of space for upward mobility and career development opportunities within the professional structures. It is often both difficult and expensive to get study leave, because health education is usually not subsidized. As noted in Section 1.3.3.2, the migration of health workers creates further constraints on the time of those who remain within the system.¹⁰³

92. Bach S (2003), *op. cit.*

93. Hicks V (2004). Health human resources demand and management : Strategies to Confront Crisis. Report of the Working Group on Demand, The Joint Learning Initiative (JLI) on Human Resources for Health.

94. *Ibid*; Liese B et al., *op. cit.*

95. Dussault G Franceschini M C (2003). Not enough here, too many there: understanding geographical imbalances in the distribution of health personnel. The World Bank Institute.

96. *Ibid*; Stilwell B (2003). Developing evidence-based ethical policies on the migration of health workers: Conceptual and practical challenges. WHO Paper prepared for HR Meeting Geneva, December.

97. Crush, J et al., *op. cit.*

98. Huddart J et al., *op. cit.*

99. PHR, *op. cit.*

100. *Ibid*; Hagopian A (2003). The flight of Physicians from West Africa: Views of African Physicians and implications for Policy, (unpublished draft), cited in Physicians for Human Rights (2004) An action plan to prevent brain: Building Equitable Health Systems in Africa.

101. Alkire S et al., *op. cit.*

102. Bailey T (2004). Skills Migration in Human Resources Development Review 2003 Human Sciences Research Centre.

103. Awases M, *op. cit.*

2.3 LIVING CONDITIONS

Living conditions are understood in terms of 'quality of life' that not only embodies material standard of living, "but also other more subjective factors that contribute to human life, such as leisure, safety, cultural resources, social life, mental health, environmental quality issues".¹⁰⁴ International Covenant on Economic, Social and Cultural Right (ICESCR) definition of adequate standard of living further includes the ability to continuously improve one's living conditions. A survey undertaken by SAMP in 2002 in South Africa found that "there was remarkable gender agreement in people's level of satisfaction or dissatisfaction with a range of 'quality of life' indicators".¹⁰⁵ Recent work by Clemens shows that the emigration of health personnel dramatically increases in situations of war showing a statistically significant difference in the pre and post war situations. His analysis shows that the "expected physician migration nearly doubles, from about 0.6 physicians per 10,000 population to about 1.0, in countries touched by war. For nurses, warfare is associated with a jump of nurses abroad per 10,000 population from 0.7 to 1.6, again roughly a doubled exodus."¹⁰⁶

PHR also regards living conditions as one of the main causes of rural-urban migration of health workers. They cite limited access to clean water and fewer educational opportunities for the children of health professionals as major reasons.¹⁰⁷ Vujcic et al note that while such rural-urban migration of health professionals is also prevalent in developed countries like US and Canada, migrant physicians from less developed world are quite willing to take up such postings, perhaps due to relative (or perceived) increase in wages or standard of living.¹⁰⁸ Indicators of 'standard of living' are not always tangible and thus not easy to quantify. But it is crucial to address these issues at structural and policy levels. Despite being exogenous factors to health care, these interventions can significantly aid any retention strategies instituted in sending countries.

Not much investigation has been carried out into the difficulties faced by emigrants in the destination country. Although the wage may be better, with higher cost of living, pressure to send remittances back home and paying back loans that may have been undertaken to cover the costs of emigration, many health workers, especially the nursing staff, may not be able to afford a very high standard of living. Moreover, as noted in the previous Section 1.3.3.1, foreign workers may not be paid at par with their local counterparts in the host country. Dumont and Myer note some such factors linked to the plight of South African nurses in the UK¹⁰⁹ while Mensah et al document the difficulties migrants face in fulfilling the expectations of relatives back home.¹¹⁰

2.4 OTHER ENABLING FACTORS

Alongside the push and pull factors discussed so far, some other factors exist that create an enabling environment for skills migration, particularly in the health sector. Most significant of these for health workers migration is an increased demand for health workers in developed countries in the recent years. Others include a growth of recruitment networks, established Diaspora linkages, and increasing ease of overseas communication and travel.

2.4.1 Increased Demand for Health Services and Health Personnel in Developed Countries

The populations of the industrialized world are aging, resulting in heightened demand for health services as well as trained health personnel. Advances in technology have achieved dramatic increases in life expectancy and formerly fatal illnesses can now be effectively treated. As a result, many Western healthcare systems are transitioning from terminal to chronic care, thus requiring massive increases in health expenditure and staffing. There is also a rise in the consumption of health services in these countries as demand for elective cosmetic, diagnostic, screening and monitoring, and age-related surgical procedures has risen sharply.¹¹¹ This has created vacancies in the health sector that need to be filled. However, while the demand for health workers is increasing, the numbers of young citizens of these developed countries enrolling in health training are diminishing.¹¹²

As a result, the healthcare systems of Europe, the United States and other Western societies simply do not have an adequate supply of trained nurses, doctors and health specialists to meet the growing domestic demand.¹¹³ Norway and Switzerland report shortfalls of 3,000 nurses. Australia and the Netherlands face shortages exceeding 6,000 and 7,000 trained nurses, respectively. Canada is short more than 16,000 nurses, and the UK has identified more than 35,000 vacancies for nurses and midwives.¹¹⁴ Far eclipsing these stark numbers, however, the American Hospital Association, last year, reported more than 118,000 vacancies for registered nurses in the United States. As the deficit of trained nurses is projected to rise, the U.S. government predicts a national shortfall of more than 800,000 nurses within the next 15 years. With a projected need for an additional 200,000 doctors, the U.S. is facing a shortage of nearly one million trained health personnel.¹¹⁵ Rather than looking inward to address these domestic shortfalls by increasing funding and augmenting targeted training programs to achieve self-sufficiency, the United States, England, and most developed

104. Wikipedia definition, See: http://en.wikipedia.org/wiki/Standard_of_living

105. Dodson B (2002). Gender and Brain Drain in South Africa. Migration Policy Series No. 23. Southern African Migration Project. Idasa. Cape Town. p. 2

106. Clemens op. cit. p. 34.

107. PHR op. cit.

108. Vujcic et al. op. cit.

109. Dumont J et al., op.cit.

110. Mensah K et al. op. cit.

111. Simoens S Villeneuve M and Hurst J (2005). Tackling Nurse Shortages in OECD Countries. OECD Health Working Paper No. 19. Organization for Economic Co-Operation and Development: Paris, France. p. 20.

112. Ibid p. 49.

113. Hamilton K and Jennifer Y. (2004). The Global Tug-of-War for Health Workers. Migration Policy Institute: Washington, DC. 2004.

114. Simoens S et al. op. cit. p. 19; Bueno de Mesquita J et al., op.cit.

115. Dugger, Celia. U.S. Plan to Lure Nurses May Hurt Poor Nations. The New York Times. 24 May 2006.

SECTION 3

countries, have looked outward to the labour supplies of the developing world.

2.4.2 Increased Ease of Access to Overseas Employment Opportunities

In the recent years, there has been a tremendous growth of formalized channels of recruitment via commercial recruitment agencies and a simultaneous increase in awareness of such options due to increasing popularity of the internet.¹¹⁶ The access to overseas options has also become easier as a result of mushrooming cheap international

116. Bach S (2006) op. cit.

travel. But most importantly, social networks amongst Diasporas are exceedingly being tapped into by new arrivals to reduce the costs and risks associated with migration.¹¹⁷ In other words, established migration pathways and migrant communities create the flow of information to potential migrants back home as well as reduce risk and costs for a new migrant, thus stimulating further migration. For instance, the growth of overseas nurse associations and other support networks- such as those of Filipino, Guyanese, Jamaican, Nigerian, and South African nurses in the UK- has acted as a significant enabling factor for migration of nurses from these countries.¹¹⁸

117. Massey D Arango G Hugo A Kououci A Pellegrino A and Taylor E (1993). Theories of International Migration: A Review and Appraisal, Population and Development Review, 19(3): 431-66

118. Bach S (2006) op. cit

SECTION 3

RETENTION ORIENTED RESPONSES TO HEALTH WORKER MIGRATION

This section suggests possible responses to some of the push, pull and enabling factors discussed in the previous section. The premise of these suggestions stems from the necessity to maximise the efficacy of responses to southern Africa's health needs rather than simply focussing on creating barriers to the out-migration of health workers within the system. Although the availability of human resources remains key in finding sustainable solutions to health promotion in this region, retention strategies have to be creative and address the structural causes in the long term. Where applicable, examples from other parts of the world, and especially the African continent, are highlighted.

This section is divided into three broad sub-sections:

- (1) Economic factors: This includes government and donor responses to enhance retention of health workers via incentive and disincentive measures.
- (2) Work conditions: Highlighted here are some strategies to improve the working conditions of health workers, including provision of proper medical supplies, better healthcare infrastructure, ensuring safety from infectious diseases (especially HIV infections) and access to good healthcare for health workers themselves.
- (3) Human Resource Management: This section focuses on interventions within health systems in southern Africa to create a motivated workforce whose skills are utilised optimally. This theme is further divided in three categories relating to equitable distribution of health professionals, organisational reform in health systems and opportunities for training and professional development.

The responses outlined in this section relate predominantly to domestic retention strategies, whereas the following section (Section 4) discusses policies, programmes and legislative responses to international migration.

3.1 ECONOMIC FACTORS IN RETENTION OF HEALTH WORKERS:

Countries in southern Africa have had a long legacy of under-investment in the public health systems. Over the past few years, such neglect has become more apparent, especially with health workers choosing to migrate to more lucrative destinations. As a result government efforts in addressing this neglect, particularly workforce problems, have become increasingly visible through both positive interventions (salary increases and other incentive schemes) as well as penalisation measures (such as instituting bonds for emigrating personnel, compulsory community service etc).

For instance, in South Africa the average pay in the public sector, including benefits, increased in 2000 by almost 5% for general practitioners, over 12% for specialists and 14% for professional nurses. Further, in January 2003, the South African Treasury approved the increase in the allowances of physicians in priority rural areas.¹¹⁹ Salary increase strategy has also been undertaken in Botswana for the nursing staff, although with limited retention impact.¹²⁰ Other financial measures include, additional pay for professionals whose work exceeds normal working hours (for instance Ghana in 1999)¹²¹, increased incentives to work in rural areas (for instance, Partners in Health program in Haiti that provides free and regular transport back to the city, free internet

119. Dumont J et al., op.cit.

120. Doviolo D. (2004). Using Mid-level Cadres as Substitutes for Internationally Mobile Health Professionals in Africa: A Desk Review. Human Resources for Health, 2(7), <http://www.human-resources-health.com/content/2/1/7>

121. Mensah K et al., op. cit. p. 23

access, boarding and lodging to recruit health workers in rural areas)¹²² etc. However, some of these measures, particularly across the board pay increases, are not necessarily possible in the short term for many southern African governments facing severe budgetary constraints. Donor organizations are also reluctant to support salary scale increases that bind them to sustaining a funding program in the long term. Measures such as the Partners in Health program in Haiti are more likely to attract donor funding as they aim to spruce up the fringe benefits and not the basic salary scales increases. This could be an interim solution to help strengthen the health systems in medium term in areas that are less attractive to health personnel, while buying the governments some time to address more deep rooted structural issues like infrastructure development.

Measures seeking to penalise migrating health professionals arise from the rationale of being able to claim back the public monetary investment put into training health professionals within the source country. An additional hope is that such financial penalties would deter health professionals from out-migrating.¹²³ These measures can range from contractual bonding that requires health professionals to pay back proportionately for the training that they have received, either by serving within the public health system for a specified number of years or by 'buying' their way out if they leave before the end of a specified period. A SAMP survey of final year students in southern Africa found that overall, students were not averse to the idea of some form of cash or service based payback for government grants and loans.¹²⁴ Another proposed payback measure is for a receiving country to reimburse the sending country for money put into the training of health professionals, as well as for various losses in terms of tax payers' money, lost work contribution of the migrant, and loss of health to the population as a result.¹²⁵

Many of these measures are contentious and have been criticized in terms of restricting the right to freedom of movement when instituted in rigid terms. They are also more likely to retain those who are economically less well off and find it difficult to pay out any government instituted penalties, and are therefore potentially discriminatory. Further, Mensah et al have argued that in Ghana, bonding policies have often been poorly enforced, lacked widespread legitimacy, have led to evasion strategies and served to discourage return.¹²⁶ Suggestions that advocate for destination countries to monitor repayment of such bonds is also likely to prove improbable due to the logistics involved

in ensuring these arrangements.¹²⁷ Hence many authors have argued for attention to be directed to more positive measures that facilitate increased recruitment and retention with the willing participation of the health personnel.

3.2 ADDRESSING WORKING CONDITIONS

It is unlikely that solely financial remuneration would be an adequate measure to retain health professionals and increase the quality of health care in the absence of improvements in the general working conditions within the health sector. It has been argued that working conditions and human resource management (discussed in 3.3) are key to increasing the motivation of health workers and hence, retention. According to Mathauer and Imhoff "many health workers are demotivated and frustrated precisely because they are unable to satisfy their professional conscience and impeded in pursuing their vocation due to lack of means and supplies and due to inadequate or inappropriately applied human resources management (HRM) tools"¹²⁸ (see also, Figure 5 below). Good working conditions can be ensured by the provision of adequate infrastructure, acquisition and maintenance of medical equipment, adequate supply of medication, instituting proper occupational health provisions (such as gloves, gowns, sterile needles, regular infection control assessments, use of medical equipment with proper safety features etc.) and specifically measures to address the risks posed by HIV and AIDS to health workers in this region. In addition to material interventions, health workers need to be adequately trained and informed about HIV and AIDS in order to decrease infection risk for workers, address fears, misconceptions and stigma, and improve patient care.¹²⁹ Recognising the importance of improving working conditions in health systems, South African government is considering allocating 61 million rand (approximately USD 6.5 million) to increasing the security of the medical infrastructure.¹³⁰

This is an area where donor funding as well as support from countries receiving health workers could be more effectively utilised. Sending countries could be assisted in rehabilitating health facilities, ensuring proper infrastructure (including, telecommunications, internet, electricity and a supply of safe water) and remote medical assistance technologies (esp. in remote rural areas).¹³¹ Other support can include improvements in drug distribution systems and training associated with proper stock management. However, the final responsibility to facilitate and bring about such conditions lies on the shoulders of the governments of the affected countries themselves. A laudable initiative in this regard has been instituted by the government of

122. Physicians for Human Rights (2006). Bold Solutions to Africa's Health Worker Shortage. www.phrusa.org/www.healthactionaids.org

123. Bach S (2006) op. cit.

124. Crush J et al., op. cit.

125. Stilwell B (2001). Health worker motivation in Zimbabwe. Unpublished paper/internal report for the Department of Organization of Health Care Delivery Geneva: World Health Organization, in Mathauer, I. and Imhoff, I (2006) Health worker motivation in Africa: the role of non-financial incentives and human resource management tools. Human Resources for Health.

126. Mensah K et al., op. cit.

127. Bach S (2006) op. cit.

128. Mathauer I and Imhoff I (2006). Health worker motivation in Africa: the role of non-financial incentives and human resource management tools. Human Resources for Health 2006, 4:24. p. 3

129. Liese B et al., op. cit.

130. Dumont J et al., op. cit.

131. PHR (2004) op. cit.

Swaziland and is described in Box 1¹³² below as an example of best practice.

BOX 1: THE CASE OF SWAZILAND: PROVIDING HEALTH CARE TO HIV AFFECTED HEALTH WORKERS

Eighty per cent of Swaziland's health workforce is women and it is estimated that they have the same HIV risk as the general population, where rates of HIV prevalence in adults have peaked at 42.6%. In 2005, 6% of the health workforce was lost to death, sickness and migration. One survey has shown that HIV has had a serious impact on health workers, both at work and at home; and when they themselves are infected they find it difficult to access HIV and AIDS services. The government of Swaziland has therefore embarked on a range of programmes to support health workers in the context of HIV and AIDS. They include expanding tailored services for health workers; integrating HIV workplace programmes in health services; programmes to combat stigma and discrimination among health workers; and integrating infection prevention and control into health care delivery. In February 2006, the first wellness centre for Swaziland's health workers was opened in Manzini, the capital city of Swaziland. It emerged from a partnership between the Swaziland Nurses Association and the Swaziland National AIDS Programme. It provides a range of services from stress management and psychosocial support to counselling and testing, prevention, antiretroviral treatment, post-exposure prophylaxis, home-based and palliative care, to all health workers in need. It aims to cater for 3000 health workers and their immediate families. Phase 2 of the project will involve expansion to three regional centres.

3.3 HUMAN RESOURCE MANAGEMENT

Human Resource Management (HRM) is pivotal for the effective development and maintenance of any health system. In the case of southern Africa, its role is even more crucial given the possibilities for enormous improvement with little additional financial inputs. Human resources have been identified as "one of three principle health system inputs, with the other two major inputs being physical capital and consumables".¹³³ At the very

heart of an effective human resource management system is the development of a strong and satisfied human resource base that is ensured by the financial and structural measures described in the previous two sub-sections. But simply providing material benefits or infrastructure is not enough to create a workforce that is motivated, feels valued and whose skills are being utilized optimally. This requires a sound management system at macro as well as micro levels of health systems administration. Kabane et al even argue for an analysis of HRM systems from a global perspective.¹³⁴ This section focuses on HRM interventions relevant to situations within southern African countries.

3.3.1 Enhancing Equitable Distribution of Health Professionals

Numerous suggestions have been made to create a more equitably managed distribution of health professionals between public and private sectors as well as rural and urban areas. Some of these include, recalling of retired nurses and doctors on a part time basis to bolster the advantages of having experienced workers; removal of compulsory retirement ages; enabling health professionals to extend their working lives from 60 to 65;¹³⁵ compulsory recruitment of graduating doctors in rural areas; and more effective public-private partnerships at the level of clinical expertise and medical facilities (such as privately subsidised referrals, use of privately owned premises by public sector employed doctors to carry out complex procedures in partnership with private doctors). In order to decrease the negative impressions of compulsory community service by many young doctors, efforts should be made to address the conditions of such service by providing benefits such as transport and communication allowances to allow for familial contact, positive reinforcement by senior members of staff on the work being carried out by junior doctors, provision of comfortable housing etc. Another way to address human resource shortages is to allow public health professionals a percentage of their time to carry out private consultations.¹³⁶ Finally, Mathauer and Imhoff argue that non-financial incentives promoting the motivation of health personnel to stay in the public sector or even rural areas play a significant role in retention (see Box 2 for Malawi's example¹³⁷). These include better treatment of junior and nursing staff by senior professionals and health managers, supportive management, strong leadership, incentives linked with performance appraisal and recognition for innovation in service etc.¹³⁸

132. The text in this box is directly quoted as it appears in the Treat, Train, Retain: The AIDS and health workforce plan. Report on the Consultation on AIDS and Human Resources for Health. World Health Organization (WHO): Geneva, Switzerland. 11-12 May 2006. p. 7.

133. Kabene S M Orchard C Howard J M Soriano M A and Leduc R (2007). The importance of human resources management in health care: a global context. Human Resources for Health 2006, 4:20.

134. Ibid.

135. Dovo D (2004) op. cit.

136. Pang T Lansang M A Haines A (2002). Brain drain and health professionals. A global problem needs global solutions. Editorial 29 (92): 273-284. Dovo D (2001) op. cit.

137. DFID (2006). Moving out of poverty – making migration work for poor people. London, Department for International Development (DFID). p. 22.

138. Mathauer I et al., op. cit.

BOX 2: MALAWI'S EMERGENCY HUMAN RESOURCE PROGRAM

For years the Government of Malawi has been largely unable to train and employ enough health sector staff to meet its domestic needs. In response to the attrition of health workers as a result of HIV/AIDS and the transfer of a large proportion of health workers out of the public health service, the government developed the Emergency Human Resource Programme. The programme aims to improve incentives for the recruitment and retention of health workers specifically through salary increases, to markedly expand domestic training capacity, and to recruit physicians from other countries on short-term contracts. Beyond increased pay, the programme intends to address the range of non-financial factors that affect health worker retention, including performance management, posting and promotion policies, re-grading, quality of housing and facilities, training, and gender issues. Additionally, the programme places specific emphasis on strengthening human resource planning and the capacity of management at the local and regional level and in the Ministry of Health.

3.3.2 Organisational Reform in Health Systems

Apart from these, organisational reform of the public health systems, policy reviews, supervisory patterns, and motivational issues need to be addressed.¹³⁹ Of primary importance to such reform is addressing the critical decision making capabilities within health ministries and training of health managers at

various structures of public health systems.¹⁴⁰ According to Bach such lack of critical strategy leaves “key questions about the distribution, qualifications, motivation, development, and performance of staff unexplored.”¹⁴¹ An intervention could be to offer workshops, increase short courses on this issue for existing managers and inclusion of this topic within pre-service training curricula.

Moves to decentralise the HRM, in order to include the transfer of power, resources and responsibilities from central agencies to local units, could substantially improve health service delivery.¹⁴² On one hand, a closer interaction between health service providers and consumers could be enabled, leading to health services being more tailored towards local needs. On the other hand a well implemented decentralization strategy has the power to enable health professionals at the frontlines to engage with health policy, formulation, planning and implementation much more effectively. This has the advantage of not only creating a well informed policy and practice but also empower health professionals by giving them a real say in the workings of health systems. However, decentralisation moves need to be carefully executed lest they become vehicles of favouritism and risk the loss of the macro factors in health systems management without the benefit of a birds eye view at the national level.¹⁴³ Governments could also undertake a review of best practice instances from other developing countries where HRM for health is more streamlined, while keeping in mind appropriateness in terms of economic ability, political will and cultural aspects.

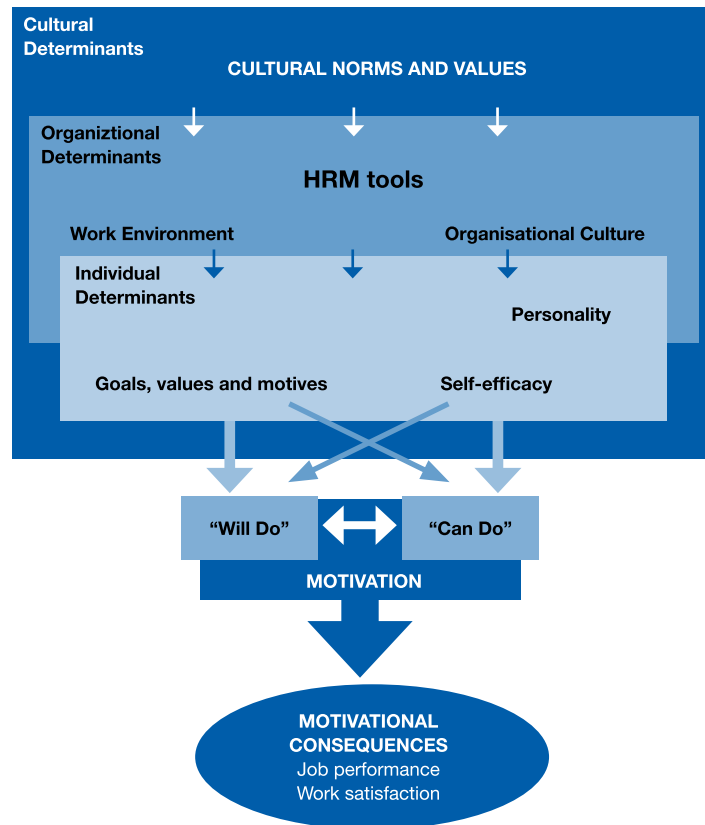
139. Fritzen S A (2007). Strategic management of the health workforce in developing countries: what have we learned? Human Resources for Health 5:4.

140. PHR (2004) op. cit.

141. Bach S (2001). HR and new approaches to public sector management: Improving HRM capacity. Paper prepared for the WHO Workshop on Global Health Workforce Strategy Agency. France.

142. Fritzen S A, op. cit.

143. Dussault G, op. cit.

Figure 5: Motivational Determinants and ProcessesSource: Figure from Mathauer & Imhoff (2006)¹⁴⁴

3.3.3 Opportunities for Training and Professional Development

Curriculum reform and skill substitution can also be effective in addressing the problems in retaining health workers in the countries of southern Africa. Curriculum reform would involve an emergence of curriculum more suited to deal with the medical problems and diseases being increasingly faced in the region by health professionals, particularly with regard to HIV and AIDS and complicated infectious conditions such as Extremely Drug Resistant Tuberculosis (XDR TB). Another approach that is becoming popular is the development of workforce strategies involving skills substitution and delegation of responsibilities to other occupational groups in order to compensate for out-migration by diversifying skills base.¹⁴⁵ Skills substitution measures are aimed at altering the skill-mix of the health workforce. An important strategy in this regard is the training of mid-level health cadres to perform some of the tasks that are currently being performed by nurses, doctors and pharmacists. Mid-level cadres of health workers refer to groups such as paramedics, phlebotomists, pharmacy technicians and assistants, clerical staff etc. Such strategies will create a class of groups that have less transferable skills but are able to provide good quality care with proper training and supervision, while freeing up the time of pharmacists nurses

and doctors for more specialized tasks. For instance, Malawi makes use of health surveillance assistants that require six weeks training; Tanzania has introduced medical licentiates, trained in basic health sciences, obstetrics, and surgery in district hospitals; Mozambique utilises a variety of surgical and medical technicians and Zimbabwe has introduced state-enrolled nurses requiring two rather than three years of training.¹⁴⁶

Such skills substitution measures must also be accompanied by initiatives to advance the skills of existing staff. As a PHR Report suggests, nurses are far more numerous than doctors in Africa and could assume advanced practice roles, including prescribing ARVs, especially in the light of new developments in this field.¹⁴⁷ For instance, WHO has now developed guidelines and training modules to help standardize AIDS treatment and ARV regimens have become simpler with the availability of fixed dose combinations. At the Lighthouse Clinic in Malawi, physicians prescribe ARVs for the first six months, followed by nurses issuing ARV prescriptions three consequent times and then a compulsory physician review to monitor the patient's progress. Many other models for advance nursing practices also exist in Africa, such as nurse midwives dispensing medication, nurses in

144. Mathauer I et al., op. cit.

145. Bach (2006) op. cit.

146. Ibid., p.19; PHR (2004) op. cit. p. 70.

147. PHR (2004) op. cit.

Zambia being allowed to perform some invasive medical procedures, nurses in Botswana prescribing medication when no doctor is present etc.¹⁴⁸ Not only will this add to the existing skills-base but will also positively motivate the health workers to stay in their home countries to advance their careers. In addition to this, community based training models with locally relevant curricula can be employed to combat the urban-rural maldistribution of health workers. The example of Ghana showcased in Box 2¹⁴⁹ below in this regard.

148. PHR (2004) op. cit.

149. The content of Box 2 has been taken (with minor editing) from Physicians for Human Rights (2006) op. cit.

BOX 3: CASE OF GHANA

To overcome disparities and extend health care to remote areas of the country, Ghana has adopted an initiative known as the Community-based Health Planning and Services program, or CHPS. Adopted as a national health policy initiative in 1999, CHPS is modeled after a successful project that was undertaken in Navrongo, a town in the northeast of Ghana near the Burkina Faso border. The Navrongo project demonstrated that the location of a mobile health professional at a health center within a rural community greatly increased the uptake of health services, resulting in improved immunization coverage, decreased fertility and other positive health outcomes. CHPS is based upon a three-pronged approach that incorporates community participation, locally-based health professionals and active outreach to surrounding populations.

CHPS has transformed the existing position of the Community Health Nurse (CHN) into the Community Health Officer (CHO). CHOs have additional training and are based in Community Health Compounds, making them more easily accessible by community members than CHNs, who are based in sub-district health centers. This title upgrade is reflective of the additional responsibility placed upon CHOs with special status conferred on

them in recognition of their central role in providing basic health services to communities within their assigned area. CHPS also seeks to utilize social resources within a community to underpin the expansion of health services. Before a CHO is placed in a rural community, traditional leaders and community members must commit to supporting the CHPS structure of care within their community. The active participation by the community is crucial to supporting the CHO in his or her role. This includes formation of a local health committee and selection of volunteers to assist the CHO. It may even involve the use of community labor to build the health compound or grow food for the CHO.

CHOs receive 18 months of training as Community Health Nurses, supplemented by a six-month field internship alongside an experienced CHO. CHO training covers such topics as educating community members on family planning and childhood immunizations; first aid care and management of ailments like malaria, fever, and diarrhea; and detecting and referring more complex cases onwards to health centers. In return for their services in remote areas, CHOs receive an additional wage allowance and are eligible to be sponsored for further study, including tuition, room, and board, after three years of service.

In addition to this, the pre-medical health education system could be reinforced by developing more and accessible basic training, specialisation and refresher courses. The PHR group suggests that this can be more effectively done by setting up nationwide or facility-based committees, with student and medical residents as members, to review the quality of graduate and residency training, particularly to address concerns of students and local physicians.¹⁵⁰ Good quality distance education learning systems

150. PHR (2004) op. cit.

and alternative and shorter training programs could especially prove useful in developing skills within remote areas, especially for skills substitution strategies described above.¹⁵¹ These are also areas where funding and expertise from more developed countries could be channelled effectively, for instance, in developing libraries with latest journals at nominal or no costs to the students and professionals as well as setting up and maintaining distance learning programs.

151. Dussault G, op. cit.

SECTION 4

MANAGING MIGRATION: POLICIES, LEGISLATIVE FRAMEWORKS & PROGRAMMES PERTAINING TO THE INTERNATIONAL MIGRATION OF HEALTH WORKERS

Individual countries and coalitions of states, international organisations, as well as trade and interest groups have implemented an array of policies and programmes in attempts to influence and manage the transnational migration of health workers. These efforts include country-specific migration policies and occupational certification requirements, bilateral agreements, ethical recruitment guidelines, international conventions and legal frameworks, among others. Broadly, this section highlights policies, programmes and other legislative frameworks (international, regional, sub-regional, national) that address the issue of migration management, regulation and protection of migrant workers, with a focus on the health sector.

The need for such macro level responses has arisen not only from the increases in skilled workers' migration from 'South' to 'North', but also from the history of quality-selective immigration policies that have been pursued by the wealthy, industrialised Organization for Economic Co-operation and Development (OECD) countries since the 1980s. Australia, Canada and New Zealand explicitly privilege skilled workers, selecting candidates based on a points system of their expected contribution to the economy. The effect on Canadian immigration, in particular, has been remarkable, with a sharp rise in professionals and entrepreneurs as a proportion of total immigrants. In 1997, alone, Canada documented an inflow of more than 50,000 highly-trained specialists and entrepreneurs, constituting 58% of total immigrants.¹⁵² Despite nearly thirty years of a zero-immigration policy throughout Europe, immigration reform and skills-based entry systems have become the new paradigm.¹⁵³ France, Ireland and the United Kingdom have all initiated programmes targeting highly qualified labour with the establishment of labour-shortage occupation lists.¹⁵⁴ Germany instituted a system of five-year green cards to recruit technological specialists and, with the adoption of the new German Immigration Act, is attempting to establish flexible migration policies to allow for improved acquisition and retention of temporary and permanent foreign skilled labour.¹⁵⁵

For the United States, quality-selective immigration and labour policies have been particularly productive. With a series of proactive legislative initiatives, including the Immigration Act of 1990 and the American Competitiveness and Work Force Improvement Act of 1998, a system of quotas favouring professionally skilled and academically qualified candidates

has resulted in massive inflows of skilled labour from around the world. Between 1992 and 2000, the annual number of H-1B visas issued to highly skilled professionals rose from 110,200 to 355,600, with the quantity increase in skilled migrants being drawn almost entirely from developing countries.¹⁵⁶ Furthermore, the U.S. Congress has recently passed a relatively unpublicised resolution within the House immigration bill to completely remove the cap on nurse migration, thereby clearing the way for hundreds of thousands of nurses and trained midwives from the developing world to immigrate to the United States in order to fill the national shortage.¹⁵⁷ Rather than looking inward to address these domestic shortfalls by increasing funding and augmenting targeted training programs to achieve self-sufficiency, the United States, England, and most developed countries, have looked outward to the labour supplies of the developing world.

Within this context, and at times in response to these efforts, a variety of international, regional and national policies, programmes, guidelines, legal frameworks, agreements and resolutions have come about that contribute to limiting, regulating and rectifying the migration of health workers from developing to developed countries. Presented here is an extensive review of the relevant efforts.

4.1 INTERNATIONAL RESPONSES

4.1.1 International Organisations

4.1.1.1 World Health Organisation (WHO)

The World Health Organization (WHO) has adopted two resolutions, the Regional Strategy for the Development of Human Resources for Health (Resolution AFR/RC48/R3) and International Migration of Health Personnel: A Challenge for Health Systems in Developing Countries (Resolutions WHA58.17), prescribing specific actions aimed at strengthening the development of human resources for health in Africa for the successful realisation of the Millennium Development Goals.¹⁵⁸ The resolution of the WHO-AFRO regional assembly of November 2002 (Harare) and the resolution Migration of Health Workers: A Challenge for Health Systems, Especially in Africa further address the issue of migration of health workers. The latter resolution, in particular, urges member states to set up necessary information systems, to monitor the movement of human resources for health, to explore the possible impact of trade agreements on the movement of

152. Docquier F et al., op.cit., p. 151

153. Bauer T Kunze A (2004). The demand for high-skilled workers and immigration policy. IZA Discussion Paper No. 999. Bonn, Institute for the Study of Labour, p. 7

154. Docquier F et al., op.cit., p. 152

155. Bauer T et al., op.cit., pp. 8, 10-13

156. Docquier F et al., op.cit., pp. 152-153

157. Dugger C (2006). U.S. plan to lure nurses may hurt poor nations. New York, The New York Times, 24 May.

158. WHA (2004). International migration of health personnel: a challenge for health systems in developing countries. Geneva, Fifty-Seventh World Health Assembly, 22 May, p. 2-3.

health workers, devise specialised retention programs, and minimise the negative impact of the migration of health workers. The resolution encourages the utilisation of the skills, expertise and other resources of the diaspora, to implement policies that will enhance mobilisation of the diaspora.

4.1.1.1.1 Human Resources for Health Systems Development Programme for Sub-Saharan Africa

The World Health Organization (WHO) developed the Human Resources for Health Systems Development Programme for SSA to respond to the global crisis related to human resources for health. The aim of this programme is to contribute to the achievement of the health objectives of the Sub-Sahara African region by strengthening the capacity of the countries to optimise the use of their human resources for health. Its objective is for each Member State to (1) define a human resources development policy supportive of the implementation of its health policy, and (2) to possess the required capacities for diagnosing the problems of human resources development for health, for formulating relevant policies, mobilising actors and implementing, monitoring and evaluating the policies. The target of this programme was for the 46 countries of the SSA region to have developed a policy for human resources development for health by 2004 and for the 46 countries of the region to have acquired the capacity to implement their policy of human resources development for health by 2007.

The programme consists of three parts: human resources for health, human resources management, and human resources education and practices. The human resources for health aims to (1) enhance national institutional capacity, (2) direct support to training institutions, professional associations and councils, and (3) to promote research on development of human resources for health. Human resource management entails promoting relevant human resource development policies and plans consistent with national health policy, improvement of the management of human resources, and strengthening of the WHO fellowships programme. The human resource education and practices promotes and supports coordinated efforts by health authorities, professional bodies and schools of health sciences to study and implement new patterns of practice and working conditions. Moreover, it promotes the reorientation of technical and professional education in health sciences, providing guidance, models and methods for the evaluation and revision of training programmes.¹⁵⁹

4.1.1.2 United Nations Development Program (UNDP)

Launched in 1977, the Transfer of Knowledge Through Expatriate Nationals (TOKTEN) programme was initiated to utilise nationals residing abroad to provide short-term service in the country of their origin, specifically in fields impacting on their country's

economic and social development. TOKTEN Consultants return to invest their expertise in their home countries. The programme is managed through the United Nations Development Program's decentralised network of country offices, providing expatriate nationals the incentive to offer their abilities and services without threat or obligation of government service or the requirement to permanently return.¹⁶⁰

4.1.1.3 International Labour Organisation (ILO)

In order to assist African governments and civil society partners in addressing the unique challenges and opportunities of migration, the ILO implemented the *Africa Labour Migration Policy Initiative*.

The initiative is designed to support national governments and their strategic partners in the management of migration in the definition, elaboration and implementation of effective and appropriate labour migration policies and practices. The Initiative is based on an active dialogue between national governments, employers and private sector partners, and the employees and labour migrants themselves, and is designed to account for the unique economic and social conditions facing the country of origin and the labour migrants both domestically and abroad. The African Labour Migration Policy Initiative consists of four core components: capacity building of data collection mechanisms and increased documentation and analysis of migration conditions; trends and policy issues, the implementation and enforcement of international labour standards as the foundation of effective and consistent national and regional policies; development and elaboration of national policy guidelines and regional frameworks; and the provision of technical assistance to governments and their key partners in managing labour migration.¹⁶¹

4.1.1.4 International Organization for Migration (IOM)

IOM's concept of migration management relates to the shaping of clear and comprehensive policies, laws, administrative and technical arrangements to ensure that population movements occur to the mutual benefit of migrants, societies and governments. The organisation's overall goal, with regard to migration and development, is to work with the international community to harness the development potential of international migration, as is consistent with the Millennium Development Goals and the objectives of the New Partnership for African Development (NEPAD).

IOM's approach to migration and development can be broadly clustered into three areas: international policy dialogue;

159. WHO (2007), Human resources for health systems development. Brazzaville, World Health Organization Regional Office for Africa (WHO/AFRO), <http://www.afro.who.int/hrd/>. Accessed 22 march.

160. UNDP (2007). TOKTEN Programme – Transfer of Knowledge Through Expatriate Nationals. New York, United Nations Development Programme (UNDP), http://portal.unesco.org/shs/en/ev.php-URL_ID=7812&URL_DO=DO_TOPIC&URL_SECTION=201.html. Accessed 23 February.

161. ILO (2002). ILO African Labour Migration Policy Initiative – a contribution to the NEPAD agenda. Geneva, International Labour Organization (ILO), p. 5

policy-oriented research; and migration management programs, including technical cooperation and capacity building. Regarding the development of human resources, IOM has engaged in the following projects.

4.1.1.4.1 Migration for Development in Africa (MIDA)

Coordinated by IOM, MIDA is an institutional capacity-building programme designed to counteract the loss of skilled labour from Africa. The program aims to assist African countries in strengthening their institutional capacities to manage and realise their development goals through the transfer of vital skills and resources of the African diaspora to their countries of origin. The programme also works to forge partnerships between government, private sector, institutions and donors involved in capacity building programmes for Africa.

MIDA is based on the notion of mobility of people and resources and, as such, offers options for reinvestment of human capital, including temporary, long-term or virtual return. It respects the dual identity of the Africans in diaspora and ensures that the rights and status acquired by migrants in the host country are preserved by guaranteeing them freedom of movement to and from the country of origin. Through the use of multimedia technologies, short-term assignments of diaspora members to their countries of origin and voluntary long-term return, the human capital of the diaspora members is invested in their country of origin.

MIDA comprises several programmes. Some examples of ongoing activities are the following:

- The Ethiopian diaspora.info website funded by the Italian government is an informational website that provides timely, relevant and accurate information to the Ethiopian community abroad. A questionnaire is used to create a database that will eventually be used to match individuals with specific skills and financial and human resources to the needs of the country.
- E-learning project of the University of Lumbumbashi in the Democratic Republic of Congo and the Congolese diaspora in the University de Libre de Bruxelles in Brussels. 700 PhD students benefited from this program that matched the competences within the diaspora with the needs of the students. It is a cost-effective way to provide training and professional development, while at the same time linking the diaspora and educational institutions within countries as well as between countries. Beyond building capacity, it contributes to retaining skilled and qualified professionals in the country of origin.

Return of Qualified African Nationals Project (RQAN)

RQAN was initiated in 1983 with the objective of enhancing the utilisation of skilled, qualified and highly-qualified African nationals in the development process of their country. This

EU-funded program facilitated the return and reintegration of over 2,000 highly-qualified and experienced African nationals, mainly from the health sector, and 2,565 fellowship students.

Within the framework of the RQAN programme, IOM and ECA entered a Memorandum of Agreement to promote human resources development through the return of skilled professionals to Africa. Since 1992, IOM funded a five year programme on Return of Skilled Professionals to Africa (RESPA). The programme was implemented by ECA in all the African ACP member countries.

MIDA Health

With a joint mandate of 46 African Ministers of Health and the cooperation of the WHO, the MIDA Health project was developed to mobilise African health professionals abroad to solve the existing problems in national health sectors, specifically through the establishment of a database to match health professionals in the African diaspora with the needs of specific national health systems. IOM and WHO set up the database by field and level of competence.¹⁶²

Cooperation between IOM and WHO on developing human resources for health is justified by two legal and operational frameworks:

- The IOM/WHO memorandum of understanding signed in 1999, in which they commit to collaborate in fields where migration and health come together (the migration of health workers is not specifically mentioned).
- The Action Plan resulting from the stakeholder forum held in Johannesburg in 2002.

4.1.2 International Trade Agreements

Beyond the requirements and guarantees of ILO conventions, international trade agreements are increasingly important in the regulation and coordination of labour migration related to health and, specifically, in the trade in health services. The World Trade Organization's General Agreement on Trade in Services (GATS) comprises a set of multilateral, legally enforceable guidelines addressing trade in services designed to encourage liberalisation of service markets (see OECD, 2002).

A number of fundamental principles of the World Trade Organisation are incorporated into GATS to ensure effective access to markets, and health markets in particular, including the Most Favored Nation (MFN) principle, which requires a country to treat the service suppliers of another member no less favourably than the service supplier of any other member, unless a country

162. IOM (2007a). Migration health. Pretoria, International Organization for Migration (IOM) Regional Office for Southern Africa, <http://www.iom.org.za/MigrationHealth.html>. Accessed 26 February.

tables an exemption.¹⁶³ Under the terms of the agreement, individual countries have the ability to choose whether or not to commit health as one of the services covered by the agreement, and they further have the ability to define many of the terms and conditions upon which they do so.

Specifically applicable to the trade in health services, GATS distinguishes between four modes through which the services can be traded:

- Mode 1 - cross border supply. This occurs when the supplier of a medical service in one country supplies that service to another country, but both provider and the consumer stay put (e.g. forms of telemedicine)
- Mode 2 - consumption abroad. In this mode the patient physically travels to another country to obtain treatment.
- Mode 3 - commercial presence. This occurs when a foreign-owned health care provider establishes a presence in another country and serves that local market, for example, by owning or managing hospitals abroad.
- Mode 4 - presence of natural persons. This is related to the provision of health services by individuals in another country on a temporary basis.¹⁶⁴

The movement of health workers on a temporary basis is an integral part of service liberalisation and is especially significant for the health sector given the labour intensive of the sector. However, GATS does not define the term “temporary”, only defining it negatively as excluding permanent migration. In GATS individuals are service providers rather than entrants to the labour market. Yet, in practice this is hard to sustain. Given that temporary entry under GATS commitments can last for up to three years (or in some cases longer), the service provider has in effect entered the labour market, even though they are not applying for citizenship.¹⁶⁵

4.1.3 Multi-Stakeholder Initiatives

4.1.3.1 Global Health Workforce Alliance

Designed as a global platform for human resources for health, the Global Health Workforce Alliance was launched in May 2006 by the World Health Organization (WHO), the Alliance’s hosting/administrative partner. It is not a new independent global entity but rather a consolidation of existing actors already working together in support of country-specific and regional efforts. It is a 10-year partnership of strategic stakeholders – including regional networks (the African Platform on Human Resources for Health, the Asian Action Alliance and the Pan American

Health Organization Observatory on Human Resources in Health), as well as national governments, non-governmental organisation, financial institutions, United Nations agencies, academic and research institutions, private corporations, foundations and professional associations as key partners – with the objective of strengthening national health systems and prioritised programming. To this end, its primary functions are to promote learning and provide support to countries through technical funding. Its efforts include fact-finding, information and knowledge transfer, advocacy, coordination, monitoring and evaluation, all with the intent to strengthen and harmonize systems development and improve aid effectiveness.¹⁶⁶

4.1.3.1.1 Treat, Train & Retain (TTR)

The WHO organised an international consultation in May of 2006 attended by 134 delegates representing governments, health workers and their organisations, international agencies, development agencies, academic institutions and civil society organisations active in the fields of HIV and human resources for health. The meeting resulted in the development of an AIDS and health workforce plan – Treat, Train, Retain (TTR).¹⁶⁷ TTR is part of the new Global Health Workforce Alliance and will be aligned with the ten-year plan proposed by the WHO for action on strengthening human resources for health.¹⁶⁸

The plan entails three core elements: a package of HIV treatment, prevention, care and support services for health workers in countries disproportionately affected by HIV; training efforts to empower health workers to improve the delivery of HIV/AIDS-related services; and strategies to retain and manage health workers in the public health system, specifically incorporating financial incentives, as well as strategies to improve working conditions. Retention programming includes national and international policies and strategies to manage migration, workplace efforts to reduce the push factors of migration, and incentive structures to retain health professionals in the public health system. TTR is to function as a “menu of options” building upon existing work. Its primary objective is to instigate, coordinate and sustain the efforts of the different actors and programmes in this broad field.¹⁶⁹

4.1.3.1.1 African Platform for HRH Development

A strategic member-partner of the Global Health Workforce Alliance, the African Platform for HRH Development is a regional network of key institutions that seeks to articulate a common African position and engage countries and international partners.¹⁷⁰ Specifically, its aims will be to provide consensus

163. Bach S, op.cit.

164. Ibid.

165. Ibid.

166. WHO (2006). Treat, train, retain: the AIDS and health workforce plan - report on the consultation on AIDS and human resources for health. Geneva, World Health Organization (WHO), p. 28

167. Ibid., p. 7

168. Ibid., pp. 8-9

169. Ibid., pp. 7, 34

170. Ibid., p. 28

of what needs to be done, to foster an enabling environment for such action, to provide a medium for information and knowledge-sharing on best practices, to facilitate collaboration and provide momentum for action, and to promote and advocate on HRH issues affecting the Africa region.¹⁷¹

4.1.3.2 Africa Health Workforce Observatory

The High Level Forum on Health Related MDGs held in Abuja in December 2004 endorsed the need for action to avert the human resources for health crisis in Africa. The consultative meeting in Oslo in February 2005 subsequently adopted the concept of a human resources for health observatory for Africa, envisioning it as a mechanism for building and disseminating HRH evidence for country, regional and international advocacy, policy-making, planning, programme development and implementation.¹⁷² The Africa Health Workforce Observatory is a cooperative network initiative among several African countries and a range of non-governmental organisations, academic and professional associations, international & sub-regional organisations and development partners to improve human resource policies and decision-making. The network aims to foster cooperation in priority-setting and strategy formation, to consolidate informational databases and provide more accurate data, as well as to more effectively track progress and promote action. The Observatory is meant to provide a vehicle for information-sharing and capacity-building to improve health workforces.¹⁷³

4.1.3.3 Regional Network on Equity in Health in Southern Africa (EQUINET)

The Regional Network on Equity in Health in Southern Africa (EQUINET), is a network of professionals, policymakers, members of civil society, state officials and others key stakeholders within the Southern African Development Community (SADC) region and in southern and East Africa working to promote equity and social justice in health. EQUINET is coordinated through the Training and Research Support Centre in Zimbabwe and is governed by a steering committee involving academic, government and civic institutions from Botswana, Malawi, Mozambique, South Africa, Tanzania, Zambia, Zimbabwe, SADC management and other international organisations.¹⁷⁴

4.1.3.4 AfricaRecruit

Launched in 2002 through a collaboration of the New Partnership

for Africa's Development (NEPAD), the Commonwealth Secretariat and the Commonwealth Business Council, AfricaRecruit broadly aims to mobilise skills and human resource capacity to benefit Africa. AfricaRecruit provides a platform for dialogue and interaction with the African Diaspora and other key international stakeholders on how to build labour, human resource and investment capacity in Africa. The programme works to raise global awareness of the need for human resource development in Africa by addressing the continent's brain drain; advocates for policies that help to develop Africa's human resource capacity; formulates and implements practical programmes to reverse African out-migration and to capitalise on the social and financial capital of the African diaspora (e.g. the Africa Diaspora Healthcare and Africa Diaspora Investment programmes); and provides technical assistance to individuals and organisations involved in Africa's human resource development.

AfricaRecruit is a practical meeting point, as well as a virtual marketplace, for jobseekers and employers, African government's and related officials, and the African diaspora. Through its job search engine (www.findajobinafrica.com) AfricaRecruit allows placement agents and employers to advertise their jobs and for qualified candidates to advertise their expertise to employers using the CV database. The Africa Human Resource Club further provides a virtual network across the continent for human resource professionals to meet and discuss challenges, solutions and best practices.¹⁷⁵

4.2 REGIONAL RESPONSES

4.2.1 Continental

4.2.1.1 New Partnership for Africa's Development (NEPAD)

The NEPAD health strategy, developed in 2003, is a medium term strategy to sustainably tackle the immense burden of avoidable disease, death and disability in Africa. It includes several plans to improve African health care systems, including short term strategies to address migration. Article 7.1.4 of the health strategy highlights the need to "reach an international agreement on migration, especially with regard to ethical recruitment of health personnel from Africa, while putting in place mechanisms to improve the value placed on health workers, to address the adverse conditions of service and to improve motivation and retention." NEPAD has engaged individual governments, regional communities, and international organisations to commit themselves to contributing to the reversal of the high levels of skilled migration from African countries. This includes efforts to reach an international agreement on migration that would establish an ethical approach to health personnel recruitment from Africa. Further efforts seek to explore and support the implementation

171. World Bank (2005a). Taking the human resources for health agenda forward at the country level in Africa: regional consultative meeting. Brazzaville, World Bank, 18-20 July, <http://info.worldbank.org/etools/docs/library/206841/FINALREPORTCONGO%201820%20JULY%202005.pdf>, p. 6

172. WHO, op.cit., p. 28

173. World Bank (2005b). Africa HRH observatory: a working document for discussion: notes from the regional consultative meeting on taking the HRH agenda forward at country level. Brazzaville, World Bank, 18-20 July, p. 2.; WHO (2006), op.cit., p. 28; and HRHGRC (2006). Meeting of the Africa health workforce observatory - 2006. Chapel Hill, HRH Global Resource Centre, <http://www.hrhresourcecenter.org/observatory>, Accessed 23 February 2007.

174. EQUINET (2007). The network on equity in health in southern Africa (EQUINET). Harare, EQUINET, <http://www.equinet africa.org>, Accessed 23 March.

175. AfricaRecruit (2007). AfricaRecruit Overview. London, AfricaRecruit, <http://www.africarecruit.com/overview>, Accessed 22 March.

of mechanisms to address the adverse conditions facing health personnel and to promote other retention strategies.¹⁷⁶

4.2.1.2 African Union (AU)

In 1998 the Organization for African Unity (OAU) signed a Memorandum of Understanding with IOM. The agreement provides a framework of technical co-operation and assistance to African governments on a broad range of migration issues which include, amongst others: the public health aspects of migration; human resource development, including reversing the brain drain; and migrant remittances. Additionally, the need to establish a strategic framework for a policy of migration in Africa was prioritised.

4.2.1.3 Economic Commission for Africa (ECA)

The Economic Commission for Africa (ECA) and IOM created a Database of African Experts in the Diaspora containing data on 800 African experts, both locally and in the diaspora. The database was launched in 2002 and can be accessed online.

In 2000, IOM, ECA, and IDRC (International Development Research Centre) organised a regional conference on brain drain and capacity building in Africa, which was attended by delegates from 29 African countries, including universities, higher learning institutions, NGOs and other development institutions. The purpose of the conference was to provide a forum for discussion and to critically examine the key issues regarding brain drain in the region.

4.2.2 Sub-Regional

4.2.2.1 Southern African Development Community (SADC)

The Southern African Development Community (SADC) Governments and IOM have pursued the AU's mandate for migration management and co-ordination at a regional level. To this end, SADC and IOM established a Migration Dialogue for Southern Africa (MIDSA) to promote migration-related regional co-operation. The MIDSA initiative has been implemented through a collaboration of IOM and the South African Migration Project (SAMP), with further involvement of the United Nations High Commissioner for Refugees (UNHCR) and the SADC Secretariat.

The MIDSA initiative has established a framework for regular migration dialogue by providing a forum in which to build cooperation between participating SADC migration officials; promoting the positive aspects of regional SADC migration; reinforcing agencies and organisations involved with migration; developing regional institutional capacity to cope with and respond to migration; and strengthening the capacity of Governments to meet their unique migration challenges in a comprehensive, self-reliant and sustainable manner.¹⁷⁷

In 1995 the Southern African Development Community (SADC) developed the Draft Protocol on the Free Movement of Persons, declaring its intention to create a southern African economic community with free movement of people by the year 2000. Like ECOWAS and other regions, Southern Africa struggled and ultimately failed to implement a policy of free movement of its citizens within the region. South Africa took the lead in opposing the initiative, forcing the subsequent formulation of the SADC Protocol on the Facilitation of Movement of Persons as a diluted effort to eliminate barriers to intra-regional migration. Despite the SADC Protocol's ratification by six member states, including South Africa, the region remains unable to substantively agree to the free movement of its population.¹⁷⁸

4.2.2.2 East, Central and Southern African Health Community 42nd Regional Health Minister's Conference

The East, Central and Southern African Health Community 42nd Regional Health Ministers Conference was held 6-11 February 2006. The African Health Ministers passed a series of resolutions specifically addressing migration and human resources for health issues. The Health Ministers urged member states to develop national systems of continuing professional development that promote on-the-job and team-based training; to develop a system to track continuing professional development; to develop and improve mechanisms for staff recruitment, to adopt a common position on compensation for health workers recruited by developed countries; to adopt a common position on the ethical recruitment of health workers; and to develop financial and non-financial strategies to encourage the retention of health professionals. The Health Ministers further urged the Secretariat to, among other things, support member states in conducting research on human resources for health (i.e. retention, effects of out-migration, workload analysis, etc.) and promote evidence-based best practices, to facilitate the development of human resource information systems in member states and to develop guidelines for the ethical recruitment and compensation for health workers.¹⁷⁹

4.3 BILATERAL DONOR RESPONSES AND BILATERAL AGREEMENTS

4.3.1 Department for International Development (DFID)

The Department for International Development (DFID), United Kingdom has initiated and supports a wide range of programmes and policies related to migration and human resources for health. In recent years, DFID has worked to integrate migration into all country programmes, prioritising its efforts on migration by region,

176. Buch E (2007). NEPAD health strategy: initial programme of action. Johannesburg, New Partnership for Africa's Development (NEPAD), <http://www.sarpn.org.za/documents/d0000588/page1.php>, Accessed 26 February.

177. IOM (2007b). Technical cooperation on migration. Pretoria, International Organization for Migration (IOM) Regional Office for Southern Africa, <http://www.iom.org.za/TechnicalCooperation.html>, Accessed 26 February.

178. Oucho J Crush J (2001). *Contra free movement: South Africa and the SADC migration protocols*. Bloomington, Indiana University Press, http://www.accessmylibrary.com/coms2/summary_0286-27319700_ITM, Accessed 22 February 2007.; and DFID (2006). Op. cit. p. 25.

179. EQUINET (2006). Retention and migration of health personnel in southern Africa - report on the regional planning meeting. Lusaka, Regional Network for Equity in Health (EQUINET) Regional Planning Meeting, 3 April, p. 5.

country and sector through the Country Assistance Plans and regional Director's Delivery Plans. In this regard, the promotion of temporary migration has been targeted as a mutually beneficial arrangement for source and destination countries, and DFID is actively supporting initiatives to develop the expertise of low-income country governments to effectively negotiate services within the World Trade Organisation on GATS Mode 4.

In the area of migration management, DFID has focused its efforts on a number of focus countries in order to support key governments in developing coherent and effective migration policies. These efforts include improving data on migration, promoting dialogue on migration policy and issues among governments, civil society and migrants themselves. Among regional and national partners, DFID is currently supporting the development and implementation of non-discriminatory legislation and guidelines, administrative policies and labour practices that more effectively protect the legal rights of migrants. These efforts have specifically targeted frameworks for regional migration management based on regional economic cooperation in Africa and Asia.¹⁸⁰

DFID has further prioritised efforts to more effectively engage, utilise and support diasporas and expatriate networks to reduce poverty and address the economic and social implications of migration in low-income source countries. With the development of the Framework for DFID-Diaspora Engagement report in 2005, DFID has committed itself to build on the knowledge, education and skills of UK-based migrants in order to foster the development of their countries of origin.¹⁸¹ These efforts include, among others, the utilisation of diaspora groups in the development of DFID's Country Action Plans, the inclusion of diaspora groups in the Commission for Africa process, and DFID's provision of funding to Connections for Development, a network of black and minority ethnic voluntary and community organisations that mobilise civil society action related to development.¹⁸²

4.3.2 U.S. Agency for International Development

The U.S. Agency for International Development has initiated and supports several programmes and projects to address strategic human resources for health needs across developing low and middle-income countries. These efforts include The Capacity Project; the Quality Assurance/Workforce Development (QA/WD) Project; Partners for Health Reformplus, the Management and Leadership Development (M&L) Project; the Leadership, Management and Sustainability (LMS) Project; the Private Sector Program and Private Sector Partnerships-One, among others. USAID has further implemented and continues to support a

range of country-specific programmes and projects aimed at addressing HRH challenges, including the Human Resources for Health/Joint Learning Initiative, the Ethiopia Essential Services for Health (ESHE) programme, Expanded Coverage of Essential Health Services Project (PECSE), and the Sudan Health Transformation Project (SHTP), among others.

4.3.2.1 The Capacity Project

Launched in 2004, The Capacity Project is a global initiative funded by USAID to assist developing countries in building and sustaining their health workforce. Working across the health education and public service sectors, the project works to improve government and health system capacity and responsiveness to key external and internal HRH challenges. HRH targeting projects seek to improve workforce planning and leadership, develop improved education and training programmes for health workers and strengthen systems to support health workers. The Workforce Development component of the Capacity Project specifically seeks to address country-specific health workforce challenges related to inadequate numbers of qualified health workers, low retention and the loss of health workers.¹⁸³

4.3.2.2 Quality Assurance/Workforce Development (QA/WD) Project

The Quality Assurance/Workforce Development (QA/WD) Project, also known as the Quality Assurance Health and Workforce Improvement Project, seeks to strengthen the quality and capacity of the health sector in developing and middle-income countries, specifically focusing on the planning and management of human resources. The QA/WD Project targets HRH by evaluating improvements in human resource management (HRM) in the health sectors of target countries, providing technical assistance to middle and low-income countries in the adaptation of their management systems to domestic human resource challenges and needs, and working to build institutional capacity and strengthen the quality assurance of priority health services in countries facing HRH shortages and deficiencies. Beyond assistance in adapting human resource management in the health sector, the project provides technical assistance in implementing health system quality assurance (QA) strategies at the national, regional and local level.¹⁸⁴

4.3.2.3 The Joint Learning Initiative (JLI)

The Joint Learning Initiative on human resources for health seeks to improve equity in global health by strengthening the role of workers in health systems. To achieve this objective, JLI has been organised into seven coordinated working groups mandated to analyse current trends and obstacles in HRH, and to generate

180. DFID, op.cit., pp. 29-31

181. DFID (1997). Eliminating world poverty: a challenge for the 21st century - white paper on international development. London, Department for International Development (DFID).

182. DFID (2006), op.cit., p. 18

183. USAID (2007a). The capacity project. Washington, U.S. Agency for International Development (USAID), <http://www.capacityproject.org>, Accessed 23 March.

184. USAID (2007b). Quality assurance/workforce development (QA/WD) project. Washington, U.S. Agency for International Development (USAID), <http://www.qaproject.org>, Accessed 22 March.

strategies to address these challenges. JLI subsequently disseminates the information and strategy reports in order to influence government HRH policymaking and the actions of managers in the health sector.¹⁸⁵

4.3.2.4 Expanded Coverage for Essential Health Services in Djibouti Project (PECSE) & Essential Services for Health in Ethiopia (ESHE) Project

The U.S. Agency for International Development's PECSE and ESHE projects are key examples of health sector human resource investment programmes. The Expanded Coverage for Essential Health Services in Djibouti Project (PECSE) is a collaborative initiative designed to support the Government of Djibouti's efforts to improve the availability of basic health care. Designed to provide a package of essential health services to improve access to healthcare and reduce morbidity and mortality rates, the project specifically targets increased and improved training of health professionals in the country. Similarly, the Essential Services for Health in Ethiopia (ESHE) Project seeks to improve the provision of basic healthcare, strengthen the health system and reduce child deaths through, among other efforts, the training of health providers in the country.

4.3.3 President's Emergency Plan for AIDS Relief (PEPFAR)

The President's Emergency Plan for AIDS Relief (PEPFAR) specifically supports national strategies to address HRH deficiencies, limited institutional capacity in low-income countries, and specific health system weaknesses related to health networks, physical infrastructure, and commodity distribution and control.

PEPFAR currently supports several partnerships to train local health care professionals and improve human resource capacity in key health system functions. One example from Ethiopia is a new initiative implemented in 2006 which uses a global health worker database to identify qualified health professionals from the Ethiopian diaspora that could potentially assist in the country's HIV/AIDS campaign. Once identified and involved in the programme, health professionals from the diaspora are placed in volunteer assignments in Ethiopia to work alongside and train national counterparts as a health system capacity building exercise. Another program is the Partnership for Supply Chain Management, a collaboration of the U.S. Government, the World Bank and the Global Fund to Fight HIV/AIDS. Launched by PEPFAR in 2005, the collaborative project seeks to build the human and institutional capacity of local partners in key health

sector supply chain areas.¹⁸⁶

4.3.4 Bilateral Agreements and Medical Exchange

4.3.4.1 UK-South Africa Memorandum of Understanding on the Reciprocal Exchange of Health Concepts and Personnel

In 2003, the United Kingdom Department of Health and the South African Department of Health entered into a Memorandum of Understanding on the Reciprocal Exchange of Health Concepts and Personnel. The UK-SA MOU is designed to more effectively manage health worker migration by creating opportunities for health professionals from both countries to undertake short-term placements that will foster knowledge exchange and the transfer of skills and technology by supporting collaboration between the countries' health systems and personnel.¹⁸⁷ South Africa health workers are placed within the UK NHS and clinicians and health professionals from the U.K. find placement in rural South African health facilities. Since the inception of the MOU, the recruitment of health personnel has reduced and there has been a significant drop in the number of South African nurses registering to work in the U.K.¹⁸⁸

4.3.4.2 SA-Cuba Bilateral Agreement

While immigration from regional and continent-wide source countries constitutes the majority of trained health worker inflow to South Africa, it is important to note the contribution of international medical migration. While attempting to prevent a regional drain of health workers, South Africa has looked outward to help fill its ranks, pursuing a bilateral agreement with Cuba in October of 1996 to transfer medical professionals through a series of three-year renewable contracts.¹⁸⁹ The aim of the program is to provide a permanent flow of Cuban medical doctors and lecturers to South Africa to fill vacant positions in the country's disadvantaged and under-served rural health facilities, while providing Cuba with taxable remittance earnings given South Africa's higher salary differential. While the number of Cuban doctors and lecturers in the country varies year by year, the total

185. JSI (2007). Human resources for health: a joint learning initiative. Boston, John Snow Inc., <http://www.jsi.com/JSIInternet/Projects/ListProjects.cfm?Select=Topic&ID=12&ShowProjects=Yes&ProjectStatus=Active>, Accessed 23 March.

186. PEPFAR (2007). PEPFAR: support for host nations. Washington, The United States' President's Emergency Plan for AIDS Relief (PEPFAR), <http://www.pepfar.gov/about/c19381.htm>, Accessed 23 March.; and ITPC (2006). PEPFAR responses to ITPC November 2006. Johannesburg, International Treatment Preparedness Coalition (ITPC), <http://www.aids-treatment-access.org/mtt3pepfar.htm>, Accessed 23 March 2007.

187. Bundred P (2005). The current status of migration into the UK's health service. Melbourne, 9th International Medical Workforce Conference, November, http://www.health.nsw.gov.au/amwac/amwac/pdf/9_migration_uk.pdf, Accessed 22 February 2007, p. 6.

188. Ibid., p. 6; and Nullis-Capp C (2005). Efforts under way to stem "brain drain" of doctors and nurses. Bulletin of the World Health Organization. Geneva, World Health Organization (WHO).

189. Dovlo D (2003). The brain drain and retention of health professionals in Africa. Accra, Regional Training Conference on Improving Tertiary Education in Sub-Saharan Africa, 23-15 September, http://www.medact.org/content/health/documents/brain_drain/Dovlo%20-%20brain%20drain%20and%20retention.pdf, Accessed 23 February 2007, p. 5.; and Hamilton K et al., op.cit.

number practicing in South Africa has yet to exceed 463.¹⁹⁰ A beneficial source of critically needed doctors, international health worker inflows, nonetheless, remains a proportionally insignificant health labour supply.

4.4 OTHER INITIATIVES

4.4.1 South African Network of Skills Abroad (SANSA)

The South African Network of Skills Abroad (SANSA) is designed to link skilled people living abroad with local experts and projects. The programme targets both South African expatriates, as well as non-South Africans, who wish to contribute to South Africa's economic and social development. SANSA was initiated as a joint venture of the Science and Technology Policy Research (STPR) and the French Institute of Scientific Research for Cooperation and Development (ORSTOM). Since its inception, the National Research Foundation (NRF) has been primarily responsible for the development of the SANSA project.

The SANSA database includes more than 2,200 network members spread throughout more than 60 countries on five continents, entailing all sectors of business, academics, government and public administration, culture and health care. Through the SANSA database, the network members are encouraged to contribute to South Africa by receiving South African graduate students in laboratories and training programs, participating in training or research with South African counterparts, transferring technology and knowledge to South African institutions, sharing information and results of research which are not locally available, sharing and disseminating cultural and artistic creations, facilitating business contacts, facilitating discussion forums and dialogue, and by initiating research projects and commercial ventures.¹⁹¹

4.4.2 The Placement Project

Launched in January of 2006, The Placement Project is a capacity-building initiative by the Foundation for Professional Development. A non-profit recruitment agency, The Placement Project was established to reduce vacancies in the South African public health sector, increase the general health infrastructure capacity and, thereby, improve access to quality health care service for all uninsured patients.

The Placement Project works in collaboration with the South African Department of Health and SAIHCM, to facilitate and support the recruitment, registration, placement and retention

of foreign and South African health care professional in the South African public health care sector; to create a conduit for SA health care professionals employed in the private sector to provide services to the public sector on a voluntary or contractual basis; to provide a network of non-governmental organisations to enhance human resource capacity in support of Public-Private-Partnership projects; and to publicise vacancies and recommend placements for both the public and the non-governmental organisation sector.¹⁹²

4.4.3 Rural Health Initiative (RHI)

The Rural Health Initiative is a programme designed to facilitate the placement of foreign and diaspora health professionals in South Africa's rural public health sector. RHI manages an array of targeted programmes to improve rural healthcare delivery in South Africa, including efforts to publicise health sector vacancies abroad, efforts to assist doctors and other health professionals to register with the Health Professions Council, job placement and staff recruitment for rural health facilities, and professional assistance programmes and support for rural health workers. The program specifically targets provinces and rural areas with acute shortages of doctors and other critical healthcare providers.¹⁹³

4.5 FRAMEWORKS ON ETHICAL RECRUITMENT AND THE RIGHTS OF MIGRANT WORKERS

Owing to the impact of the international migration of health professionals on low-income source countries and greater awareness of the vulnerability of labour migrants, international conventions on the rights of migrants and codes of practice on ethical recruitment have become important tools for managing migration. Some of these are highlighted in this section.

4.5.1 The Commonwealth Secretariat

The Commonwealth Code of Practice for the International Recruitment of Health Workers was adopted at the Pre-WHA (World Health Assembly) Meeting of Commonwealth Health Ministers (Geneva) in 2003 to provide governments with a framework for recruiting foreign health workers. While the Code of Practice is voluntary and associative, primarily concerned with addressing recruitment by and relations between Commonwealth countries, it is designed to provide the basis of an 'international code of ethical guidelines' for broader adoption by non-Commonwealth countries.¹⁹⁴

The Code of Practice does not challenge the right of health workers to migrate, but serves to safeguard the potential benefits of migration. It provides recommended guidelines for international

190. DOH (2001). Press statement issued by the South African department of health. Pretoria, South African Department of Health (DOH), 18 January, <http://www.info.gov.za/speeches/2001/0101221245p1001.htm>, Accessed 22 February 2007.; and ANC (1995). On the recruitment of Cuban doctors - press statement. Marshalltown, African National Congress (ANC), 23 November, <http://www.anc.org.za/anodocs/pr/1995/pr1123b.html>, Accessed 23 February 2007.; and IMCSA (2004). Cuban skills In South Africa. Houghton, International Marketing Council of South Africa (IMCSA), http://www.southafrica.info/public_services/foreigners/immigration/cuban-doctors.htm, Accessed 22 February 2007.

191. NRF (2007). South African network of skills abroad. Pretoria, National Research Foundation (NRF), <http://sansa.nrf.ac.za/>, Accessed 23 February.

192. TPP (2007). The placement project. Pretoria, The Placement Project (TPP), <http://www.theplacementproject.co.za>, Accessed 22 March.

193. RHI (2007). Rural health initiative. Rivonia, Rural Health Initiative (RHI). <http://www.rhi.org.za>, Accessed 22 March.

194. Commonwealth Secretariat (2003a). Commonwealth code of practice for the international recruitment of health workers. Geneva, Pre-WHA Meeting of Commonwealth Health ministers, 18 May.

recruitment that take into account the potential impact of such recruitment on services in the source country. As such, it discourages the targeted recruitment of health workers from source countries facing human resource crises or shortages.

A summary of specific provisions within the code follows:

- Transparency should characterise any recruitment effort and an agreement between recruiting and source countries is recommended
- Recruiters are required to detail the number of recruits, type of skills, expertise and grades being sought in the source country.
- Health care workers who have an outstanding obligation to their own country should not be recruited (i.e. in breach of a contract of service agreed upon as a condition of their training).
- Recruiters should provide full and accurate information on the nature and requirements of the job, the countries to which they are being recruited, administrative and contractual requirements, and their rights and protections.
- Recruiters should ensure that recruits, while working abroad, are protected by the same employment regulations and laws and have the same rights as equivalent grades of staff in the receiving country (i.e. remuneration and rate of pay, working hours, continuing education and professional development, etc.).
- Governments recruiting from other countries should reciprocate for the advantages gained by their action through technical assistance and skills transfer, financial assistance or training programmes.
- Governments recruiting from other countries should facilitate the return of those recruited.

The Code is supplemented by the 'Companion Document' which provides definitions of terms and detailed explanations of concepts used in the Code. Primarily, the Code of Practice is designed to be a framework of responsibilities between governments, the agencies responsible to them and the recruits themselves. The Code is not legally binding on individual states, but is intended to be obligatory given the Commonwealth principles of co-operation and consensus.¹⁹⁵

195. Commonwealth Secretariat (2003b). Companion document to the commonwealth code of practice for the international recruitment of health workers. Geneva, Pre-WHA Meeting of Commonwealth Health ministers, 18 May.

Codes of practice on ethical recruitment typically have three objectives: protecting individuals in recruitment and employment, ensuring individuals are properly prepared and supported in the job, and protecting countries from unethical and aggressive recruitment. The process of developing the codes has greatly raised awareness of their potential impact on health care systems elsewhere.¹⁹⁶

4.5.2 WHO Code of Practice on the Ethical Recruitment of Health Workers

Several efforts have been mounted by a variety of organisations, governments and private/public coalitions advocating for the streamlining, implementation and enforcement of a code of practice more stringent than the Commonwealth Code of Practice in order to more effectively regulate health worker migration. To this end, Public Services International (PSI), a global federation of public sector trade unions, initiated a 16-country campaign in 2005 for ethical recruitment in international migration, and in the recruitment of female health workers specifically. The campaign called for the adoption of a World Health Organization (WHO) Code of Practice on the International Recruitment of Health Personnel which would supersede the Commonwealth Code of Practice.¹⁹⁷ To date, the WHO Code of Practice remains unrealised.

4.5.3 International Council of Nursing and the International Confederation of Midwives

Both the International Council of Nursing and the International Confederation of Midwives published a position statement for their member organisations on the ethical recruitment of nurses and midwives. These statements emphasise the freedom of nurses and midwives to migrate, but stress the importance that this is done in an ethical way for both the nurses and midwives as well as for the developing source country.

4.5.4 Melbourne Manifesto: A Code of Practice for the International Recruitment of Health Professionals

On 3 May 2002, the delegates to the 5th WONCA (World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians) World Health Conference in Melbourne, Australia adopted the Melbourne Manifesto. Markedly more specific in its guidelines and, thus, potentially more useful as a policy and legislative tool than the Commonwealth Code, the Melbourne Manifesto is an alternative code of practice for the international recruitment of health care professionals.¹⁹⁸

196. JLI, *op.cit.*, p. 107

197. Gencianos G (2005). Public services international: promoting workers' rights and equity in the global health care workforce. Ferney-Voltaire, Public Services International (PSI), http://www.old.who.int/en/PDF_Files/mhr/Presentations/presentation_gencianos.pdf, Accessed 22 March 2007, pp. 6-9.

198. Labonte R Packer C Klassen N (2006). Managing health professional migration from sub-Saharan Africa to Canada: a Stakeholder Inquiry into Policy Options. *Human Resources for Health*, 4(2).

The Melbourne Manifesto was largely based on the “Health for All Rural People” Declaration WONCA released in 1997 which explicitly calls for countries to commit themselves to:

- 1) ensuring appropriate delivery of public health measures;
- 2) development of multidisciplinary multi-sectoral teams with a community oriented approach;
- 3) ensuring a mix of primary health care, public health, clinical and development approaches that are appropriate to each community;
- 4) ensuring appropriate training for adequate numbers of rural doctors and other health professionals and promoting the reorientation of universities for such training;
- 5) ensuring continued educational support of health professionals in rural areas;
- 6) sustaining and enhancing the provision of rural health care by the provision of incentives and appropriate conditions for rural doctors and other health professionals; and
- 7) the provision of adequate resources and facilities for rural health care.¹⁹⁹

4.5.5 UK National Health Service (NHS) Code of Practice on Ethical Recruitment of Healthcare Professionals

By implementing the Code of Practice on Ethical Recruitment of Healthcare Professionals, the United Kingdom became one of few countries that have established official regulation and substantive federal policies aimed at reducing the unethical poaching of trained health workers from the neediest developing countries. These policies are particularly important given the draw of tens of thousands of health workers from the poorest regions of the world to the U.K. in recent years, particularly doctors and nurses of African origin.

More than 170 agencies that directly supply nurses and other health workers to the UK National Health Service have been forced to sign onto an ethical code of practice barring recruitment of personnel from developing countries, unless an intergovernmental or reciprocal exchange agreement between the countries otherwise permits (as in the case of India).²⁰⁰ While the efforts have stemmed the drain to an extent, the policies have been largely ineffective in preventing nursing homes and private hospitals from drawing health workers from banned low-income

countries. The failure of the ethical recruitment code is evident in that from 2004 to 2005, 3,301 nurses and midwives were recruited from banned countries and registered to work in the U.K. Of the total number of emigrating nurses and midwives, 2,624, or nearly 80%, were drawn from sub-Saharan Africa.²⁰¹ Despite the existence of loopholes and inefficiencies in legal framework, the Code of Practice is an important legal precedent and highlights the, often unutilised, ability of national governments to stem the flow of skilled migrants from low-income source countries.

4.5.6 South Africa's Voluntary Prohibition on SADC Recruitment

Similar to the United Kingdom, the South African government has taken the unusual step of voluntarily prohibiting the in-flow of international health workers to its national health system. With the end of Apartheid and subsequent gains by the South African economy, health analysts and politicians projected massive inflows of health workers from Zambia, Zimbabwe, Malawi and all other countries of the developing region. Given the substantial draw of high salary differentials and significantly improved working conditions, SADC countries feared South Africa would become a regional threat to their health services and drain the limited medical labour supplies in a comparable fashion to European and American emigration flows.²⁰² To effectively stem this threat, the South African government issued a mandate in 1995 prohibiting the recruitment of doctors from the fourteen SADC member countries, followed by a moratorium by the Health Professional Council on the registration of all foreign doctors in 1996. While the moratorium has since been lifted, the South African government continues to refuse the provision of work visas for permanent employment to health workers from low-income developing countries unless a bilateral government agreement otherwise allows. Where such agreements exist, foreign health professionals are largely restricted to employment in the public health sector.²⁰³

The efficacy of these programs to mitigate a regional drain of health workers helps to further explain South Africa's dilemma today. Perhaps too effective in their implementation, these efforts and others by the Department of Home Affairs to restrict a skilled labour drain from the region have resulted in not only substantially diminished immigration inflows, but a net loss of skilled labour to other SADC countries in the last decade. An unintended burden on South Africa's healthcare system and economy, these policies are being reassessed and the government is expected to change course in favour of allowing greater regional skilled immigration.²⁰⁴

199. WONCA (2002). The Melbourne manifesto. Ontario, WONCA Working Party on Rural Practice, http://www.globalfamilydoctor.com/aboutWonca/working_groups/rural_training/melbourne_manifesto.htm, Accessed 22 February 2007.

200. Hamilton K et al., op.cit.; and Carvel J (2005). Rich states told to stop poaching doctors. London, The Guardian, 28 June, <http://society.guardian.co.uk/NHSstaff/story/0,,1516168,00.html>, Accessed 22 February 2007.

201. Boseley S, op.cit.

202. Martineau T et al., op.cit., p. 4; and Padarath A et al., op.cit., p. 16

203. DOH (2006). A national human resources plan for health 2006. Pretoria, South African Department of Health (DOH), <http://www.doh.gov.za/docs/hrplan-f.html>, Accessed 22 March 2007, p. 13.; and Padarath A et al., op.cit., p. 16; and Hamilton K et al., op.cit.

204. Bhorat H et al., op.cit., pp. 16-17

4.5.7 A Best Practice Example of Source Country Migration Management: The Philippines Migration Promotion and Protection Programme

Among migration source countries, the Philippines arguably maintains the most comprehensive programmes and initiatives to monitor, regulate and protect its citizens. The Philippines Overseas Employment Agency (POEA) is responsible for regulating the licensing and monitoring of recruitment agencies; the Overseas Workers Welfare Administration (OWWA) is responsible for welfare and protection of its migrants; and the Philippines Overseas Labour Office (POLO) maintains around 45 labour attachés in 32 countries of destination to guarantee the provision of counselling, legal assistance, conciliation and liaison services. In addition to the formal programmes implemented by the Filipino government, non-governmental organisations, the media and the church are key actors in the provision of pre-departure information and efforts to prevent irregular migration flows. In order to protect the welfare and rights of its migrant citizens while fostering cooperation and further employment flows, the government has entered into bilateral agreements with 12 destination countries. Additionally, the government actively pressures destination countries to sign onto the UN Convention on the Protection of the Rights of All Migrant Workers and Their Families.²⁰⁵

4.5.8 United Nations (UN) International Human Rights Instruments

The International Covenant on Civil and Political Rights (ICCPR) is a United Nations treaty based on the Universal Declaration of Human Rights. It has 152 state parties and provides for a range of rights, such as freedom from forced labour and from inhuman or degrading treatment. While most of the rights in this covenant apply to regular and irregular migrants alike, specific rights – such as the right to vote – are limited to citizens. Additionally, the International Covenant on Economic, Social and Cultural Rights is a multilateral treaty adopted by the United Nations General Assembly and ratified by 155 member states. It commits states to work towards a range of rights, including guarantees that migrants are entitled access to primary education for their children and services, such as emergency healthcare, on a non-discriminatory basis. There is an important exception, however, “in that developing countries have the ability to exclude migrants from access to economic rights, such as the right to work.”²⁰⁶

4.5.9 International Labour Organization (ILO) Conventions Relating to Migrant Workers

The International Labour Organization (ILO) operates on the basis of establishing and monitoring international standards on the treatment of labour. ILO conventions, thus, cover all types of migrant workers, including migrant health workers. The ILO Declaration on Fundamental Principles and Rights at Work,

approved by delegations from all 176 member countries of the ILO, established that all Member States, even if they have not ratified the fundamental Conventions, have an obligation arising from their membership in the organisation to respect and uphold the fundamental rights of workers to freedom of association and the right to collective bargaining, the elimination of all forms of forced or compulsory labour; and the elimination of discrimination in respect of employment and occupation, among other rights.

Beyond the range of ILO conventions that guarantee the core rights and obligations of employees, employers and individual governments, several ILO conventions specifically address the treatment of migrant workers, including health workers:

- The Migration for Employment Convention, 1949 (No. 97), provides for equal treatment between national and regular migrants in recruitment, working conditions, social security regulations, taxation, access to justice, etc. It has been ratified by 42 countries.
- The Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143), regulates migration flows, in order to eliminate trafficking and clandestine migration, as well as to facilitate the integration of migrants into their host society. It has been ratified by only 18 countries.
- The Private Employment Agencies Convention, 1997 (No. 181), outlines the expected protections private employers are required to confer on migrant workers. It has been ratified by 20 countries.

Furthermore, the ILO Migration for Employment Convention and the ILO Migrant Workers (Supplementary Provisions) Convention provided the foundation for the 1990 UN International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families which expanded the recognition of economic, social, cultural and civil rights to migrant workers. The International Convention has been ratified by 19 countries and signed by 12 more.²⁰⁷

More specific conventions have been drafted and ratified to address nursing personnel, including:

- The Nursing Personnel Convention, 1977 (No.149) is designed to strengthen the rights of nursing personnel in the areas of employment, training, career development, remuneration and working time and involvement of the nurses. It has been ratified by 37 countries.

205. DFID (2006) op. cit. p. 24.

206. Ibid. p. 23.

207. Taran P (2003). Globalization, labour and migration: protection is paramount. Geneva, International Labour Organization (ILO), p.11-15, 20.; and ILO (2005). ILO nursing personnel convention no. 149 – recognize their contribution, address their needs. Geneva, International Labour Organization (ILO), pp. 1-2.

- The Nursing Personnel Recommendation, 1977 (No.157) provides more detailed guidance in these areas.²⁰⁸

208. Ibid., p. 3, 4, 7-22.

SECTION 5

CONCLUSION

The preceding four sections have demonstrated that the phenomenon of 'medical migration' is complex in terms of its extent and impact, underlying causes, retention oriented responses and policy related frameworks for international migration management. Yet, there are many aspects of the health worker migration in southern Africa that still remain understudied. Some of these include: a gendered understanding of health worker migration²⁰⁹; economic analysis of skills migration; the phenomenon of brain circulation (or reversal of brain drain) claiming that health personnel return to the country of origin after a few years abroad²¹⁰; and finally, research on the working and living conditions of migrant health workers in destination countries, especially with respect to the equity in workplace, conditions of work and standard of living. Despite these gaps, the literature sheds significant light on a range of issues pertaining to health worker migration. This concluding section recaptures some of the important points made in the previous sections and places them in the context of prevailing debates.

Section 1 provided a range of data on the migration flows, patterns and numbers involved in health worker migration in southern Africa. Although the knowledge about the extent of migration flows is incomplete, the existing body of literature gives us enough evidence to generate a broad consensus that the mobility of health workers from southern Africa has increased over the last decade. Within this scenario, South Africa emerged as a both an exporter of health workers to OECD countries as well as an importer from within the SADC region. The prevailing norm in skilled labour migration literature has been to emphasise the negative impacts of migration on the source country. But recent research interrogates this assumption and necessitates a more thorough analysis of health worker migration impact. For instance, Clemens' findings broadly highlight that there is no significant correlation between health worker migration and a degradation of basic public health conditions.²¹¹ He provides convincing evidence that physician and nurse emigration, even at high rates, does not adversely affect infant or child mortality rates, measles vaccination rates, diphtheria/pertussis/tetanus (DPT) vaccination rates, the prevalence of acute respiratory infections

(ARI) in children, the incidence of diarrhoea among children under five, the proportion of people infected with HIV, the proportion of people accessing ARVs, or the proportion of deliveries attended by trained health personnel, among others.²¹² Clemens goes on to argue that the source countries do not have the capacity to absorb the staff they train. Even if the source countries were able to retain all their staff, there is no evidence to suggest that there would be any substantial gains to the public health system or that an equitable distribution of skills between rural and urban areas would be ensured. Meanwhile, the sending countries may in fact be benefiting from skills emigration due to financial remittances and relief from high unemployment rates. Bach, for example, argues that the mobility of skilled labour is associated with several positive feedback effects, such as financial investment and benefits associated with remittance of income, the acquisition of knowledge and skills which eventually return to the country with the health migrant, and spill-over effects related to increases in the incentive to pursue higher education in the source country.²¹³

However, there is little tangible data to demonstrate whether the positive impacts from remittances overflow to the larger community or simply remain restricted to personal gains for the close family members of the remitter. An additional outcome lies in the projection of perceptions at an international level about a country from where skilled professionals are emigrating. This may be seen as a sign of economic or political instability and may further discourage foreign investors.²¹⁴ Moreover, a loss of skilled persons from a country also means a depleting middle class that has the largest potential to be consumers and investors, thereby affecting economic growth. Also, while an assumption is made about the eventual return of health workers to the sending country, there is little systematic evidence to suggest the extent of this phenomenon.

Regardless of the extent of numbers or the debates regarding impacts, there is an increasing realisation that skills migration in the health sector is more often a symptom rather than a cause of the relatively low level of health care standards and human resource management issues in the sending countries. Section 2 of this document analysed the push, pull and enabling factors from the

209. Bach S (2006) et al.

210. Bhorat H, op. cit.

211. Clemens M, op. cit.

212. Ibid. p. 30, 31.

213. Bach S, op. cit. p. 15.

214. Ibid

perspective of both the sending as well as the destination countries. Overall, we have argued that migration of health workers can be seen to reflect a balance of supply and demand within inequitably resourced health care systems and economic imbalances across the developed and developing world. The push and pull factors such as wages, living conditions, working environment, human resource management etc. represent two sides of this imbalance where the skilled worker makes a decision based on relative personal benefit. The enabling factors refer to the conditions that ease the possibility of migration at a macro level such as, increase in information flows, recruitment agencies, established diaspora communities and most importantly, quality selective immigration policies that aim to fulfil the increased demand for health care in the destination countries.

Section 3 outlined some of the responses to push and pull factors, predominantly oriented towards positive measures to increase retention of health workers and enhancing the level of health care in source countries of health workers. While acknowledging the need to address factors such as working and living conditions, the recent literature is most emphatic about the need for proper human resource management within the health sector in developing countries. Human resource management issues (including better training, equitable distribution, and health system reform) have the potential to serve an important role even in the short to medium term where effective donor inputs can also be made. This will help the governments of developing countries to buy the necessary time to address the systemic factors, such as living conditions and economic issues that have been shown to impact upon the retention rates of personnel in the health sector.

In order to diminish the impacts of quality selective immigration policies aimed at encouraging skills migration to the developed countries, a variety of international, regional and national policies, programmes, guidelines, legal frameworks, agreements and resolutions have come about, as discussed in Section 4. The focus of these formulations is to provide an ethical basis to the migration of health workers from developing to developed countries. There is a welcome shift in the policy level responses from draconian, reactive measures aimed at preventing migration towards an agenda of migration management, ethical recruitment policies and an increased attention to the underlying structural factors that spur migration of health workers.

There is still little consensus on whether the extent migration of health workers from developing to developed countries constitutes a health crisis in the source countries. But in any case, the debate has moved from a preoccupation with numbers and has relocated itself within the need to enhance healthcare in the source countries. The emphasis seems to be moving towards promoting strategies aimed at the retention of health workers by strengthening health systems capacity in developing countries and protection of the rights of migrant workers in destination countries. The first responsibility for action aimed at domestic retention is placed squarely on shoulders of the governments of the source countries but the global community must fulfil its obligations to provide the necessary financial and technical support.²¹⁵ The underlying challenge is to advance an ethical stance that is mindful of individual freedom of health workers to seek gainful employment while maximising the standards of health and health care in the source countries.

215. Chen L C and Boufford J I (2005) Fatal Flows- Doctors in the Move. *The New England Journal of Medicine*. 353:17.

ANNEX 1

LIST OF SELECTED LITERATURE

YEAR	AUTHOR(S)	TITLE	PUBLISHER	COUNTRY / REGION	ABSTRACT
2007	Fritzen, S.A.	Strategic Management of the Health Workforce in Developing Countries: What Have We Learned?	Human Resources for Health 2007. Vol. 5.	Global	This paper reviews lessons in four areas relating to strategic human resource management challenges and their relation to the effectiveness of health systems. These areas are identified by the author as imbalances in workforce structure; difficulties of central-level steering of the health workforce; worker capacity and motivation; and reforms centering on service contracting and improvements to human resource management.
2007	Monare, M.	Plan to Lure Academics Back to South Africa	Pretoria News 14 February 2007	South Africa	The newspaper article outlines a measure proposed by the South African Minister of Education to increase research funding and invest in improved university laboratories and facilities in order to lure South African academics working abroad back to the country.
2006	Bach, S.	International Mobility of Health Professionals - Brain Drain or Brain Exchange?	World Institute for Development Economics Research (WIDER), United Nations University (UNU); Research Paper No. 2006/82	Global	The paper examines international patterns of health profession mobility, the primary determinants of these mobility dynamics, as well as the impact and policy implications of these mobility patterns. The paper highlights the shift from reactive policy agendas focused on mitigating migration flows to proactive policy responses aimed at managing migration in order to benefit both source and destination countries.
2006	Clemens, M.	Do Visas Kill? The Effects of African Health Professional Emigration	Center for Global Development (CGD)	Africa	The study uses a new database of African health worker emigration to test the influence of emigration on domestic health professional supplies, the availability of primary health care, and public health outcomes. The study suggests that an increase in the emigration rate does not necessarily diminish the domestic labour supply, decrease the availability of basic health care or negatively influence health outcomes, and that inadequate health staffing levels and poor public health outcomes result from factors unrelated to the international migration of health professionals.
2006	Clemens, M. & G. Pettersson	Medical Leave: A New Database of Health Professional Emigration from Africa	Center for Global Development (CGD)	Africa	The paper provides a systematically-compiled database of the cumulative bilateral net flows of African-born physicians and nurses to the nine largest destination countries.
2006	DFID	Moving Out of Poverty - Making Migration Work Better for Poor People (Draft Policy Paper)	Department for International Development (DFID)	Global	The paper sets out DFID's migration-related policy positions and programming. Specifically, the paper outlines DFID's extensive efforts to harness the poverty-reduction and developmental benefits of migration while reducing risk to the poor.

YEAR	AUTHOR(S)	TITLE	PUBLISHER	COUNTRY / REGION	ABSTRACT
2006	Docquier, F. & A. Marfouk	International Migration by Education Attainment, 1990-2000	The World Bank/Palgrave Macmillan	Global	The paper provides data on estimated global emigration stocks and flows between 1990 and 2000, classified by the emigrant's education level. The paper calculates migration rates and the net gain of OECD countries.
2006	Dugger, C.	U.S. Plan to Lure Nurses May Hurt Poor Nations	New York Times Newspaper 24 May 2006	U.S./Global	The article discusses the potential implications of legislation in the 2006 U.S. Immigration Bill that would remove existing limits on nurse migration as a means to draw hundreds of thousands of nurses from developing countries to the U.S. in order to offset shortages in the country's domestic nurse supply.
2006	EQUINET	Retention & Migration of Health Personnel in Southern Africa - Report on Regional Planning Meeting	Regional Network for Equity in Health in Southern Africa (EQUINET)	Southern Africa	The report details regional initiatives in southern Africa, as well as country-specific programmes and policies in Namibia, Zambia and Malawi aimed at supporting the retention of health workers, reducing emigration and managing human resources for health.
2006	Kabene, S., C. Orchard, J.M. Howard, M.A. Soriano & R. Leduc	The Importance of Human Resources Management in Health Care: A Global Context	Human Resources for Health 2006. Vol. 4	Global	This paper explores secondary sources for generating a global perspective on the importance of human resources management (HRM) within health care systems to improve overall patient health outcomes and delivery of health care services. It compares and contrasts selected developed and developing countries to gain a deeper understanding of the practical and crucial role of human resources management in health care.
2006	Kober, K. & W. Van Damme	Public Sector Nurses in Swaziland: Can the Downturn be Reversed?	Human Resources for Health. Vol. 4. No. 13.	Swaziland	The paper discusses the human resources for health situation in Swaziland, identifies the key factors contributing the resource crisis, and proposes a range of policies and programmes to address the problem.
2006	Labonte, R. C. Packer & N. Klassen	Managing Health Professional Migration from sub-Saharan Africa to Canada: A Stakeholder Inquiry into Policy Options	Human Resources for Health. Vol. 4. No. 2.	Africa	The report details the magnitude and trends in health-related human resource flows from sub-Saharan Africa to Canada, including analysis of domestic labour shortages and the influence of Canadian labour demand on South African emigration flows.
2006	Mathauer, I. & I. Imhoff	Health Worker Motivation in Africa: The Role of Non-Financial Incentives and Human Resource Management Tools	Human Resources for Health. Vol. 4. No. 24.	Africa	The journal article analyses the role of non-financial incentives and human resource management tools as motivation for health workers in Benin and Kenya. The primary hypothesis of the research is that non-financial incentives and human resource management (HRM) have an important impact upon the motivation of health professionals, thus reducing the inclination to emigrate. The findings of this study confirm the starting hypothesis and the authors advocate for adequate HRM tools and quality management to enable health professionals to meet their personal and the organizational goals.

ANNEX 1

YEAR	AUTHOR(S)	TITLE	PUBLISHER	COUNTRY / REGION	ABSTRACT
2006	OCHA	Health Worker Migration - Can it be Stemmed?	Integrated Regional Information Network (IRIN), U.N. Office for the Coordination of Humanitarian Affairs (OCHA)	Africa	The article briefly describes African health worker migration flows and impact, labour shortages in the health sector, and factors influencing health worker emigration.
2006	PHR	Bold Solutions to Africa's Health Worker Shortage	Physicians for Human Rights (PHR)	Africa	The report details a range of policy initiatives and programmes that have been implemented throughout Africa to address health worker shortages, including labour retention, HIV/AIDS treatment for health workers, utilization of paraprofessionals and targeted health labour distribution, among others.
2006	WHO	Treat, Train, Retain: The AIDS and Health Workforce Plan	World Health Organization (WHO)	Global/Sub-Saharan Africa	The report outlines and defines the WHO Treat, Train, Retain Health Workforce Plan which includes a series of strategies to retain health workers in the public health sector and manage their migration through financial and non-financial incentives and efforts to improve structural conditions for health workers in developing migration source countries.
2005	Boseley, S.	UK Agencies Still Hiring Poorest Nations' Nurses	The Guardian Newspaper 20 December 2005	Global/Sub-Saharan Africa	The article examines a persisting loophole in the NHS Code of Practice that allows for the recruitment of nurses from banned low-income countries through private sector nursing homes. The article details the origins of 3,031 nurses poached from 16 "banned" countries in 2004-2005 despite the implementation of the NHS Code.
2005	Bueno de Mesquita, J. & M. Gordon	The International Migration of Health Workers: A Human Rights Analysis	Medact/British Medical Association	Global	The report utilizes a human rights framework to analyze the social, economic and political consequences of health worker migration from developing countries, specifically the impact of emigration on health systems and the right to health and equitable access of health system users in migration source countries. The report recommends a combination of preventative and mitigating efforts that address both the causes and consequences of health worker migration in order to guarantee that the right to work and the freedom of movement of health workers does not negatively impact the right to health of the population.
2005	Carvel, J.	Rich States Told to Stop Poaching Doctors	The Guardian Newspaper 28 June 2005	South Africa	The article provides information on the magnitude and effect of health worker migration from South Africa to the U.K. and criticizes the recruitment of developing country health workers to wealthy countries.

YEAR	AUTHOR(S)	TITLE	PUBLISHER	COUNTRY / REGION	ABSTRACT
2005	Chen, L. & J.I. Boufford	Fatal Flows - Doctors on the Move	New England Journal of Medicine; Vol. 335, No. 17: 1850-1852	Global	The journal article briefly summarizes the primary aspects of health worker migration from poor to rich countries and prescribes a range of recommendations to advance human health while protecting health workers' rights to seek gainful employment. The editorial calls for countries to establish national plans to increase salaries and working conditions, to revitalize education and to mobilize community health workers; for the U.S. government to implement domestic and global policies to move itself toward self-sufficiency; and for a global political consensus involving both inter-governmental and multilateral agency leadership to address the "fatal flows" of health worker migration.
2005	Crush, J., W. Pendleton & D.S. Tevera	Degrees of Uncertainty: Students and the Brain Drain in South Africa	Southern African Migration Project (SAMP) Migration Policy Series No. 35	Southern Africa	The report details the findings of the 2003 SAMP Potential Skills Base Survey (PSBS) which analyzed the migration-related perceptions of 10,000 final-year students at universities, colleges and technikons in SADC countries.
2005	Hatton, T. & J. Williamson	What Fundamentals Drive World Migration?	Palgrave Macmillan	Global	The paper assesses the demographic and economic factors driving global migration both historically and today. Specifically, it analyses the appropriateness of standard migration theories in light of historic evidence, the impact of inequality and poverty on migration flows and the comparative importance of push and pull factors driving migration.
2005	Mensah, K. M. MacKintosh & L. Henry	The Skills Drain of Health Professionals from the Developing World: A Framework for Policy Formulation	Medact	Global	The paper analyses the economic and governance dimensions of existing health worker migration policies, concluding that current policies tend to underestimate and confuse migration influencing factors, overestimate the impact of recruitment policies and ignore policy side-effects.
2005	Mullan, F.	The Metrics of the Physician Brain Drain	New England Journal of Medicine; Vol. 335, No. 17: 1810-1818	Global	The journal article analyzes the reliance of the United States, the United Kingdom, Canada and Australia on international medical graduates, providing a listing of source countries and computation of an emigration factor for each, as well as analysis of physician cycling among the four primary destination countries.
2005	Nullis-Capp, C.	Efforts Under Way to Stem "Brain Drain" of Doctors and Nurses	Bulletin of the WHO. Vol. 83. No. 2. World Health Organization (WHO)	Global/Sub- Saharan Africa	The article outlines initiatives undertaken to reduce the flow and impact of health worker emigration from developing countries, including the development of ethical Codes of Practice, bilateral agreements, emergency human resource programmes, MOUs on health worker recruitment, MIDA initiatives and other efforts to address the push/pull factors of migration. The article proffers that the migration of doctors and nurses from developing countries is a primary determinant of health worker shortages in developing countries.

ANNEX 1

YEAR	AUTHOR(S)	TITLE	PUBLISHER	COUNTRY / REGION	ABSTRACT
2005	Simoens, S., M. Villaneuve & J. Hurst	Tackling Nurse Shortages in OECD Countries (Health Working Paper # 19)	Organization for Economic Co-Operation and Development (OECD)	Global	The working paper identifies current surpluses and shortages in the global nurse workforce, details factors affecting the future supply and demand for nurses, outlines policies that impact the domestic and international migration flows of nurses, and examines policies specifically influencing nurse retention and turnover.
2004	Alkire, S. & L. Chen	Medical Exceptionalism in International Migration: Should Doctors and Nurses be Treated Differently?	Joint Learning Initiative, Human Resources for Health, and the Global Equity Initiative, Harvard University Asia Center	Global	The paper analyses the South-to-North international migration of health workers, factors influencing health worker migration, consequences of the phenomenon and policy options available to both source and destination countries.
2004	Anso, T.	Where Are All Our Doctors Going?	The Star Newspaper 29 July 2004	South Africa	The article briefly details the flow of doctors and nurses from South Africa to the U.K., Canada and New Zealand; and outlines the nature and magnitude of labour shortages, as well as the rural/urban distribution of health workers affecting the South African health care system. The article further presents data on vacant public health posts by province for 2003.
2004	Bauer, T. & A. Kunze	The Demand for High-Skilled Workers and Immigration Policy (IZA Discussion Paper No. 999)	Institute for the Study of Labour	Europe/ Global	the paper analyzes demand for skilled labour in the European Union using the IZA international employer survey 2000 and describes temporary immigration policies implemented to draw high-skilled labour from source countries.
2004	Buchan, J. & I. Seccombe	Fragile Future? A Review of the UK Nursing Labour Market in 2003	Royal College of Nursing	U.K./Global	The report profiles the NHS workforce, details staffing dynamics and the influence of domestic and international health worker flows, and outlines the likely nature of the NHS nursing workforce in the future.
2004	Carvel, J.	Nil By Mouth	The Guardian Newspaper 27 August 2004	Global/Sub-Saharan Africa	The article critiques the shortcomings of the NHS Code of Practice on ethical recruitment - the foundation of the government's policies to stem the flow of nurses and health workers from developing countries to the UK. The article provides data on the flow of nurses into the UK from South Africa, Zimbabwe, Nigeria, Ghana, Zambia, Kenya, Botswana and Malawi from 2000-2004.
2004	Diallo, K.	Data on the Migration of Health Workers: Sources, Uses and Challenges	Bulletin of the WHO. Vol. 82. No. 8. World Health Organization (WHO)	Global	The paper details the strengths and limitations of the primary sources of data on the migration of health workers.
2004	Dovlo, D.	Using Mid-Level Cadres as Substitutes for Internationally Mobile Health Professionals in Africa - A Desk Review	Human Resources for Health. Vol. 2. No. 7.	Global	The paper analyzes the potential for utilizing substitute cadres in the public health sector in order to increase service access.

YEAR	AUTHOR(S)	TITLE	PUBLISHER	COUNTRY / REGION	ABSTRACT
2004	Dumont, J.C. & J.B. Meyer	The International Mobility of Health Professionals: An Evaluation and Analysis Based on the Case of South Africa	Organization for Economic Co-Operation and Development (OECD)	South Africa	The paper analyses reforms in South Africa's health sector and their impact on health worker migration, including: the introduction of compulsory community service, training, improved working conditions and pay, and greater international cooperation with key destination countries. The authors conclude that emigration is not always the primary cause of health system problems and that health sector policies play a key role in promoting and improving human resource management in response to health worker emigration.
2004	Forcier, M., B. Simoens & S. Giuffrida	Impact, Regulation and Health Policy Implications of Physician Migration in OECD Countries	Human Resources for Health	Global	The paper details the impact of physician migration on source and destination countries and outlines national policies fostering the migration of health workers. The authors argue for the need to create an enforceable global framework requiring physician migration policies to benefit both source and destination countries, as well as the need for OECD countries implement necessary education and training policies rather than rely on physicians from low-income source countries.
2004	Friedman, E.	An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa	Physicians for Human Rights (PHR)	Africa	The paper examines the magnitude and impact of health personnel shortages in sub-Saharan Africa; outlines a framework of guiding principles for action; and details specific policies and programmes to address push & pull factors influencing labour migration, human resource planning and management, external sourcing of health workers, health worker distribution management, the utilization of health personnel in the diaspora, and the development of supportive macroeconomic policies. The authors conclude that while the situation is not hopeless, the solutions require political will, shared commitment between the nations of the South and North and need to take a human rights approach to human resources that takes into account the right of movement of all persons and the right to health at individual and societal levels
2004	Hamilton, K. & J. Yau	The Global Tug-of-War for Health Care Workers	Migration Policy Institute	Global	The paper outlines the contributing factors of health care migration, the impact of health worker loss on source countries and explores policy proposals to respond to the phenomenon.
2004	Hicks, V.	Health Human Resources Demand and Management: Strategies to Confront Crisis	Joint Learning Initiative (JLI)		The report provides a model of HRH demand, supply and management issues and briefly outlines the role of HRH in healthcare and prevention efforts. It further examines external and internal factors impacting human resources for health.
2004	IOM	The Migration of Health Care Workers: Creative Solutions to Manage Health Workforce Migration	International Organization for Migration (IOM)	Global	The paper details successful strategies used to manage the migration of health workers globally, including specific efforts to utilize the diaspora in order to strengthen human resources for health and bilateral agreements aimed at harnessing the potential benefits of migration.

YEAR	AUTHOR(S)	TITLE	PUBLISHER	COUNTRY / REGION	ABSTRACT
2004	JLI	Human Resources for Health - Overcoming the Crisis	Joint Learning Initiative (JLI) Fellows of Harvard College	Global	The report analyzes the constraints facing the global health care systems and its human resource base, outlining the health workforce crisis (Chapter 1) and migration flows (Chapter 4) in particular.
2004	JLI	The Health Workforce in Africa: Challenges and Prospects	Joint Learning Initiative (JLI), Africa Working Group.	Africa	The report examines the HRH challenges and key factors underlying health workforce shortages in Africa, details existing and available international and African responses to counter the human resources for health crisis, and provides recommendations for regional organizations and international agencies.
2004	Kupfer, L., K. Hofman, R. Jarawan, J. McDermott & K. Bridbord	Strategies to Discourage Brain Drain	Bulletin of the WHO. Vol. 82. No. 8. World Health Organization	Global	This paper details the political, scientific and economic strategies employed to discourage brain drain by investigators of five International Training and Research Program (AITRP) projects.
2004	Nyberg-Sorensen, N.	The Development Dimension of Migrant Remittances - Towards a Gendered Typology	Institute of Migration	Global	The paper examines the increasing complexity and feminization of international migration flows and the influence of gender on migrant remittance practices and their impact.
2004	Stiwell, B., K. Diallo, P. Zurn, M. Vujicic, O. Adams & M. Dal Poz	Migration of Healthcare Workers from Developing Countries: Strategic Approaches to its management	Bulletin of the WHO. Vol. 82. World Health Organization	Global	The article examines key issues relating to the international migration of health workers and offers a variety of management strategies. Among the strategies discussed, the need for enhanced data collection (especially data to facilitate qualitative understanding of reasons influencing migration), intergovernmental agreements, ethical recruitment policies and a variety of incentives to discourage health worker migration are emphasized.
2004	Vujicic, M., P. Zurn, K. Diallo, O. Adams & M. Dal Poz	The Role of Wages in the Migration of Health Care Professionals from Developing Countries	Human Resources for Health. Vol. 2.	Global	The paper analyses the influence of wages and remuneration in the decision to migrate and discusses the potential for wage increases in low-income migration source countries to reduce emigration flows.
2004	Willetts, A. & T. Martineau	Ethical International Recruitment of Health Professionals: Will Codes of Practice Protect Developing Country Health Systems?	Liverpool School of Tropical Medicine	Global	This study reviews the potential impact of existing instruments for ethical recruitment of health professionals. Analysing eight national and international level codes of practice, or similar instruments, the authors found that while the instruments have been adequately disseminated, they lack the necessary support systems, incentives, sanctions and monitoring systems to effectively implement and sustain the instruments.
2003	Awases, M. J. Nyoni, A. Gbary & R. Chatora	Migration of Health Professionals in Six Countries: A Synthesis Report	World Health Organization (WHO) - Division of Health Systems & Services, Regional Office for Africa	South Africa, Zimbabwe, Uganda, Ghana, Senegal & Cameroon	The report presents findings of a 2001/2002 study on the migration of health professionals from Cameroon, Ghana, Senegal, South Africa, Uganda and Zimbabwe. The report details the magnitude and nature of migration patterns, reasons for migrating, the impact of migration on health care in the source country, and programmes and policies utilized to reduce outward migration from the study countries.

YEAR	AUTHOR(S)	TITLE	PUBLISHER	COUNTRY / REGION	ABSTRACT
2003	Bach, S.	International Migration of Health Workers: Labour and Social Issues	International Labour Organisation (ILO)	Global	The report discusses patterns of health worker migration, environmental factors influencing the phenomenon, the impact of health worker emigration on source country health systems, working conditions in destination countries, recruitment policies and the role and impact of international trade agreements and legal standards on health worker migration.
2003	Bailey, T.	Skills Migration	Human Resources Development Review 2003. Human Sciences Research Centre (HSRC)	South Africa	This paper focuses on the nature and extent of skills migration in South Africa, the potential impact on society and the economy and international policy responses. It concludes with a discussion on ways to constructively manage migration. While acknowledging the need for short-term solutions, it advocates for movement away from reactionary policies and development of a long term perspective that addresses root causes, structural factors and views skills circulation in a positive light.
2003	Buch, E.	NEPAD Health Strategy: Initial Programme of Action	New Partnership for Africa's Development (NEPAD)	Africa	The report identifies the health-related policies and programmes NEPAD has prioritized for action, including the establishment of the African Health System Observatory and the pursuit of an ethical international agreement on the recruitment of health workers from Africa.
2003	Buchan, J., T. Parkin & J. Sochalski	International Nurse Mobility: Trends and Policy Implications	Royal College of Nursing	Global	The paper analyses migration trends and policy issues relating to the transnational mobility of nurses.
2003	Commonwealth Secretariat	Commonwealth Code of Practice for the International Recruitment of Health Workers	Commonwealth Secretariat	Global	The Code of Practice is a voluntary framework for the ethical recruitment of foreign health workers developed specifically for adoption by Commonwealth member countries, but intended for broader incorporation by non-Commonwealth countries and organisations.
2003	Commonwealth Secretariat	Companion Document to the Commonwealth Code of Practice for the International Recruitment of Health Workers	Commonwealth Secretariat	Global	The Companion Document to the Code of Practice provides detailed explanations of concepts and definitions of terms used in the Code.
2003	Commonwealth Secretariat	Human Resources for Health	Report of the East, Central and Southern Africa Commonwealth workshop: Johannesburg, South Africa, January 2003	Sub-Saharan Africa	The report details the proceedings and findings of the workshop, including a review of factors contributing to the loss of health personnel, strategies to counter the adverse effects of the migration of health workers, international efforts address international recruitment, and national coping strategies and methods to mitigate loss.

ANNEX 1

YEAR	AUTHOR(S)	TITLE	PUBLISHER	COUNTRY / REGION	ABSTRACT
2003	Dovlo, D.	The Brain Drain and Retention of Health Professionals in Africa	Regional Training Conference on Improving Tertiary Education in Sub-Saharan Africa	Africa	The paper broadly outlines African health worker migration data and trends, organizes push/pull factors of migration into relevant gradients, and details specific coping strategies that have been undertaken to minimize the impact of emigration on source country health systems and to augment the education and replacement of health workers within source countries.
2003	Dussault, G. & M.C. Franceschini	Not Enough Here, Too Many There: Understanding Geographical Imbalances in the Distribution of Health Personnel.	World Bank	Global	The paper examines the determinants of geographic imbalances in the distribution of health personnel in developed and developing countries and outlines and critiques policies and programmes that have been implemented to address health worker maldistribution.
2003	Huddart, J. & O. Picazo	The Health Sector Human Resource Crisis in Africa: An Issues Paper	Academy for Educational Development (AED)	Africa	The paper outlines the nature and magnitude of the human resource crisis in health care in sub-Saharan Africa. Specifically highlighting the failures of donor neglect and the continued fragmentation of health systems, the authors recommend, among other policies and programmes, increasing the responsibilities and flexibility of health worker functions, adopting increasingly flexible health sector service provider and employment arrangements, and implementing systems to more effectively identify human resource and health system problems.
2003	IOM	Linkages Between Brain Drain, Labour Migration and Remittances in Africa	World Migration 2003, Chapter 12.	Africa	The chapter details sub-regional labour migration patterns from Africa and the magnitude of skilled outmigration before analyzing the benefits and losses associated with outmigration, including the impact of remittances on source countries. The chapter concludes that migration can significantly contribute to development and poverty-alleviation in African countries and highlights the need for national policies and mechanisms to more effectively utilize foreign remittances.
2003	Keeton, C.	Brain Drain Shrinks Mental Care	The Sunday Times 24 August 2003	South Africa	The article details existing labour shortages affecting the mental health care sector in South Africa, the impact of health worker migration on the sector, and the subsequent nature and quality of mental health service delivery in the country.
2003	Lethbridge, D.	Trade in Health Services, GATS Mode 4, Movement of Natural Persons	World Health Organization (WHO).	Global	The paper analyses implications of the General Agreement of Trade in Services (GATS) Mode 4 Movement of Natural Persons for the skilled migration of health workers and for healthcare systems of individual countries.
2003	Liese, B., N. Blanchet & G. Dussault	The Human Resource Crisis in Health Services in Sub-Saharan Africa	World Bank	Africa	The paper analyses health workforce trends in sub-Saharan Africa and examines factors influencing human resource availability in the health sector, including workforce motivation and perceptions and geographic maldistribution of personnel.

YEAR	AUTHOR(S)	TITLE	PUBLISHER	COUNTRY / REGION	ABSTRACT
2003	Meeus, W. & D. Sanders	Pull Factors in the International Migration of Health Professionals	Presentation at the 2003 Public Health Conference: Cape Town, SA	Global	The paper broadly examines the economic and political aspects of international migration as well as the consequences of health worker migration on African health systems, specifically concentrating on analysis of pull (demand) factors of migration from a human rights standpoint.
2003	Newland, K.	Migration as a Factor in Development and Poverty Reduction	Migration Policy Institute	Global	The paper analyses the costs and benefits of migration to source countries, including remittances, the impact of the loss of highly skilled human resources, and the development of transnational networks. The author then outlines the development implications of immigration policies in wealthy countries.
2003	OCHA	Zimbabwe: Focus on the Extent of the Brain Drain	Integrated Regional Information Network (IRIN), U.N. Office for the Coordination of Humanitarian Affairs (OCHA)	Zimbabwe	The article outlines study findings on the flow of Zimbabwean migrants, the magnitude of the Zimbabwean expatriate community, reasons given for Zimbabwean emigration and the nature and impact of health worker migration from the country.
2003	Padarath, A., A. Ntuli & L. Berthiaume	Human Resources	South African Health Review. Ed. 22.	Southern Africa, South Africa	The paper analyses human resources for health in southern Africa, with a specific emphasis on HRH in South Africa. In particular, the paper argues for consistency in human resource strategies between countries, the need for a comprehensive national human resources for health strategy in South Africa, as well as the need to more actively monitor the migration of health personnel from rural to urban areas, from the public to the private sector and between countries.
2003	Padarath, A., C. Chamberlain, D. McCoy, A. Ntuli, M. Rowson, R. Loewenson & C. Thompson	Health Personnel in Southern Africa: Confronting Maldistribution and Brain Drain	Regional Network for Equity in Health in Southern Africa (EQUINET), Health Systems Trust & MEDACT	Southern Africa	The report describes health personnel flows from rural to urban areas, public to private sectors, lower to higher income countries within southern Africa and from African countries to industrialized countries. The report analyzes endogenous and exogenous push, pull stay and stick factors, movement patterns, as well as the production and attrition of health workers in the context of current approaches to training and retention of health personnel in southern Africa.
2003	Shisana, O., E. Hall, K.R. Maluleke, D.J. Stoker, C. Schwabe, C. Colvin, M. Chauveau, et al.	The Impact of HIV/AIDS on the Health Sector: National Survey of Health Personnel, Ambulatory and Hospitalised Patients and Health Facilities	Human Sciences Research Council (HSCR)	South Africa	This report analyses the impact of HIV/AIDS on the South African health system. The authors conclude that the epidemic primarily impacts the health system through the loss of staff due to illness, absenteeism, low morale and increased patient load. The sub-systems affected by HIV/AIDS are wide ranging, and include primary, secondary and health care and public hospitals, as well as private health services. The authors call for a human resource plan for the South African health sector to cope with the loss of health workers.

YEAR	AUTHOR(S)	TITLE	PUBLISHER	COUNTRY / REGION	ABSTRACT
2003	Stilwell, B.	Developing Evidence-Based Ethical Policies on the Migration of Health Workers: Conceptual and Practical Challenges	WHO Paper prepared for the Human Resource Meeting: Geneva, December.	Global	The paper examines key issues in the international migration of health workers, including analysis of impact and available entry points to develop policies and programmes in order to manage migration.
2003	Taran, P. & E. Geronimi	Globalization, Labour and Migration: Protection is Paramount	International Labour Organisation (ILO)	Global	The paper describes the influence of globalization on labour and migration; outlines existing international conventions, labour norms, employment standards and legal rights related to the protection of migrant workers; and details the necessary components of subsequent migration-related policies and programming.
2003	Tawfik, L. & S. Kinoti	The Impact of HIV/AIDS on Health Systems and the Health Workforce in Sub-Saharan Africa	U.S. Agency for International Development (USAID) - Bureau for Africa, Office of Sustainable Development	Sub-Saharan Africa	The paper analyses the impact of HIV/AIDS on the sub-Saharan African health workforce. The authors argue that there has been inadequate analysis of the impact of HIV and AIDS on the human resources for health (HRH) sector, and that the available evidence suggests that HIV/AIDS has led to an increased demand for health services, while simultaneously decreasing the number and productivity of health service providers. The authors recommend that a HRH needs-assessment in the health sector is needed across sub-Saharan Africa to improve the performance of national AIDS control programmes and identify key components for inclusion in the assessment.
2002	Bhorat, H. J.B. Meyer & C. Mlatsheni	Skilled Labour Migration from Developing Countries: Study on South and Southern Africa.	International Labour Organisation (ILO)	South Africa/ Southern Africa	The study provides estimates of the outflow of skilled migrants from South and Southern Africa that contradict official migration records. Proffering that actual skilled migration far exceeds the official recorded migration estimates of source countries, the study recommends increased international cooperation in migration data gathering and management as well as increased utilisation of the African diaspora.
2002	Chanda, R.	Trade in Health Services	Bulletin of the WHO. Vol. 80. No. 2., World Health Organization	Global	The article utilizes the framework of the General Agreement on the Trade in Services (GATS) to analyze the international trade of health services through the cross border delivery of trade, the consumption of health services abroad, the transnational commercial presence of healthcare institutions and the movement of health personnel.
2002	Dodson, B.	Gender and the Brain Drain from South Africa	Southern African Migration Project (SAMP) Migration Policy Series No. 23	South Africa	The report details the findings of two studies analyzing the gender dimensions of South African skilled migration.

YEAR	AUTHOR(S)	TITLE	PUBLISHER	COUNTRY / REGION	ABSTRACT
2002	DOH	Policy on Recruitment, Employment and Support of Foreign Health Professionals in the Republic of South Africa	Department of Health (DOH), Republic of South Africa	South Africa	The report outlines the South African government's official policies relating to the recruitment, employment, legal rights and residence support of foreign health workers.
2002	Frommel, D.	Global Market in Medical Workers: Exporting Health	Le Monde Diplomatique		The article outlines a variety of nation-specific recruitment policies that foster the international migration of health workers, reasons for health worker migration. The author offers several strategies to reduce health worker emigration from low-income source countries.
2002	Health Ministers of the SADC Region and	Johannesburg Declaration on Health and Sustainable Development	World Health Organization (WHO)	Global	The Declaration outlines several resolutions and recommendations calling for action on issues related to Health and Development. Among other recommendations addressing human resources for health (HRH), the Declaration calls for an international code of conduct to regulate the recruitment of skilled personnel from developing countries.
2002	ILO	ILO Africa Labour Migration Policy Initiative - A Contribution to the NEPAD Agenda	International Labour Organisation (ILO)	Africa	The document outlines the ILO's efforts to assist African countries in their management of labour migration. Specifically, it details the ILO's framework and initiative for labour migration-related policy development and programme implementation.
2002	Martineau, T. K. Decker & P. Bundred	Briefing Note on International Migration of Health Professionals: Levelling the Playing Field for Developing Country Health Systems.	Liverpool School of Tropical Medicine	Global	The brief details contemporary and historical issues relating to health worker migration from developing countries, highlights the likely increase in future demand for health workers and proposes moving beyond codes of ethical recruitment to reduce health worker loss from low-income source countries.
2002	McDonald, D. & J. Crush	Destinations Unknown: Perspectives on the Brain Drain in Southern Africa.	Southern African Migration Project (SAMP)	South Africa/ Southern Africa	The book provides an outline and detailed discussion of various issues related to skilled labour emigration from South and Southern Africa, including: analysis of perceptions and migration-related attitudes of skilled workers in South Africa, Botswana and Lesotho; the gendered dimensions of skilled migration, employer responses to skilled labour loss and emigration, regional migration flows and skill gains, as well as detailed analysis of emigration rates and migration flows from the region.

YEAR	AUTHOR(S)	TITLE	PUBLISHER	COUNTRY / REGION	ABSTRACT
2002	Ndulu, B.	Human Capital Flight: Stratification, Globalization, and the Challenges to Tertiary Education	Unpublished Paper	Africa/ Global	The paper comparatively outlines and characterizes African skilled migration in a historical and international context, analyzes human capital flows in the context of globalization, and highlights the challenges African countries face in addressing brain drain. The paper recommends shifting incentive structures to draw and retain skilled labour; initiatives to increase the domestic demand for skilled workers; collective initiatives to ease regional labour mobility and increase professional network interaction as a means of improving skilled labour retention; and programmes and policies specifically aimed at increasing the involvement of the diaspora, mobilizing emigrants for technical assistance, and increasing repatriation.
2002	Pang, T., M.A. Lansang & A. Haines	Brain Drain and Health Professionals: A Global Problem Needs Global Solutions	British Medical Journal. Vol. 324.	Global	The editorial briefly outlines international health worker migration and proposes a series of measures to reduce emigration from developing countries.
2002	Tjadens, F.	Health Care Shortages: Where Globalisation, Nurses and Migration Meet	Eurohealth. Vol. 8. No. 3.	Europe/ Global	The journal article explores the cross-border movement of both patients and health workers as means of addressing structural health care personnel shortages, including analysis of existing policies and practices and their ethical and practical implications.
2001	Adlung R. & A. Carzaniga	Health Services Under the General Agreement on Trade in Services	Bulletin of the WHO. Vol. 79. No. 4.	Global	The article discusses the nature and limitations of the international trade in health services as they relate to the General Agreement on Trade in Services (GATS)
2001	Lowell, L. & A. Findlay	Migration of Highly Skilled Persons from Developing Countries: Impact and Policy Responses	International Labour Office/ Department for International Development (DFID)	Global	The report summarizes research on the impacts of skilled labour emigration on developing countries and examines the array of policy options available to manage international labour flows.
2001	Oucho, J. & J. Crush	Contra Free Movement: South Africa and the SADC Migration Protocols.	Africa Today - Volume 48, Number 3, Fall 2001, pp. 139-158, Indiana University Press	Southern Africa	The paper examines the history, development and failure of cooperative regional SADC initiatives on population movement and migration and details the key obstacles to regional agreements on migration management in southern Africa.
2001	Xaba, J. & G. Phillips	Understanding Nurse Emigration: Final Report	Trade Union Research Project (TURP)	South Africa	The report investigates the nature and magnitude of nurse emigration from South Africa and examines factors and perceptions driving the phenomenon.
2000	Bundred, P. & C. Levitt	Medical Migration: Who are the Real Losers?	The Lancet. Vol. 356. Issue 9225.	Global	The journal article briefly outlines the recruitment and migration of health workers from low to high income countries, the attempted establishment of barriers to emigration by some countries, domestic distribution and supply issues in the U.S. and Canada as migration influencing factors, and proposed responses to address the phenomenon.

YEAR	AUTHOR(S)	TITLE	PUBLISHER	COUNTRY / REGION	ABSTRACT
2000	De Haan, A.	Migrants, Livelihoods, and Rights: The Relevance of Migration in Development Policies	Department for International Development (DFID)	Global	The paper outlines potential negative impacts of migration, including heightened inequality and destitution of those left behind, and then details the potential benefits of migration for the poor. The author argues that the benefits of migration for poverty reduction are often overlooked.
2000	Mudyarabikwa, O.	An Examination of Public Sector Subsidies to the Private Health Sector: A Zimbabwe Case Study	Regional Network for Equity in Health in Southern Africa (EQUINET) & University of Zimbabwe Medical School	Zimbabwe	The paper analyzes the Zimbabwean government's partial provision of public sector subsidies to the private sector as an incentive for private investment in health service provision and more equitable access to health care.
2000	Mugabe, J., P. Kivlonzi & C. Mwango	Return and Reintegration of Qualified African Nationals Programme (RQAN III) Phase 3 Report	International Organization for Migration (IOM)	Africa	The report details the impact of returnees in the workplace in the third phase of the program of Return and Reintegration of African Nationals (RQAN)
1999	Faist, T.	Transnationalization in International Migration: Implications for the Study of Citizenship and Culture	Institute for Intercultural and International Studies (InIIS), University of Bremen	Global	The paper examines immigrant adaptation, acculturation and cultural retention in destination countries, and discusses factors relevant to the formation and maintenance of transnational social spaces.
1999	Meyer, J.B. & M. Brown	Scientific Diasporas: A New Approach to the Brain Drain	Management of Social Transformations (MOST) Discussion Paper No. 41. UNESCO.	Global	The paper outlines the magnitude of S&E migration from developing countries, discusses the organization and nature of existing intellectual diaspora networks, and details the prospects and implications for utilizing intellectual diaspora network.
1993	Massey, D., G. Arango, A. Hugo, A. Kououci, A. Pellegrino & E. Taylor	Theories of International Migration: A Review and Appraisal	Population and Development Review. Vol. 19. No. 3.	Global	The journal article details and evaluates the contemporary models and theories of international migration and transnational population flows.



IOM Regional Office for southern Africa
PO Box 55391 Arcadia 0007 Pretoria South Africa
tel +27 (0)12 342 2789 fax +27 (0)12 342 0932

www.iom.org.za