



Save the Children



# One Million More

Mobilising the African diaspora healthcare professionals  
for capacity building in Africa





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*One Million More* presents some of the interventions, debates, discussions and conclusions of a conference held in London from 21–22 March 2006. The conference was organised to create a stimulating and interactive forum to discuss the crisis in human resources for health, in an effort to influence national, regional and international policies for the promotion of sustainable skills capacity in Africa and to engage the African diaspora in innovative, practical steps to move the agenda forward.

The conference was organised by AfricaRecruit and supported by Save the Children UK, the Commonwealth Secretariat, NEPAD (The New Partnership for Africa's Development), DFID (Department for International Development), the Royal African Society, the Commonwealth Business Council, IOM (International Organization for Migration), SAB Miller, PA Consulting Group and Songhai Health Trust Ltd.

The views and analysis presented in this report are the responsibility of Save the Children, except where quoted.

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# One Million More

Mobilising the African diaspora healthcare professionals for capacity building in Africa

Karl Blanchet, Regina Keith and Peter Shackleton

**Save the Children fights for children in the UK and around the world who suffer from poverty, disease, injustice and violence. We work with them to find lifelong answers to the problems they face.**

**Save the Children UK is also a member of the International Save the Children Alliance, the world's leading independent children's rights organisation, with members in 27 countries and operational programmes in more than 100.**

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*Cover photo shows Matron Zainabu Mataradas in the maternity ward at Sokoine Regional Hospital, Tanzania. Photo by Teri Pengilly.*

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# Forewords

**by Dr Titilola Banjoko, Chairperson,  
AfricaRecruit**

AfricaRecruit,<sup>1</sup> a programme of the New Partnership for Africa's Development (NEPAD), together with the Commonwealth Secretariat and the Commonwealth Business Council (CBC), organised a two-day conference entitled 'Mobilising the African Diaspora Healthcare Professionals for Capacity Building in Africa' in collaboration with the Department for International Development (DFID), the Royal African Society, the Foreign and Commonwealth Office (FCO), Save the Children UK, the International Organization for Migration (IOM), SAB Miller, PA Consulting Group and Songhai Health Trust Ltd.<sup>2</sup> The British Medical Association, Royal College of Physicians and Royal College of Nursing were also partners.

The conference sought to find solutions that would enable Africa to address its capacity to meet the health-related Millennium Development Goals (MDGs) while involving the diaspora in the revitalisation of Africa's health systems and structures. The wider aims of the conference included:

- developing a profile of the 'brain drain' and its use in the West
- establishing a forum to bring together all stakeholders inside and outside Africa from public, private and non-governmental sectors to engage in constructive dialogue

- the development of healthcare networks, knowledge and skills in the diaspora, which can be repatriated to Africa
- sharing success stories/best practices and how they can be scaled up or adapted
- looking at untapped opportunities and practical implications of current policies to come up with key recommendations for ongoing work to strengthen existing capacities.

The online survey conducted by AfricaRecruit prior to the conference recognised the immense contributions that African healthcare professionals are making to the healthcare systems in the West. The aim of the survey was to provide an insightful analysis from the diaspora themselves on why they left Africa, their experience in their country of training/origin, their professional experience in the West, whether they are currently engaged in Africa's healthcare, and suggestions on how they can be of added value to Africa.

Some of the results of the survey are discussed in the appendix. For full details, visit [www.africarecruit.com](http://www.africarecruit.com)

**by Ann Keeling, Director, Social Transformation Programmes Division,  
Commonwealth Secretariat**

Migration of health professionals from Commonwealth African countries is probably the most serious human resource problem those countries face. Commonwealth countries contain around 30 per cent of the world's population but bear a disproportionate burden of the world's ill health. Sixty per cent of global maternal deaths and HIV and AIDS cases occur in Commonwealth countries. We are most concerned, therefore, about countries with under-resourced health systems and a high disease burden that are losing health professionals to both migration, and HIV and AIDS.

On health worker migration, two sets of rights are in the balance. First, the right of the individual health professional from Africa to migrate. And secondly, the

right to health – and even the right to life – of citizens in the African countries they are leaving.

Alongside these rights are the broader obligations of governments and the international community to ensure that health systems in Africa are adequately funded. It is against this background that Commonwealth health ministers in 2003 adopted a Commonwealth Code of Practice for the International Recruitment of Health Workers to protect the most vulnerable states from unmanaged migration but also to protect the rights of migrating health workers. We see this two-day conference as a valuable means of harnessing the talent and expertise of Africans in the diaspora for the development of Africa.

# Abbreviations

BMA	British Medical Association
CBC	Commonwealth Business Council
DFID	Department for International Development
GDP	Gross domestic product
ICM	International Confederation of Midwives
ICN	International Council of Nurses
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP	Gross national product
ILO	International Labour Organization
IMF	International Monetary Fund
IOM	International Organization for Migration
MDG	Millennium Development Goal
NEPAD	The New Partnership for Africa's Development
NGO	Non-governmental organisation
NHS	National Health Service
NORAD	Norwegian Agency for Development Cooperation
PRGF	Poverty Reduction Growth Facility
RCM	Royal College of Midwives
RCN	Royal College of Nurses
SSA	Sub-Saharan Africa
THET	Tropical Health and Education Trust
WHA	World Health Assembly
WHO	World Health Organization
WMA	World Medical Association

# Executive summary

This report describes some of the interventions, debates, discussions and conclusions from the conference 'Mobilising the African Diaspora Healthcare Professionals for Capacity Building in Africa', which was held in London from 21–22 March 2006. Voices in the report come from many diverse stakeholders, including health ministers from Africa, civil society, donors and the diaspora. The conference was organised to create a stimulating and interactive forum to discuss the crisis in human resources for health, in an effort to influence national, regional and international policies for the promotion of sustainable skills capacity in Africa and to engage the African diaspora in innovative, practical steps to move the agenda forward.

The report describes the nature of the problem, while examining the causes and possible ways forward, concluding with recommendations on how to plug the gap of one million healthcare professionals needed by Africa today, to reach its Millennium Development Goals (MDGs) for health.<sup>3</sup> 2006 has been dedicated, by the World Health Organization (WHO), to human resources for health. The 2006 World Health Report focuses on the human resource crisis and is entitled *Working Together for Health*. It was launched in Zambia on 7 April, World Health Day.

This report will be used as an advocacy tool in various international health fora (like the Commonwealth Health Ministers meeting and the World Health Assembly (WHA)) to ensure that the voices from this meeting are heard and are able to influence strategies and policy discussions. It must be noted, however, that while adequate representation cannot be secured in a short meeting and voices from such a diverse group will not be homogeneous, opportunities must be sought to harness the valuable skills of the diaspora. There are many innovative mechanisms described in this report, but it is only by involving the diaspora in context-specific planning, research, training, advocacy and policy formation that their support can be used to help strengthen Africa's health systems.

The meeting heard calls for donors to fund the recommendations from the Commission for Africa to give more financial support to healthcare (\$1–6bn for human resources and \$9bn for strengthening health systems) while calling for African nations to meet their promised Abuja target of spending 15 per cent of their national budgets on health. The diaspora was asked to support national ministry plans while countries were advised to carry out detailed human resource gap analyses, and to use their consulates to develop databases for migrant health workers willing to return

## Recommendations

- 1 Developed countries should financially compensate poor countries that have a shortage of health professionals.
- 2 International donors' investment in human resources should be included in health systems-strengthening strategies and poverty reduction strategy papers.
- 3 Invest in people: increase the human resource capacity of developing countries.
- 4 Stop attracting, start training: address health worker needs in Western countries.
- 5 Facilitate brain circulation and return migration.

home to work. Positive retention policies – including improved salaries, working conditions, rural post incentives, enhanced career opportunities and improved mechanisms to return home – were put forward as ways to improve staff motivation and retention. The issues of HIV and conflict were highlighted along with poverty and economic policies as causal factors in a growing global health worker

market. Save the Children UK called on the UK government to pledge 10 per cent (\$100 million annually) of the \$1bn needed, by 2007, to support the training and retention of 100,000 health workers in Africa as part restitution for the unjust subsidy the UK NHS and Department of Health receive from African health systems through health worker migration.

# The human resources crisis in Africa: a healthcare emergency

Today, the world is facing an unprecedented shortage of health workers. The current 59 million health professionals are not sufficient to cover the health needs of the world's population.<sup>4</sup> WHO estimates that 4.2 million health workers need to be recruited to meet global health needs. The World Health Report 2006<sup>5</sup> demonstrates that a minimum of 2.3 health workers per 1,000 population is required to meet the health-related MDGs, (eg, to meet the goal set for MDG 4, nations would need to reach an 80 per cent coverage rate for children under the age of one immunised against measles). Fifty-four countries are currently below the minimum index. Countries in sub-Saharan Africa (SSA) will be 150 years late in meeting MDG 4 if they continue at current rates of progress. One enormous factor is that many countries' health systems are not functioning and although they shoulder the highest burden of disease they have the fewest health workers per population. SSA alone requires an additional one million health workers by 2015, which will cost in the region of \$1–6bn per year.<sup>6</sup> One impact of health staff shortfalls in resource-limited health systems with the most serious health problems is that women and children continue to die needlessly from preventable causes.

Human resources for health, and health systems in developing countries, have been underfunded for decades due to harsh economic policies like structural adjustment (which led countries to promote fiscal stability and growth by reducing their expenditures on social spending, devaluing currencies and privatising national services, leading to increased inflation and poverty). The situation has been exacerbated by conflict, the HIV pandemic, weak institutional capacity, and the failure of donors to invest in recurrent expenditure like staff salaries. This chronic under-investment has led to collapsing health systems,

appalling and unsafe working conditions for health professionals and an unfair distribution of health workers between rich and poor countries.

*"I would like to bring to the attention of international donors that it is impossible to deliver quality care with \$12 per capita per year. This is poverty that underlines this situation. If donors respect their promises, they should spend 0.7 per cent of their GDP [gross domestic product]. This would have a significant impact on poverty in developing countries. It is unrealistic to analyse the present human resources crisis without relating it to poverty issues. To be able to attain the Millennium Development Goals, we urgently need significant investments in both human resources for health and poverty reduction strategies."*

Dr H Ntaba, Minister of Health, Malawi

The shortage of qualified staff in Africa has been aggravated by the increasing emigration of health workers to a number of developed or 'recipient' countries. Countries like Ghana have more doctors working overseas (60 per cent) than in their own system. In Zimbabwe, only 360 physicians out of the 1,200 trained in the 1990s remain in their country. These health workers are supporting the healthcare delivery and effectiveness of recipient countries' healthcare systems. Recipient developed countries, in response to their own health staff shortages, have actively drained highly skilled health personnel from developing countries, without reinvesting in the health systems of those 'source' countries, especially in Africa.

*"Kenya is short of 5,000 nurses. Yet, 6,000 nurses are looking for a job. In Malawi, the situation is even worse. Seventy per cent of nurses' positions have not*

*been filled. We need to convince governments and donors to inject more money in human resources for health.”*

Mr Edwin Macharia, Director of Rural Initiative – HIV/AIDS Initiative, Clinton Foundation

The human resources crisis in developing countries has become a global challenge. At stake is nothing less than the future of global health and development. Immediate national and international financial and technical support and political mobilisation is needed for the decade 2006–2015,<sup>7</sup> to develop an effective health workforce to ensure that the world’s poorest countries can achieve the MDGs.<sup>8</sup>

*“If we cannot sort out the human resources crisis, we are not going to stop one in eight children dying in Africa.”*

Professor Eric Buch, Health Advisor to NEPAD

## The scale of the problem

The scale of the problem is such that Africa must triple its number of health professionals in order to attain the MDGs.<sup>9</sup> An extra one million health workers need to be recruited, trained and effectively supported with resources and safe working conditions.

## The inequitable distribution of human resources for health

Although African countries suffer 24 per cent of the global burden of disease, they have less than three per cent of the world’s health workers and account for less

than one per cent of global health expenditure (see Table 1). The distribution of health staff in the world favours developed nations, with the Americas having 41.70 health workers per 1,000 population while Africa has 2.1 health workers per 1,000 population.<sup>10</sup>

*“In Ghana, one out of 10 children dies compared with one out of 150 in the UK. There are only nine doctors per 100,000 population in Ghana who struggle to take care of these children, as there are 166 doctors per 100,000 in the UK.”<sup>11</sup>*

Dr Michael Pelly, Associate Director Global Health, Royal College of Physicians

Staff inequities also exist within countries, with rural posts being the hardest to fill. Doctors, nurses and midwives tend to move from rural to urban areas to secure better working conditions, salaries, and schools for their children. Career advancement and learning opportunities are mostly provided in secondary- and tertiary-level services, leaving remote communities without qualified health staff. In Malawi, for example, two-thirds of all health workers work in urban areas whereas 85 per cent of the population is concentrated in rural areas.<sup>13</sup> A study conducted in Ghana and Zimbabwe showed that health workers in urban areas had a lesser workload than health staff working in rural areas, where health facilities are often understaffed.<sup>14</sup> This internal migration has also been amplified in Africa by the drain of qualified staff from public services to the private sector. The private sector often offers better salaries and working conditions, including reliable drug supplies, equipment and salaries.<sup>15</sup>

**Table 1: Imbalances in health<sup>12</sup>**

The Americas	Sub-Saharan Africa
14% of the world’s population	11% of the world’s population
10% of the global burden of disease	24% of the global burden of disease
37% of the world’s health workers	3% of the world’s health workers
>50% of global health expenditure	<1% of global health expenditure

## What are the root causes of the crisis in human resources?

### Health workforce: decades of neglect

Human resources for healthcare have been neglected for decades by governments, donors, international organisations and development policy-makers.<sup>16</sup> The investments of the international donor community have never reached the expected level of \$22bn per annum needed by 2007, as recommended by the Commission on Macroeconomics and Health.<sup>17</sup> In some cases, spending levels on health have even decreased in absolute terms, particularly in countries facing economic decline and in the process of structural adjustment. The Commission on Macroeconomics and Health recommended in 2001 that minimum health spending should be \$34 per capita per year.<sup>18</sup> Currently, only 13 out of 55 sub-Saharan African countries spend more than \$30 per capita per year on health. Developed nations have delayed meeting promises made over 30 years ago to increase aid spending to 0.7 per cent of GDP and there has as yet been little visible progress on implementing the promises made by the G8 in July 2005, to double aid and erase debt. Developing countries have not yet honoured their commitment, made in Abuja, Nigeria, in 2001, to increase national health spending to 15 per cent of their gross national product (GNP). The donors and partners are not yet ensuring that available resources are spent on national priorities to meet the needs of the most vulnerable; too often priorities are set globally with no involvement of the most vulnerable populations. Health sector reforms have not yet ensured that adequate resources, management and decision-making powers are decentralised, and accountability mechanisms are weak or non-existent. Many of these issues have made providing healthcare an enormous challenge for most health workers. Other policy barriers that reduce utilisation of healthcare services by the most vulnerable, such as health user fees, have also had a negative impact on poor people's access to healthcare services.<sup>19</sup>

### The International Monetary Fund (IMF) and the Poverty Reduction Growth Facility

The Poverty Reduction Growth Facility (PRGF) agreement signed between individual countries and the IMF has often been cited as another major barrier to increasing national investments in human resources for health. The IMF supports countries to maintain fiscal stability, at times encouraging them to cap or cut civil service expenditure and social spending. Some countries set their own ceilings to ensure continued fiscal stability and sustainability of national services. In the last decade, economic policies like structural adjustment encouraged developing countries to maintain fiscal stability, by increasing privatisation of nationally owned enterprises, devaluing national currencies and reducing social spending. As a consequence, services promoting human development (including health and education) have been the ones that have faced the most dramatic cuts. In Kenya, for example, 50 per cent of nursing positions are vacant, whereas a third of nurses are unemployed.<sup>20</sup> The IMF promotes short-term reforms that only focus on public expenditure reduction without evaluating the impact of these measures on poverty reduction, and without considering different macroeconomic alternatives.

*“Some African countries limit their own expenditures and do not want to recruit additional personnel for financial reasons. In other countries, the IMF and the World Bank are the ones responsible for low investments in human resources.”*

Dr Akpa Gbary, Regional advisor for HRH,  
Regional Office Africa, WHO

Large investments are necessary to urgently improve the availability and quality of human resources. The scale of global investment needed in human resources for health is estimated to be \$2bn in 2006, rising to \$7.7bn in 2010.<sup>21, 22, 23</sup>

### The impact of the HIV and AIDS pandemic on Africa's health workforce

The HIV and AIDS pandemic has also constituted a real threat for health workers in Africa. It has been estimated that HIV and AIDS account for anywhere from 19 per cent to 53 per cent of all

deaths among government staff in a typical African country.<sup>24</sup> In Swaziland, 10 per cent of health workers are being lost to HIV and AIDS.<sup>25</sup> A quarter of Malawi's remaining health workers are expected to die from AIDS within the next five years. The pandemic has also overwhelmed health workers by increasing workload and stress, with 39 per cent of absenteeism attributed to HIV and AIDS.<sup>26</sup>

### The global 'brain drain'

The emigration of health workers from poorer countries to richer countries constitutes another cause of the increasing health worker crisis threatening public healthcare services in Africa. The situation is catastrophic. In 2005, 43 per cent of doctors employed in the UK's National Health Service (NHS) as health and safety officers came from abroad.<sup>27</sup> In Ghana, 604 out of 871 medical officers trained between 1993 and 2002 have left the country. Ghana also lost about 2,500 nurses to Europe between 1999 and 2002. Today, two-thirds of the doctors trained in Ghana are working abroad.<sup>28</sup>

*"The decision to migrate has dropped from eight years in 1985 to two years in 2002 between their graduation at medical schools and their departure. Sixty per cent of our doctors are currently working abroad. This is a real challenge for Ghana Health services."*

Dr Ken Sagoe, Director of Human Resources,  
Ministry of Health, Ghana

*"Take nurses' numbers. There are more nurses in the system – that is undeniably true. But something like 45 per cent of new registrants in the UK are international nurses."*<sup>29</sup>

Sylvia Denton, President, Royal College  
of Nursing

The active recruitment by Western countries of overseas workers from the poorest countries is an unfair response to the increasing demand for healthcare from their ageing populations and the extreme budgetary pressure put on Western healthcare systems (financial deficit of trusts, increasing job cuts,

high turnover of nurses).<sup>30,31</sup> Developed countries have clearly failed to address their training, recruitment and retention problems. The present and future needs of developed countries in terms of health staff are huge and will need to be fulfilled in a context of financial restrictions.<sup>32</sup> By 2008, the UK will need to recruit 25,000 more doctors and 35,000 new nurses.<sup>33</sup> The US will need to recruit an extra one million nurses by 2010.<sup>34</sup>

*"UK nurses' pay is so bad that 27 per cent of nurses are forced to take a second job because they simply don't earn enough to live on. I would like to focus on another key human resources challenge for the UK: deficits. Our research shows that:*

- 27 per cent of nurses work in trusts where patient treatment is being delayed*
- 31 per cent of nurses work in trusts where posts are being lost*
- 38 per cent of nurses work in trusts where wards are being closed*
- 69 per cent of trusts have stopped using bank and agency staff to cover nurse shortages."*<sup>35</sup>

Sylvia Denton, President, Royal College  
of Nursing

### An unjust subsidy

It costs African countries £270m to train doctors and nurses.<sup>36</sup> The UK has saved ten times that amount by not training these doctors and nurses themselves. For Ghana, the estimated cost of training is estimated to be £35m. The UK has saved £65m in training costs recruiting Ghanaian doctors since 1998.<sup>37</sup> For source countries, the effect of lost care on the economy and the high costs of replacement should be added to the training costs.

*"Every year, 20,000 skilled health workers leave the African continent. To train a doctor, a government has to spend \$60,000 and \$15,000 for a nurse. This represents a total annual loss of \$500m superior to the international development aid."*

Mrs Ndioro Ndiaye, Honourable Minister  
and Deputy Director, International  
Organization for Migration

### The scale of the problem: overview

- 4.2 million health workers need to be recruited globally, SSA needs one million more.
- \$1–6bn per year needs to be invested in Africa to fill the human resources gap.
- Africa has the lowest health worker: population ratio in the world with a ratio of 2.17 per 1,000 population.
- The health worker: population ratio is nine times higher in Europe than in Africa.
- The health worker: population ratio is 19 times higher in America than in Africa.
- HIV/AIDS in some African countries accounts for half of all government staff deaths.
- Every year 20,000 skilled health workers leave the African continent.
- By 2008, the UK will need 25,000 more doctors and at least 35,000 more nurses.
- By 2010, the USA will need to recruit an extra one million nurses.
- The 'brain drain' of doctors has cost Ghana £35m and saved the UK £65m in training costs since 1998.

A recent report released by the International Council of Nurses showed that some 'unethical' recruitment agencies charged migrant workers abusive travel fees or provided false information about living and working conditions in destination countries.<sup>38</sup> Migrant workers represent a flexible workforce which more easily accepts poor working conditions or unsocial shifts, (eg, night shifts) and geographical regions that nationals are reluctant to take. For example, a survey conducted by the Royal College of Nursing in 2002 showed that overseas-qualified nurses were more likely to work full-time than their UK colleagues.<sup>39</sup>

### The push and pull factors

#### Push factors in source countries

The drivers that motivate African health professionals to leave their country are diverse and linked to the situation in their country of origin.

- **Economic decline, political instability and conflicts**

There is a clear relationship between economic decline and migration.<sup>40</sup> The lack of funding by most governments in various sectors of the

economy has contributed to the deterioration of working and living conditions. In most countries, the lack of all-weather roads isolates rural communities, making emergency health referrals almost impossible. The costs of accessing such services also pull families into poverty or destitution.<sup>41</sup> In East and Central Africa, almost 30 per cent of the rural population cannot access healthcare while another 30 per cent are plunged into poverty by accessing healthcare, as they are forced to sell off finite capital assets like land or livestock and crops.<sup>42</sup> Some populations do not have access to safe drinking water, electricity or food, with famine and floods seen to be increasingly prevalent annual occurrences. In Zimbabwe, a study found that economic decline and the deterioration in living conditions were the main reasons cited for migration by 50 per cent of the doctors and nurses interviewed.<sup>43</sup> Armed conflicts are also a key determinant for migration. Civil wars in Lusophone African countries were followed by a flow of migration by health workers.<sup>44</sup>

*"Sixty per cent of our physicians have left Sudan. 800 graduates emigrate each year. They have been*

*recruited by agencies or have followed some relatives in Saudi Arabia, UK or Ireland. The armed conflict has ended. We now hope health workers will come back to Sudan.”*

Dr Bahr Elsheikh, Director of the State Affairs,  
Ministry of Health, Sudan

- **Collapse of health systems**

The inadequate funding of health systems in Africa has resulted in unsafe and under-supported working conditions for health professionals.

The lack of basic equipment and regular drugs combined with many districts having less than \$1 per person per year to spend on healthcare services reduces the ability of health workers to carry out their jobs effectively. When poor working conditions are combined with long delays in salary payment (up to six months in some districts) and compounded by delays in health-seeking behaviour (mostly due to the cost of the service), these factors lead to increased numbers of unnecessary deaths.

These deaths reduce health worker motivation and the communities' trust in health workers and the services they provide. Lack of health facilities and shortage of human resources have overburdened remaining health workers. The lack of staff leads to increased workload for the remaining workforce: long working hours, and night and weekend shifts without financial compensation. In South Africa and Zimbabwe, the degradation of quality of care was perceived as a key factor for migration.<sup>45</sup>

In these countries, the impact of HIV on health workers, their communities and the health system is catastrophic.

*“I tried to find a job in my country. But I did not get any opportunity. There was no option for me. I had to leave. I would like to go back to my country, Swaziland, for short periods of time. I know I could help with all my experience acquired in the UK. I think I could do a lot of changes.”*

Precious Dlamini, Health sociologist,  
living in the UK for two years

*“In some areas, we have lost all our experts. We can't choose the right equipment. We have difficulties to plan and cannot get support from Nigerien technicians. This has effects on our capacity to respond to donors' requirements. We cannot recruit new staff. The World Bank and the IMF control our expenses.”*

Dr Abdoulaye Bagnou, Coordinator,  
Prime Minister's Office, Niger

- **Inadequate retention, management and training policies**

In Africa, government health workers receive low salaries that do not enable them to meet their daily living expenses. Health workers complain about limited opportunities for career development, (eg, promotion, further education, additional qualifications) and the lack of support and supervision received.

- **Pull factors in recipient countries**

The pull factors mirror the push factors. Better working conditions, salaries, the chance of advancement in their profession, further educational opportunities, international experience, increased safety for their family, reduced workload and enhanced living conditions are all cited as pull factors. Additional drivers motivating health workers to work overseas are linked to the active pull by recruitment agencies and the increasing demand for health staff in developed countries. Diaspora networks have also played a key role in attracting family members and colleagues and facilitating their integration into the new environment. It is also hard to return once you have migrated. Dr Sagoe from Ghana stated that the media and others were painting very negative pictures of migrants and efforts are needed to halt this practice.

# What can we do to halt the crisis?

## A window of opportunity, or just another unimplemented promise?

The 57th World Health Assembly in May 2004 recognised the amplitude and gravity of the human resources crisis for developing countries and adopted a resolution (57.19) on the international migration of health personnel, urging member states to “develop strategies to mitigate the adverse effects of migration of health personnel and minimize its negative impact on health systems”.

Today, most major international organisations and donors (WHO, IOM, NEPAD, European Union, DFID) agree that the global human resources crisis endangers national health systems and reduces the chances of meeting the health-related MDGs. However, little concrete commitment has yet been made by the major international actors. The UK government is presently supporting the implementation of Malawi’s human resource strategy with £100m but the G8 should really be scaling up its support for human resources in more developing nations and seeing it as additional and specific support to implement the above resolution. If the UK committed £100m in extra resources (10 per cent of the minimum \$1bn needed to ensure one million more health workers) each year until 2015 in order to support 100,000 extra health workers, it would be making real, lasting and accountable change in the lives of the poorest in Africa. The diaspora can help by holding their own governments to account on health sector spending and ensuring that human resources are prioritised, while at the same time calling for donor governments to fulfil their promises and implement resolution 57.19, committing specific resources and technical support to priority countries.

## How do we mitigate against migration?

During the conference, participants discussed a number of ways to train, retain and sustain national workforces. Many were relatively small-scale, local and bilateral projects. However, a number of more substantial and successful measures were also discussed.

There was a general consensus that the human resources crisis required a global partnership based on the commitment of a broad range of actors including ministries of health, international donors and organisations, non-governmental organisations (NGOs), professional associations and trade unions. Overcoming the human resources crisis will necessitate immediate action for implementing measures over the short, medium and long term.

Several initiatives have been tested in different African countries showing that the motivation and retention of health workers can be effectively enhanced by appropriate financial and non-financial measures. At the conference, the private and voluntary sectors presented innovative programmes for improving health worker capacity and motivation like telemedicine, distance learning and hospital linkage programmes.

## What should be done? Voices from International Health Stakeholders

- WHA Resolution 57.19: *“Establish mechanisms to mitigate the adverse impact on developing countries of the loss of health personnel through migration, including means for the receiving countries to support the strengthening of health systems in particular human resource development in the countries of origin”*; *“Frame and implement policies and strategies that could enhance effective retention of*

*health personnel including but not limited to strengthening of human resources of health planning and management and review of salaries and implementation of incentive schemes.”*

- WHO: *“The four priorities for action encompass educating and training health workers, supporting and protecting them, enhancing their effectiveness, and tackling health imbalances and inequities.”*<sup>46</sup>
- International Organization for Migration: *“While brain drain is one of many factors contributing to under-development in parts of Africa, it is an important element that needs to be addressed through policies and sustained programmes that facilitate and harness the development potential of migrants.”*<sup>47</sup>
- NEPAD: *“Building human and institutional capacities for health requires a comprehensive approach [...], nutrition and social integration. The NEPAD strategic vision for health development can only be achieved through increased resource mobilisation, strengthened management and more equitable distribution and allocation of financial and human resources.”*<sup>48</sup>
- The International College of Nursing: *“Overcoming the crisis [...] will require determined advocacy, leadership and a deep and sustained political and financial commitment on the part of individual nations and the international community.”*<sup>49</sup>
- The European Union: *“The EU will engage with the crisis in human resources for health in developing countries at country, regional and global level. [...] The global demand for human resources for health issues dictates that multiple actions at all three levels will be needed if the crisis in the most affected countries is to be overcome.”*<sup>50</sup>
- Save the Children UK: *“Globally Save the Children UK has found that positive retention practices like increasing wages and improving working conditions help improve staff motivation and retention while policies like bonding, migration tax and codes of practice do not. The G8 and national governments must allocate urgent resources for increasing the quantity, coverage and quality of health professionals. The UK should pledge 10 per cent of additional resource needed by 2007.”*

Many African nations have completed human resource strategies, undertaking national research and implementing innovative retention programmes. The examples below are some of the country-led programmes that have had positive impacts on national retention and migration practices.

### Malawi

Dr H. Ntaba, the Minister of Health of Malawi, presented his government’s vision for increasing human resource capacity by **increasing salaries, adding new cadres of health workers and modifying their training** to suit the context in which they would be working. The Ministry of Health in Malawi requested additional investments from international donors for training, capacity building, increased salaries for all health workers, and broader interventions in strengthening health systems. Malawi received full support for this human resources strategy and has successfully benefited from a co-ordinated financial commitment from DFID, the Norwegian Agency for Development Cooperation (NORAD), the World Bank and the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM).

### Ghana

Dr Ken Sagoe, Director of Human Resources from Ghana’s Ministry of Health, presented the numerous strategies they are employing. Ghana is one of the leading African countries in human resources strengthening. It has introduced a **deprived area incentive allowance** to encourage health workers to accept posts in rural areas. These incentives represent 40–50% of the salary budget in the health sector. Ghana has also **enhanced the capacities of its training schools**. The number of health workers trained in Ghana has tripled during the past six years thanks to a \$2m investment by the World Bank in health training schools.<sup>51</sup> Ghana has also initiated **Temporary Return Schemes** that encourage migrant workers to bring their expertise home and contribute to the improvement of health services, particularly through service provision, training and research.<sup>52</sup> This programme has been completed by the Migration and Development for Africa

programme (MIDA) of the International Organization for Migration. The programme focuses both on permanent return and mobilising competencies among the diaspora for short-term periods. Car, home and education loans have also begun to have positive impacts on migration.

*“The International Organization for Migration really believes in the positive impact that migrants can have on their country of origin. The MIDA programme has been a very good tool to mobilise the African diaspora.”*

Mrs Ndioro Ndiaye, Honourable Minister and Deputy Director, International Organization for Migration

*“We try to recruit Ghanaian migrants who work abroad. We have set up recruitment services in all our embassies in Western countries to facilitate contacts and procedures with applicants.”*

Dr Ken Sagoe, Director of Human Resources, Ministry of Health, Ghana

### **Uganda**

In Uganda, the Ministry of Health put in place specific measures to retain national health workers. In 1996, it set up the payment of lunch allowances, and in 2001 it increased health worker salaries by 60%, while also increasing drug allocation and abolishing user fees. These measures had a positive impact on the motivation and retention of staff, and utilisation of health services.<sup>53</sup>

### **Ethiopia**

In Ethiopia, the levels of maternal and infant mortality and morbidity are among the highest in the world. The maternal mortality rate is 816 per 100,000 live births, and the infant mortality rate is 160 per 1,000. To improve access to health services for rural people and adapt to the shortfall of doctors and nurses, Ethiopia has completed an ambitious human resource strategy. They have already trained more than 20,000 health extension workers, aiming to have one worker per 2,500 population. These extension workers (all women) have specific roles and

standardised training modules. They are seeking to deploy highly qualified nurses and midwives to health centres to ensure that women can be delivered by skilled attendants.

*“Ethiopia has recruited other profiles than doctors and nurses. Health extension workers can do many basic tasks that lighten the workload of the other health workers.”*

Mr Edwin Macharia, Director of Rural Initiative – HIV/AIDS Initiative, Clinton Foundation

### **Zambia<sup>54</sup>**

In order to increase the coverage of health services in rural areas, the Public Service Reform Programme introduced new job contracts accompanied by financial and non-financial incentives for health workers, including a housing subsidy, a remote area allowance, the payment of school fees for a maximum of four children, access to loans and mortgages, and training opportunities. The programme was very successful: 66 new doctors decided to sign this new contract to work in rural areas. With the recent abolition of user fees with donor support, increased utilisation of health services utilisation should quickly follow, changing lives.

### **Mauritius**

In Mauritius, the government has implemented, with success, temporary measures to meet its immediate needs in human resources.<sup>55</sup> Retired doctors and nurses (up to the age of 70) have been recruited and integrated into the workforce. Bank databases are maintained and increased numbers of health workers are being trained; Indian doctors are being hired and links have been established with French training institutions to offer nationals postgraduate degrees. They are now exploring telemedicine and private training schools. These changes were possible due to strong political will, government stewardship, national research carried out on retention practices, enhanced partnerships, and increased health sector budget allocations.

## What does not seem to work?

Lessons must be learned from previous attempts to reduce staff shortages and international migration.

### Coercive measures

Coercive measures were put in place in a few countries in order to reduce permanent migration. Coercive measures include compulsory bonding schemes, retention of academic certificates, migration tax, loss of rank when migrants return or obstructing return of migrants who have failed to honour bonds. In Ghana, these measures have deterred migrants from returning, and increased social tensions and the risks of industrial strikes.<sup>56</sup>

### Codes of practice

The objective of the codes of practice is to promote international ethical recruitment. These guidelines aim to protect health workers' rights to migrate while reducing the negative impacts of that migration on the healthcare systems of source countries. Current codes of practice (for instance, the UK code of practice<sup>57</sup> or the Commonwealth Code of Practice for the International Recruitment of Health Workers<sup>58</sup>) are not legal documents. They are guidelines whose application depends on effective enforcement and the goodwill of parties to the codes. The impact of ethical recruitment policies on the 'brain drain' has thus far been limited. Evidence indicates that the flow of health workers to the UK did not decrease despite the implementation of the UK code of practice in 2001 and its subsequent tightening in 2004.<sup>59</sup> Furthermore, the UK code of practice does not regulate private recruitment in Africa. Bilateral agreements between countries are seen as an effective method of ensuring the application of the codes of practice and making recruitment by wealthy countries from the diaspora ethical.<sup>60</sup> These codes can, however, support and protect migrant workers.

## Recommendations

The global shortage of health workers is inextricably linked with poverty, conflict, the HIV and AIDS pandemic and the chronic under-investment in health systems. These factors have led to collapsing health systems with health professionals working on low salaries, and enduring poor working and living conditions in developing countries.

A comprehensive response is required to tackle both health system issues and poverty issues. This should include policy interventions that address country-specific needs with regard to health worker retention, recruitment, deployment and development, while addressing the underlying reasons that drive health workers from their home countries. Investments in human resources to strengthen health systems are urgently needed in developing countries and more specifically in Africa. Some have called for increased 'global responsibility'<sup>61</sup> in relation to the 'brain drain' and financial compensation for source countries.<sup>62</sup> The G8 commitment to relieve the debt of developing countries provides an additional window of opportunity to disburse further financial resources to invest in human resources for health.

Training additional doctors, nurses and midwives will only bring new, qualified staff in a few years. Thus, it is crucial to combine long-term solutions with short-term ones. In the short term, strategies are needed to increase the performance and effectiveness of existing staff by improving supervision, management and deployment of health workers. In the long run, strategies should focus on the training of additional staff, retention policies (salaries, working conditions) and strengthening health systems.

Western countries must plan more effectively for their own health worker needs and put more resources into domestic health professional training in order to respond to demand in the North. A key determinant will be the capacity of developing countries to retain national health workers. The unjust subsidy must be mitigated against and plans (with resources) must be developed to close the human resources for health gap.

To enable developing countries to achieve the MDGs and respond to the human resources crisis, we recommend the following measures:

**I Developed countries should financially compensate poor countries that have a shortage of health professionals**

Developed countries should recognise the significant contribution made by migrant health workers to sustaining their own healthcare systems. The financial commitment to human resources for health needs to be a continuous effort for the next decade (2006–2015) to enable developing countries to implement their health-related human resource strategies. International donors (in particular the G8 nations, the GFATM, the World Bank, the European Commission and all bilateral donors) should pledge additional resources to ensure that the \$1–6bn needed to fund an extra one million health workers is in place and being allocated to national health ministries by 2007. The UK government must allocate at least an additional \$100m to support 100,000 extra African health workers.<sup>63</sup>

International donors' investments should be used to train, recruit and retain health staff in developing countries, including increases in salaries and improvement in working conditions.<sup>64</sup> Highest priority must be given to countries with the lowest density of health workers and the highest mortality rates. It is estimated that almost all 54 countries in this group are in sub-Saharan Africa.<sup>65</sup>

Solutions need to be **country-led** with the **active participation** of civil society, health workers, professional associations, unions and the diaspora. The strategies of international donors should support the national priorities of African governments and be country-specific.<sup>66</sup> **Cohesion and co-ordination** between international donors should be ensured in order to avoid inefficiency, duplication and competition.

*“We need to organise roundtables between donors, governments and diaspora and push all countries to*

*adopt the same policies on human resources. Global coherence is a key success factor.”*

Dr Thyoka Mandela, Specialist Registrar,  
Surgery, living in Aberdeen

It is also essential to seek agreement with the IMF and other international financial institutions to allow finance ministers to increase funding for health systems and human resources by way of salary and recruitment. The conference heard time and again that IMF-sponsored limits on spending are one of the critical blocks to the improvement of health systems. These blocks have led to perverse results where some countries have thousands of available and trained professionals but are unable to hire them. The IMF fiscal stability guidelines need to prioritise social outcomes rather than simply economic growth indicators. Budgets should be designed to achieve poverty reduction objectives and mechanisms established which enable countries to increase social sector budgets as a means of ensuring economic stability through poverty reduction, and improved health of the nation.

*“In Niger, we have a number of doctors, nurses and midwives who have no job in the health sector. Because of the restrictions imposed by the International Monetary Fund, our government cannot hire these people. It is a waste of resources.”*

Dr Abdoulaye Bagnou, Coordinator,  
Prime Minister's Office, Niger

**Governments have the responsibility** to develop human resource policies and strategies that are adapted to local realities. All other actors such as international donors, NGOs and the diaspora must provide harmonised financial and technical support in the implementation of these national health plans.

**2 International donors' investment in human resources should be included in health systems-strengthening strategies and poverty reduction strategy papers**

Health professionals migrate for a combination of interlinked reasons related to the poor state of

health systems in their home country, and to poverty. Investments in human resources (such as the \$1–6bn annually recommended above) need to be combined with the additional \$9bn called for by the Commission for Africa<sup>67</sup> to effectively **strengthen health systems** in developing countries and address the essential health needs of populations.

### **3 Invest in people: increase the human resource capacity of developing countries**

Financial and technical assistance from donor countries should be focused on supporting developing countries to train, recruit and retain more health staff, in line with WHA resolution 57.19. Inequalities and imbalances in the global distribution of health workers need to be addressed. Hence, priority should be given to the **deployment of health workers to under-served areas**. Measures should include: increases in salaries; improved health worker supervision; planning; incentives to serve rural areas and poor populations (eg, salary supplements, housing allowances, opportunities for career progression); opportunities for further training; and safe working environments for health workers (including universal precautions such as protective gloves, waste management, post-exposure prophylaxis, psychosocial support, and other HIV-prevention measures).

The decision to deploy additional staff should be **based on evidence** following analysis of the staffing situation and future demand projections: realistic evaluation of the types of health workers needed, based on the country's burden of disease; the balance between different categories of workers (skill-mix) and the geographical coverage of health services; and the role of private providers. At every country level, data and research on human resources should be strengthened to monitor the progress made in terms of health workers' capacity. Health workers should also be involved in the analysis of data available.

**Pre-service training institutions** for health professionals such as medical, nursing and pharmacy schools should have the means to expand their capacities to be able to fill the gap of health workers.

Support should be provided in terms of curricula review, physical space, teaching and administrative personnel. They should also be able to develop new training courses to reflect the priorities and changing needs of the population.

As discussed above, a number of sub-Saharan African countries have experienced a shortage of health workers but cannot hire national unemployed health professionals. It is important to take all necessary budgetary and financial measures to **re-engage these health workers** and re-integrate them into the healthcare system. Where shortages exist, employment flexibility should also be considered to be able to rehire national health professionals who, for example, may be retired or who have changed career. Training modules need to be adapted and developed to ensure that health workers have the skills they need to deliver effective care.

Many countries have responded to health worker shortages and inappropriate distribution of health workers through training and recruiting **mid-level and community health worker cadres** and deploying them in primary healthcare facilities in under-served areas. This strategy has been successful in some contexts.<sup>68</sup> These categories of health staff should receive adequate recognition, standardised training, supervision, and compensation. They should be included in qualification and career paths that will enable them to build their competencies and enhance their responsibilities.<sup>69</sup> Community health workers need to have clear roles, from social mobilisation and health promotion to integrated management of childhood illnesses, depending on the training they receive. They need to provide a continuum of care and be supported, supervised and have access to on-the-job training while ensuring that resources and time are allocated to the development of a functioning referral system.

### **4 Stop attracting, start training: addressing health worker needs in Western countries**

Ever-increasing demand for health professionals in high-income countries means that international migration will not diminish in the next few years.

Developed countries need to take immediate measures to better plan for their own human resources needs and **increase their national capacities of training**, while also improving their retention policies. Governments should reaffirm their commitment to the 2004 WHA resolution 57.19 on developing strategies to mitigate against the impact of migration and increase retention.

Ethical recruitment should be established to protect health workers rather than to deny them their right to migrate. If codes are in place they need to be effectively implemented, enforced, and extended to include the private sector. Recipient countries also need to support migrant health workers with relevant training and support. This is an area where the diaspora could organise support groups, national information days, and the development of welcome packs with relevant information to support the migrants' smooth transition into another culture.

### **5 Facilitate brain circulation and return migration**

Many African nationals in the diaspora are already supporting their countries. Such expertise and skills should be encouraged to support and strengthen national health systems. Migrant workers can inspire young people and constitute role models for the new generation. **Role modelling** should be promoted by the diaspora and national health ministries to encourage and inspire young people to take up health as a career. The diaspora must discuss plans for support with ministries of health to ensure that their skills and efforts support national priorities and plans. Developing countries should develop a databank with information on all programmes being supported by NGOs, civil societies and the diaspora to ensure they are effectively regulated and supported for maximum impact. Mechanisms have also been explored in some developing countries on ways to increase the impact of remittances on health systems, by agreeing for certain percentages of remittances to be invested in human resource training. To facilitate this process, blockages to returning migrants need to be removed and campaigns to portray migrants in a negative light need to be arrested.

*“In Mali, the healthcare coverage has increased by 30 per cent during the last five years thanks to the investment of the diaspora in health facilities.”*

Dr Akpa Gbary, Regional advisor for HRH,  
Regional Office Africa, WHO

*“I needed to acquire higher surgical training. This is why I migrated to the UK. I now intend to go back to Malawi and make sure that people will benefit from my services. We need to encourage the diaspora to go back to their country.”*

Dr Thyoka Mandela,  
Specialist Registrar, Surgery,  
living in Aberdeen

A national gap analysis needs to be developed exploring which technical skills are needed. A database could be developed to identify which of these skills are available among the diaspora. This database may help African governments and donors to mobilise appropriate expertise. An initiative has already been launched in 2003 by the International Organization of Migration.<sup>70</sup> Further efforts should be made by the diaspora to feed into this database, including financial, technical and material support to national health systems and strategies (service delivery, research, in-service training, telemedicine, e-learning). This could be undertaken through temporary return or short-term visits. Consulates could host information-sharing evenings and fundraising events.

Individual initiatives which involve diaspora members already exist, such as hospital twinning projects led in the UK by the Tropical Health and Education Trust (THET), or the implementation of other local projects. However, such programmes need to be properly co-ordinated and support national priorities. To be heard by national governments, the diaspora should organise themselves in **structured network organisations**. Their members will need to receive training on governance, advocacy and project management. They could use their professional expertise and new skills to lobby national governments and international donors to ensure that the commitment to human resources for health will be respected by all stakeholders.

Unions and professional bodies (like RCN, ICN, BMA, RCM, ICM and WMA) can be pivotal in helping the diaspora use their voice effectively in relevant policy fora while also supporting national mechanisms for health workers to feed into national health policies.

*“The diaspora need to link with the Ministry of Health and show they do not threaten the systems in place.”*

Professor Makgoba Malegapuru,  
Vice-Chancellor and Principal,  
University of KwaZulu-Natal

### **NHS Links**<sup>71</sup>

One excellent example of twinning is the NHS Links programme. It forges health partnerships between a UK NHS trust and a counterpart health institution

overseas. Such partnerships provide opportunities for health workers to share ideas, experiences and skills, benefiting both partners. The purpose of Links is mutual development. THET (Tropical Health and Education Trust) has been asked to become the NHS umbrella organisation to develop NHS Links.

This meeting is the first step towards increasing diaspora health workers’ voices in health policy determination.

*“We, the diaspora, should speak with one voice and make sure our efforts are well co-ordinated. This would be the most optimal way to contribute to national health systems.”*

Mrs Akintola, Director, African Council  
for Sustainable Health Development

# Notes

- <sup>1</sup> www.africarecruit.com
- <sup>2</sup> See www.africarecruit.com for further information on sponsoring agencies
- <sup>3</sup> MDG4 (reduction by  $\frac{2}{3}$  in the child mortality rate by 2015), MDG5 (reduction by  $\frac{3}{4}$  in the maternal mortality rate by 2015), and MDG6 (halt and reverse the prevalence of HIV, TB and Malaria).
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# Appendices

## Conference Participant Survey

Full details of the survey can be found at the conference website, at [www.africarecruit.com](http://www.africarecruit.com) or by contacting AfricaRecruit.

AfricaRecruit carried out an online survey of all participants registering to attend the conference. The questions ranged from reasons for migration to living conditions in source countries. Tellingly, 42 per cent of respondents were recruited while still in Africa, highlighting aggressive recruitment practices of Western recruitment agencies. Two thirds of all respondents are presently working in the UK NHS, while almost three quarters have worked in the public sector at one time.

The survey revealed that 70 per cent of respondents would consider returning to work in their home country permanently while 95 per cent were willing to return temporarily on a consultancy basis. This highlights the need for an improved policy environment and innovative recruitment mechanisms to reduce the barriers for health workers who wish to return to their own country.

Other findings show that the African diaspora healthcare professionals contribute an estimated value of over \$100bn per annum in personnel value to the West while Africa continues to suffer from the impact of acute skills shortage.

## About AfricaRecruit

The healthcare survey is one in a number that AfricaRecruit carries out in a bid to provide first-hand information from the diaspora on various topical issues such as remittances and skills flows. This information assists in defining and setting the agenda on the issues that are most important to the diaspora and key stakeholders inside and outside Africa.

The build-up for the event generated significant interest from all stakeholders inside and outside Africa, with some of the feedback coming from many within Africa who have devised various programmes and incentives on how to effectively engage the diaspora skills such as the use of telemedicine.

AfricaRecruit has been at the forefront of mobilising skills and human resource capacity building in and outside of Africa since 2002. It also facilitates the African diaspora in capacity-building in Africa either through skills or investment in areas such as remittances. Using its various networks within and outside Africa, AfricaRecruit acts as a platform for

debate with the African diaspora on how to add value to capacity-building in Africa with main skills, labour, human resources and investment as the main drivers.

AfricaRecruit uses information technology and other modern communication techniques to provide information about opportunities in Africa to African professionals in the diaspora and at home. It also uses these techniques to promote reforms in Africa that should make it a more attractive environment in which professionals and technocrats may pursue careers.

To date, AfricaRecruit has successfully undertaken and completed several educational, promotional and technical assistance projects in pursuit of its mission. Annually it has facilitated and enabled the return of over 500 personnel back to Africa, retained skills in Africa, increased circular migration of skills, identified and disseminated best practices in human resources management in Africa, as well as informing the policy-making process.









