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

JOINT VENTURE:
RURAL HEALTH INITIATIVE
&
THE PLACEMENT PROJECT

# Report on the Stakeholder Meeting on the Facilitation of the Recruitment and Placement of Foreign Healthcare Professionals to work in the Public Health Sector in South Africa.

**17 April 2008**

**Pretoria, South Africa**

## Foreword

The International Organization for Migration (IOM), in partnership with the Joint Venture between the Rural Health Initiative and the Placement Project (RHI), organised a stakeholder meeting on the recruitment and placement of foreign healthcare professionals to work in the public health sector in South Africa. The meeting was held on Thursday 17 April 2008 at The Villas Conference Centre, Arcadia, Pretoria.

The meeting's specific objectives were to:

1. share lessons learned, experiences, and good practices of the facilitation of the recruitment and placement of foreign healthcare professionals (including Diaspora) to work in the public health sector in South Africa;

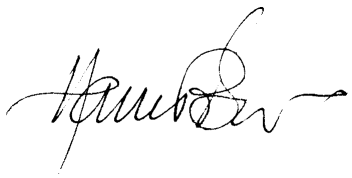
2. identify key components of existing campaigns and their gaps and challenges;

3. facilitate networking and increased coordination among partners and stakeholders; and

4. outline the way forward ("Roadmap") for future interventions and activities.

Participants at the stakeholder meeting comprised members of the non-governmental organisation (NGO) sector, researchers, voluntary and employee organisations, international organisations, government and donors. The diversity of participants facilitated fruitful and constructive information sharing.

The meeting stimulated meaningful dialogue and discussion of the issues at stake and provided an opportunity for participants to explore different ways of addressing the challenges to the abovementioned campaign. The different areas of expertise that each participant brought with them helped the group to find a number of mutually-agreed upon activities with which to address the gaps and challenges in the field.



H P Boe, IOM Regional Representative for Southern Africa

Saul Kornick, Director,
Joint Venture between the Rural Health Initiative and the Placement Project

## Acronyms and Abbreviations

| | |
|---|---|
| AIHA | American International Health Alliance |
| ALP | AIDS Law Project |
| ASANUK | Association of South African Nurses in the UK |
| BBC | British Broadcasting Corporation |
| BMJ | British Medical Journal |
| CALS | Centre for Applied Legal Studies |
| CDE | Centre for Development and Enterprise |
| COHSASA | Council for Health Service Accreditation of Southern Africa |
| CPD | Continuing Professional Development |
| DENOSA | Democratic Nursing Organisation of South Africa |
| DfID | UK Department for International Development |
| DoH | Department of Health (provincial) |
| EEC | European Economic Community |
| EQUINET | The Network for Equity in Health in Southern Africa |
| FPD | Foundation for Professional Development |
| FQDs | Foreign Qualified Doctors |
| FWMP | Foreign Workforce Management Programme |
| HPCSA | Health Professions Council of South Africa |
| HRH | Human Resources for Health |
| HST | Health Systems Trust |
| ICEHA | International Center for Healthcare Access |
| IDASA | Institute for Democracy in South Africa |
| IMF | International Monetary Fund |
| IOM | International Organization for Migration |
| MassMed | South African Partners and Commonwealth of Massachusetts |
| Medunsa | Medical University of Southern Africa |
| MOU | Memorandum of Understanding |
| NDoH | South African National Department of Health |
| NEPAD | New Partnership for Africa's Development |
| NGO | Non-Governmental Organisation |
| NHS | UK National Health Service |
| NMC | United Kingdom Nursing and Midwifery Council |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| RHI | Joint Venture between the Rural Health Initiative and the Placement Project |
| RuDASA | Rural Doctors Association of South Africa |
| SABC | South African Broadcasting Corporation |
| SADC | Southern Africa Development Community |
| SA-HCD | Southern African Health Capacity Development Coalition |
| SAIHCM | South African Institute of Health Care Managers |
| SAMP | Southern African Migration Project |
| SANC | South African Nursing Council |
| SANEC | South Africa/Netherlands trade organisation |
| SAPC | South African Pharmacy Council |
| SIDA | Swedish International Development Cooperation Agency |
| TARSC | Training Resource and Support Centre |
| UCT | University of Cape Town |
| UK | United Kingdom |

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| UKCC | United Kingdom Central Council |
| US | United States |
| USAID | United States Agency for International Development |
| UWC | University of the Western Cape |
| VHC | Voluntary Health Corps |
| VSO | Voluntary Service Overseas |
| WHO | World Health Organisation |
| WIHRE | Wits Initiative for Rural Health Education |
| Wits | University of the Witwatersrand |

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## Background

### The human resource constraints in the South African public health sector

South Africa faces complex human resource challenges, including that of ensuring an adequate human resource pool for the staffing of the public sector health system, on which the majority of the population is dependent. In a service industry like healthcare, the quality of the service delivered is directly proportionate to the quality and number of human resources available to perform the work. In other words, there is a strong correlation between quality of care and healthcare outcomes on the one hand, and the availability of healthcare personnel on the other.

Although South Africa, next to Mauritius, has more professional healthcare workers per population than any other country in Sub Saharan Africa, it is also characterised by substantial differences in healthcare worker density between the public and private sectors, as well as between rural and urban areas of the public sector.[1]

One of the key factors exacerbating this difference is the migration of healthcare workers, both from the public to the private sector, and from South Africa to developed countries in Europe, Australasia or North America.[2] There has been a marked increase in professional migration from the public to the private health sector, which results in the misdistribution of human resources in healthcare. Only 25% of all physicians in South Africa work in the public sector, despite the fact that 75% of the population is dependent on the public sector for healthcare.[3]

Furthermore, there is substantial migration of healthcare professionals from South Africa to wealthier countries such as the United Kingdom, Canada, and the United States, commonly referred to as the "brain drain". In 2001, the total number of South African-born healthcare workers practising a medical profession in Australia, Canada, New Zealand, the United Kingdom and the United States of America combined was 23,407.[4] Considering that only 11,332 doctors and 41,617 nurses were working in the public sector in South Africa in 2001, this is a worrying statistic.[5]

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[1] Sanders, David and Lloyd, Bridget, "Chapter 6: Human Resources: International Context." In the South African Health Review 2005. Health Systems Trust. P.77-78.
See: http://www.hst.org.za/publications/682

[2] Department of Health South Africa (DOH SA). A Strategic Framework for the Human Resources for Health Plan – Draft for Discussion. August 2005. P.24.
See http://www.doh.gov.za/docs/discuss/hr2005/main.html.

[3] The Foundation for Professional Development (FPD). Feasibility Study: On mechanisms to recruit national & international clinicians for the South African Public Health Care Sector. November 2004. P.5.

[4] DOH SA, Strategic Framework, 2005, p. 34.

[5] Ibid.

## Recruitment of foreign qualified healthcare professionals as a policy response

The South African government has implemented a number of strategies in an effort to redistribute healthcare professionals, to relieve shortages in the public sector, and particularly to address the disparities and backlogs in the underserved, rural areas. Such strategies include a policy on compulsory community service and improvement of salary remuneration through scarce skills and rural allowances.[6]

Another policy response is the recruitment of foreign qualified healthcare professionals, which has been facilitated primarily through bilateral agreements between South Africa and countries such as Cuba, Iran and Tunisia.[7] Healthcare professionals from developed countries with relevant qualifications and skills can work in the South African public sector for up to three years, with an option for renewal. Such foreign professionals may be motivated by factors other than remuneration, such as the desire to work in a country that is highly recommended as a tourist destination, the possibility of acquiring clinical experience that would not be available in their home countries, and an interest in contributing to improving health service delivery conditions in South Africa.[8] [9]

The process for foreign healthcare professionals to apply for work in South Africa requires that the applicants register with the relevant professions councils, such as the Health Professions Council of South Africa (HPCSA) or the South African Nursing Council (SANC), where they are assessed on the basis of qualifications, experience, and examinations (both written and oral).[10] However, due to limited capacity at these councils, as well as lack of sufficient information targeted at foreign healthcare

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[6] The policy on compulsory community service was introduced with the aim of distributing resources equitably in order to improve public sector service delivery, and exposing doctors to work in the rural areas for longer-term retention. However, only a small portion of community service professionals remained in the public service upon completion of their community services, and some even argue that compulsory community service could be regarded as one of the push factors in the out-migration of health care professionals (Rensburg, van HCJ. Health and Healthcare in South Africa. Van Schaik Publishers, 2004).

Remuneration was improved for certain skills and for those working in certain geographical areas through the scarce skills and rural allowance policy. In the health sector, allowances for occupational groups designated as 'scarce skills' such as clinicians, dentists, pharmacists, pharmacologists, as well as nurses and allied workers, were implemented in July 2003. Also since July 2003, rural allowances were added to the salaries of health care professionals, interns and community service workers in 13 rural nodes (FPD, Feasibility Study, p.15.).

[7] As of end 2004, 463 Cuban doctors, 136 Iranian doctors, and 35 German volunteer doctors have been placed in various public sector health institutions throughout South Africa (FPD, Feasiblity Study, p.8-9).

[8] FPD, Feasibility Study, P.20.

[9] The South African government does not support the recruitment of health professionals from any developing country. This includes non-retention of foreign students in the health professions who have completed their studies in South Africa – these students are not entitled to do their internship or community service in South Africa, except for those students coming from SADC countries, which do not have the necessary accredited academic health facilities (DOH SA, Strategic Framework, 2005).

[10] Department of Health. Recruitment of Foreign Health Professionals Guidelines. DOH; January 2003. Health Professions Council of South Africa, Guidelines for Registration of Foreign Qualified Medical Practitioners, www.hpcsa.co.za

professionals, the process for them to apply for work in South Africa may be confusing and unclear.[11]

Also, there is limited infrastructure to recruit and register interested foreign health care professionals. Currently the National Department of Health (NDoH) resources are predominantly committed to healthcare professionals coming through the bilateral agreements and have only a reactive function with regard to other healthcare professionals who approach them for possible work opportunities in South Africa. Furthermore, there is an overwhelming backlog of registration applications for foreign healthcare professionals at the HPCSA.[12]

In response to these limitations, several initiatives have been implemented to facilitate the recruitment and placement of foreign healthcare professionals from developed countries to fill vacancies in underserved areas in the public sector health services in South Africa.

The RHI supports healthcare delivery in rural areas of South Africa through support to doctors and other healthcare workers, and through community care and development projects. In partnership with the Rural Doctors Association of South Africa (RuDASA), RHI invites doctors and other health professionals from developed countries to work in rural hospitals in South Africa.[13]

In 2007 the IOM conducted an assessment to identify and map relevant institutions and associations in the Netherlands, United Kingdom (UK) and the United States (US), to gauge the interest and availability of foreign healthcare professionals to work in the public health sector in South Africa. Furthermore, the assessment made recommendations on future activities that aim to strengthen the capacity of the public health sector services in South Africa by facilitating the recruitment and placement of foreign healthcare professionals, as well as South African healthcare workers currently residing in the Diaspora, in the three selected countries. A summary of this report was presented at the stakeholder meeting, which will be discussed in more detail below.

Building on the work of the RHI and IOM outlined above, the two institutions jointly organised the stakeholder meeting on the facilitation of the recruitment and placement of foreign healthcare professionals to work in the public health sector in South Africa. It was convened on 17 April 2008 in Pretoria. This report summarises the discussions and recommendations agreed upon at this meeting.

The following report is divided into a number of different sections, which reflect the proceedings of the stakeholder meeting. They are as follows:

- The introduction to the meeting and welcoming remarks;
- The early-morning presentations from the RHI and the IOM, which covered the background and context of the issues at stake in health worker migration;

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[11] FPD. Feasibility Study, p.21.

[12] Ibid, p.33.

[13] See www.rhi.org.za for more information.

- The mid-morning presentations from a number of the participating stakeholders, which outlined the activities and nature of the organisations they represented; and

- The afternoon plenary discussion, in which an advocacy plan for a campaign to recruit and place foreign healthcare professionals in South Africa was discussed. This discussion covered areas such as the key role players in such a campaign, ways of engaging these key players, and a detailed discussion and action plan relating to the “roadmap” for the facilitation and recruitment of foreign healthcare professionals to work in the public health sector in South Africa (see Appendix three).

## Introductions and Welcoming Remarks

The meeting was opened by Ms. Liselott Verduijn, Senior Regional Project Development Officer at the IOM. She welcomed the participants to the meeting and remarked that it was encouraging to see so many stakeholders in attendance, reflecting a broad interest in the theme of the meeting. She highlighted the importance of having such a dialogue on the issue of healthcare worker migration, in particular the placement and recruitment of foreign healthcare professionals in South Africa, an issue to which many of the participants are deeply committed. She also gave a brief introduction to the IOM, outlining the objectives and the activities of the organisation, which follows.

### Introduction to the International Organization for Migration (IOM)

The IOM is the leading intergovernmental organisation in the field of migration. It works closely with governments, intergovernmental and nongovernmental partners. It currently has 122 member states and more than 400 field locations. The Southern Africa Regional Office is based in Pretoria and there are Country Missions in Angola, Democratic Republic of Congo (DRC), Madagascar, Mauritius, Mozambique, Zambia and Zimbabwe.

The IOM is committed to the principle that humane and orderly migration benefits both migrants and society in general. It has a number of programmes in South Africa in the following areas:

- Assisted voluntary repatriation
- Counter-trafficking
- Migration health, with a focus on HIV and AIDS
- Humanitarian/Post-conflict
- Migration and development
- Migration management
- Policy development

The IOM's work in healthcare worker migration has the following objectives:

1. Collect and disseminate intelligence and evidence on healthcare worker migration that will assist governments' and other key stakeholders' capacity to manage the impact of migration of healthcare workers.
2. Technical cooperation on the management of healthcare worker migration to strengthen governments' capacity to manage the impact of migration of health workers, particularly pertaining to information management.
3. Facilitate linkages between sending and receiving countries to strengthen human resources for health (HRH).

### Introduction to the Joint Venture between the Rural Health Initiative and the Placement Project

Mr. Saul Kornik, director of the RHI, outlined the purpose and main activities of the RHI.

The organisation addresses the human resources crisis in the public health sector through a variety of targeted activities, namely recruitment; orientation and retention; marketing; and research, monitoring and evaluation. The RHI recruits healthcare workers in two ways.

Firstly, it redistributes healthcare workers from the South African private health sector into the public health sector. Secondly, it recruits healthcare workers from overseas to work in the public health sector. The organisation works with doctors and nurses. It attempts to place healthcare workers in facilities which provide HIV-related services, although because of the pervasiveness of the HIV epidemic in South Africa, most facilities in the country deal with HIV/AIDS in their routine work.

The RHI is funded by the President's Emergency Plan for AIDS Relief (PEPFAR) and operates out of offices in Johannesburg and Durban. The former serves the provinces of Mpumalanga and Limpopo, and to a lesser extent, Gauteng, and the latter KwaZulu-Natal, Eastern Cape, and to a lesser extent, the Western Cape. The RHI runs a number of orientation and support programmes for foreign healthcare workers, which it intends to strengthen in the near future, with the intention of retaining foreign healthcare workers once they are in South Africa.

The organisation runs a sophisticated and creative marketing campaign, using the pro-bono services of a leading advertising agency, Network BBDO. It also presents at international medical schools, publishes articles in the British Medical Journal (BMJ), builds partnerships in countries like the US, and runs local advertisements for specific placements in South Africa. The RHI assists with research conducted by other organisations in the field, for example, the IOM, and conducts its own research, which focuses on recruitment, orientation and retention strategies.

There has been interest from the news media in the work of the RHI. The British Broadcasting Corporation (BBC) has produced a pilot television documentary entitled "Bush Doctors" on British healthcare workers working in the rural areas of South Africa. It is hoped that this will develop into a 13-part series which will attract UK doctors to South Africa. The South African Broadcasting Corporation (SABC) has also expressed an interest in producing a programme along similar lines.

The RHI considers itself to be a small part of a broader network of service delivery partners and remains entrepreneurial and open to ways in which to address the human resources crisis in the public health sector in South Africa.

Mr. Kornik also gave a brief presentation on the Foundation for Professional Development (FPD). It deals with the clinical and management education of health professionals. It is the first fully fledged private university in South Africa. It has the task of mapping HIV/AIDS in South Africa. It currently runs a treatment campaign for HIV/AIDS and TB in 40 clinics, with more than 40,000 patients. Together the RHI and FPD have a vision for healthcare in South Africa. Gustaaf Wolvaardt, director of FPD, added that it is a 700 person organisation, with a 1 million client reach. Its underlying philosophy is that in order to fix the healthcare system one has to work with management.

## Workshop objectives and expected outcomes

Ms. Reiko Matsuyama, Project Officer at the IOM, outlined the workshop objectives, which were as follows:

1. To share lessons learned, experiences, and good practices of the facilitation of the recruitment and placement of foreign healthcare professionals (including Diaspora) to work in the public health sector in South Africa;

2. To identify key components of existing campaigns and their gaps and challenges;

3. To facilitate networking and increased coordination among partners and stakeholders; and

4. To outline the way forward ("Roadmap") for future interventions and activities.

Furthermore, the expected outcomes of the workshop were as follows:

- Understanding and ownership of the successes and challenges of campaigns which address healthcare worker migration;

- A draft roadmap of short term and long term activities which could be implemented to provide a framework for a campaign to recruit and place foreign healthcare professionals in South Africa; and

- Identifying the key role players to undertake these activities.

## IOM and RHI Presentations

### Recruitment and placement of foreign healthcare professionals to work in the public health sector in South Africa: Assessment

Ms. Matsuyama (IOM) gave a presentation on the recent report, "Facilitation of the recruitment and placement of foreign health care professionals to work in the public sector health care in South Africa," which was conducted by the IOM in consultation with the NDoH in November 2007. The full report is available on the IOM website, www.iom.org.za.

#### *Objectives and methods*

The objective of the report was to assess the feasibility and interest among stakeholders in the Netherlands, UK and US in facilitating recruitment and placement of foreign healthcare professionals to work in the public health sector in South Africa.

The method consisted of the identification and mapping of relevant institutions and associations, especially ministries and departments; academic/professional partnerships and exchanges; and private initiatives, including foundations, NGOs, and for-profit institutions. The mapping was achieved through desktop research, literature reviews, field visits and key informant interviews. It is impossible,

however, to produce a comprehensive map, as there are many disparate and diffuse initiatives in the field.

### *Overview of health worker migration trends to and from South Africa*

There are a number of push factors in source countries and pull factors in destination countries which encourage migration. The former include fear of crime, perceived and/or actual discrimination, issues of governance, threats of or actual violence, war, and conflict. The latter include increasing demand for health workers with aging populations, recruitment strategies, and health care career structures that limit young entrants into the workforce but require large numbers of junior employees.

These are moderated by stick factors in the source country, which predispose a person not to migrate, and stay factors in the destination country, which discourage them from returning home. Social, economic and political factors play an equally important role. These include labour wage differentials, political and social unrest, labour market discrimination, regulation of migration, and the role of structural adjustment policies leading to downsizing of the public sector workforce.

Although there is a human capacity crisis in the South African public health sector, the country is still classified as having "moderate" density of health personnel in relation to need. In comparison, Malawi and Ghana, for example, are classified as having "low" density. In 2003, there were 4,000 vacancies for doctors and 32,000 for nurses in the public health sector in South Africa. The financial losses incurred are substantial. Addressing these losses would not only benefit South Africa, but also the Southern African Development Community (SADC) region. Healthcare workers from the latter are attracted to job opportunities in South Africa and often find work by illegal means.

### *Human Resources for Health (HRH) environment in the three countries and examples of interventions in South Africa and elsewhere*

**In the Netherlands** there is a strong tradition and supply of doctors and nurses who are interested in working abroad, especially recent graduates, those who seek to specialise in tropical and infectious disease, and those nearing retirement. In fact, medical schools and institutions look favourably upon healthcare professionals who work abroad for a period of time.

The migration of nurses and doctors from South Africa to the Netherlands diminished considerably with the adoption of the Netherlands-South African Memorandum of Understanding (MOU) for Health (1991, 1997 and 1998) which restricted the recruitment of health care personnel to the public health sector in the Netherlands. Since all major Dutch medical and health care institutions are public, this could be enforced across the board. Although the MOU is no longer in force, active recruitment has virtually stopped and South African healthcare workers have difficulty obtaining the right to work in the Netherlands, given the general restrictions on migration from outside the European Economic Community (EEC).

With more restrictive migration policies in the Netherlands, most South Africans have difficulty in obtaining work permits and the trend has been downward. In 2005, only a total of 90 South African healthcare workers were issued permits (80 were with exchange programmes at universities). In 2006, a total of 70 work permits were

issued to South Africans of all professions, of which only 18 were for healthcare workers. Even amongst those 18, several may have been renewals. Currently, it would be very difficult for any South African health worker to obtain a work permit outside of a formal exchange programme. Although there is still some migration of South African dentists to the Netherlands, they are usually in private practice. The South African Diaspora is primarily organised through the SANEC, a South Africa/Netherlands trade organisation.

**In the UK** there is a high policy profile of HRH issues in developing countries. The "Inter-Ministerial Group on Health Capacity in Developing Countries" has been tasked to implement recommendations from the Lord Crisp Report to establish various health partnerships. Prime Minister Tony Blair requested Lord Nigel Crisp, the former Chair of the UK National Health Service (NHS), to review how the UK's experience and expertise in healthcare could benefit developing countries to address healthcare worker shortages. The ensuing report, "Global Health Partnerships", argues for a variety of health partnerships, including private and government exchanges, Diaspora returns, and international internships, education, research, and training and the establishment of a global health partnership centre. In addition, NHS downsizing may create an available pool of professionals to work in South Africa. Usually healthcare workers are interested in working abroad at the beginning or end of their careers.

There are a high number of South African Diaspora nurses in the UK, but numbers are dwindling. For example, between 1998 and 2005, there were 9,249 South African nurses registered in the UK. However, from 2000 onwards, the number has declined due to various policies. The NDoH Guidance for International Nurse Recruitment (1999) and Code of Practice for the International Recruitment of Health Care Personnel (2001) ensures that NHS employers no longer actively recruit health care personnel from South Africa or any other countries with healthcare worker shortages, unless there is a specific MOU (for example, India, Philippines). Also, the Commonwealth Code of Practice for the International Recruitment of Health Workers (2002) calls for "transparency" in recruitment between origin and source countries, "fairness" in terms of not recruiting health workers with outstanding obligations to their countries and offering the same conditions as workers in the destination countries, and "mutuality" of providing technical assistance and considerations of other forms of compensation to source countries. The Association of SA Nurses in the UK (ASANUK) reports there are many members interested in returning to South Africa but there are obstacles to working in the public sector. Doctors comprise the third major group of Diaspora in the UK (after Indian and Pakistani doctors), despite the tightening of registration regulations since April 2006.

**In the US** the healthcare system is highly privatised and largely financed through private insurance companies and health management organisations. However, there is a big interest in the US to address HRH issues in developing countries, as evidence, for example, by the proposed establishment of a Global Health Service. A major financial constraint for young healthcare professionals in the US to volunteer abroad is the need to pay back substantial educational loans. From 1997 to 2000, South Africa and Nigerian nurses accounted for 7.4% of the 26,506 applicants for nurses' licences in the US. There are some 2,006 South African doctors registered in the US, and South Africa ranks 23rd among countries supplying doctors to the US and second amongst African countries (after Nigeria). Dentists are also reported to migrate to the US in large numbers, primarily to set up private practices. The South African Diaspora in the US mainly practices in the private sector, is geographically

dispersed, and is not well organised. They may also be less likely to return to South Africa owing to the high costs of their initial migration and a high standard of living in the US.

**Interventions in South Africa** to address its HRH shortages include:

- Rural scholarships, for example, Mosvold Hospital in Kwazulu-Natal and Wits Initiative for Rural Health Education (WIHRE).
- Compulsory community service for university graduates to underserviced areas.
- Task-shifting.
- Public-private partnerships, for example, BroadReach Healthcare and Aid for AIDS.
- Recruitment of healthcare workers from Cuba, Iran and Tunisia.
- Facilitation of recruitment and placement of doctors in rural facilities through organisations like the RHI.

**Interventions in other countries** to address HRH shortages, which could be replicated in South Africa, are:

- Incentive payments instead of compulsory service, for example, in Indonesia.
- Improving salaries, benefits and working conditions, following programmes in Haiti, Ghana, Malawi. However, resources and sustainability are challenges.
- Task shifting to community health workers to fill critical gaps and lower costs, for example, in Haiti, Uganda, Ghana and Kenya.
- Health Centres of Excellence, for example in Iran and Swaziland.
- Virtual support – for example, telemedicine and web-based advisory and diagnostic services (between Ghana and the US, for example).
- Mobile Units.

***Mapping of relevant institutions and associations in the three countries***

**In the Netherlands**, based on its "Policy Memorandum on Development and Migration", the Ministry of Foreign Affairs presently promotes the MIDA/Ghana programme to encourage circular and short-term migration of health care workers from the Netherlands and UK to Ghana. It is currently investigating ways to expand this programme.

KIT, the Royal Institute of Tropical Medicine, is interested in developing twinning projects and collaborative exchanges with South African institutions to create "Centres of Excellence" in rural and underserved areas.

Worldwide Surgery has funding to develop a database of all doctors that are active in developing countries and/or wish to be posted there. Within the coming year, it expects to have an operational website in which countries and employers may list available openings and that will provide profiles of doctors interested in working abroad.

**In the UK**, there are a number of exchange and/or twinning programmes, for example:

- Royal Free and University College Medical School and others and the University of Transkei
- King's College training of South African nurses
- University Hospital of Radcliffe College, Oxford University, internships in Western Cape and twinning partnership with Northern Cape Department of Health and Kimberly Hospital Complex

Furthermore, the King's Fund offers leadership and management training and sees opportunity in sending senior NHS administrators to South Africa. Also, Netcare and Homecoming Revolution implements a programme in returning Diaspora nurses, and have, to date, successfully returned 60 nurses to the private health sector in South Africa.

**In the US**, PEPFAR's Placement Project had an internship programme that matched Masters of Public Health students with South African AIDS service organisations. The Bill and Melinda Gates Foundation recognises that HRH shortages are a major constraint to addressing HIV/AIDS, malaria, and tuberculosis. They are testing virtual and technical networking projects through internet and cellular phones in South Africa. United States Agency for International Development (USAID)'s Capacity Project was set up to "strengthen the human resources needed to implement quality health programs" and currently contracts through IntraHealth International.

BroadReach Healthcare, an American NGO, utilises private sector providers to offer services to poor and uninsured clients. By networking with private treatment programmes, such as Aid for AIDS, a South African-based organisation, BroadReach encourages private physicians (so far a network of over 4,500 doctors across the country) who have the capacity to take on public patients, including the uninsured and those in remote areas who would not otherwise have access to any care. South African Partners and the Commonwealth of Massachusetts (SA Partners/MassMed), with the Province of the Eastern Cape, are playing a critical role in the development of the Masihlanganeni "Let Us Come Together" network.

### *Migration-relevant recommendations for policies and programmes*

The following are some migration-relevant recommendations that came out of the assessment. These are categorised into two areas: 1) Recommendations on domestic retention and promotion of new internal flows; and 2) Recommendations to attract foreign healthcare workers and Diaspora to the South African public health sector.

*Domestic retention and promotion of new internal flows:*

- *Common regional strategies:* Regional HRH strategies and lessons should be shared and implemented through a SADC forum.
- *Sharing successful models regionally:* Successful donor-funded models and retention strategies (for example, the Malawi experience) should be generalised across the SADC region.

- Strategies to encourage *new internal migration flows* of healthcare workers.

- *Retaining public employees and increasing private responsibility:* Reversing flows to the private sector, attracting health workers to work in disadvantaged areas, and encouraging health care workers who have stepped out to re-enter the profession require a mix of incentives and commitment.

- *Mobility of labour:* Retention strategies must focus on providing the proper mix of incentives and wise management of all available resources rather than restrictive policies to curb migration or labour flows to the private sector.

- *Burden sharing:* A mixture of private/public services should be considered to free up public services for the most critical services and to prioritise the needs of the most underserved.

- *Improving management systems:* HRH shortages demand sophisticated management, information, and administrative systems that are fully equipped to engage all available resources and partners.

- *Rural scholarships, student loans and information systems:* More scholarships are critical for attracting suitable candidates from rural and other underserved areas who are willing to return to serve in those areas following graduation.

- *Task sharing and shifting*: The South African government should continue to attract social service, public health, and community health workers to fill gaps in homecare and other services that do not require health care qualifications and training.

- *Rural Centres of Excellence* are a means to create more productive community-service experiences, to encourage rural rotations, and to avoid burn out through regular rotations and promotions for going to HR-scarce areas.

*Attracting foreign healthcare workers and Diaspora to the South African public health sector:*

- *Encourage engagement through various forms of investments and exchanges*: Particularly for Diaspora, this will provide a chance for them to assess possibility of longer-term return.

- *Long-term collaborative exchanges and twinning relationships*: Establishment of "rural centres of excellence" which can facilitate research, training and information sharing.

- *Up-to-date web-based postings* and centralised databases for recruitment, matching, and tracking.

- *Centralised clearing house of information* should be established. It is important to develop a central clearing house in South Africa to encourage overseas and foreign health care professionals and organisations (both public and private initiatives) to register their activities. This will prioritise placements to areas of greatest need and facilitate information sharing and best practices.

- *Placement and post-placement assistance*: Address concerns such as security, appropriate level placement, registration and licensing assistance, citizenship/residency/visa requirements, and assistance to families (modelling programmes by Homecoming Revolution and RHI).

- *Diaspora:* Encouraging engagement through various forms of investments, training assistance, and temporary and circular returns is also a way to attract more Diaspora input and support, and in a few cases, may lead to long term, more permanent returns.

  There are no obstacles in the three northern countries for the Diaspora returning although all three countries are providing various incentives to retain skilled doctors and nurses (primarily salary and benefits).

  For the Diaspora, major constraints to returning are South Africa's security situation, concerns about being able to practice again at an appropriate level and in some cases, in the public health sector, perceived bureaucratic hurdles in re-licensing and/or with regularising citizenship and meeting residency requirements again.

## The South African Health Human Capacity Crisis

Mr. Kornik of RHI gave a presentation on the South African human capacity crisis in healthcare.

### *South Africa in context*

In comparison to a country like the US, there are very few doctors in South Africa per 100,000 people in the population. There are even fewer in the South African public health sector and hardly any working in rural contexts. This points to the major human capacity crisis in the South African public health sector.

### *South African burden of disease*

South Africa has a quadruple burden of disease:

- HIV/AIDS;
- alcohol and violence-related injuries;
- diseases of poverty; and
- diseases of affluence.

The Actuarial Society of South Africa statistics for 2006 show that:

- There are 48 million people in South Africa.
- 5.4 million are HIV positive (11%).
- 19% of the working population are HIV positive (aged 20–64).
- There are 1.5 million maternal orphans.
- Life expectancy in 1990 was 63 years old; in 2008, 48 years old.

In 2007:

- There were 700,000 new infections.
- 71% of deaths between 19 and 49 were HIV-related.
- 500,000 children were orphaned.

### *Inequities in South African healthcare delivery*

82% of the population rely on the public health system, but only 27% of general practitioners serve it. There are also substantial inequities between the number of specialists per million in urban and rural provinces.

Some statistics:

- There are 1,250 admissions to medical schools in South Africa per annum.
- 1,200 South African doctors work in Canada.
- 3,500 South African doctors are registered and work in the UK (6% of the UK health workforce is South African).
- 2,200 South African doctors work in the US.
- There are 4,000 vacancies in the public health sector.
- There are more qualified South Africa doctors working abroad than in the public health sector in South Africa.

### *The current status of potential solutions*

Some of the solutions to the problem are as follows:

- Redistribute health professionals out of the private sector into the public sector.
- Train more health professionals – there are the same number of universities since the 1970s.
- Recruit doctors from overseas – ones that can serve the South African population well.

Many students who are entering universities are ill-equipped at school level to cope with health sciences. Entry and completion fallout demographics support evidence that previously disadvantaged students are not properly supported through the process of study. There are fewer previously disadvantaged students who go onto graduate study after their medical degrees, meaning that there are fewer specialists from this group. Considering that specialists tend to work in the communities from which they originate, this has an impact on geographic distribution of specialists in the country. Another point is that the fact that more than 50% of medical students are female, may have an impact on the number of years of service they are able to give. In general, women have competing priorities in terms of family commitments – one in which women may need to prioritise family time more than their male counterparts may need to. This, in turn, may impact on the number of years of service they are able to give fully to the medical profession.

Currently, 15% of the healthcare workforce is Foreign Qualified Doctors (FQDs). The average figure for developed countries is 25%. It is unclear, then, why the NDoH only sets a policy target of having 5% of FQDs in the healthcare workforce.

Another area of policy that is of concern is that of preventing doctors from African developing countries to work in South Africa. There are certain conditions under which these doctors can work, which are discussed before and during Ms. Larissa Pienaar's presentation below.

Civil society is doing an enormous amount to solve the human capacity crisis. Out of the 1,200 graduates of medical schools per annum, only around 70 will end up working in rural facilities. In comparison, in just two years, RHI has managed to place a total of 133 doctors in rural facilities.

There is also the challenge of changing mindsets and understanding the factors which push doctors out of public sector. These are multiple, but the most worrying is that 21% of doctors feel abused by management, that there is no recognition or appreciation of their contribution and that there is a lack of respect. This needs to be addressed, as rural doctors are passionate about and committed to their work.

The production of nurses has also decreased. It is estimated that between 1996 and 2004 South Africa lost 69% of its professional nurses. The private sector alone has trained an enormous amount of nursing assistants.

After Mr. Kornik's presentation the participants posed questions and made comments on the presentations. One participant said that many nursing schools have been closed down and teaching has migrated to universities. This creates a situation where less nurses are produced. In addition, the South African population is not only bigger, but more ill. This produces an overload. This makes task-shifting difficult because there are not enough nurses to take on that work. Nursing is no longer an attractive career option for young people. The private sector is only able to train nursing assistants, not registered nurses – which produces "low grade" nurses in high numbers. One participant disagreed with this statement, asserting that the private sector is allowed to train professional nurses, but only in small numbers.

## The recruitment and placement of foreign healthcare workers in Kwazulu-Natal: a case study

The RHI conducted a recent study in which it spoke to health care workers in rural hospitals. Therese Hansen of RHI gave a presentation on the preliminary findings.

Interviews were conducted with 16 doctors, including 12 FQDs, one medical manager, one CEO, and a few members of staff at the provincial DoH. The interviews were conducted at Hlabisa, Eshowe and Nkandla hospitals. One of the objectives of the study was to create a tool kit for the DoH to find out, "if you want doctors, what do you need?"

FQDs are attracted to South Africa for the following reasons:

- Unseen pathologies, immediate hands-on practice, surgery, and HIV treatment;
- Latitude in planning patient care;

- Build-up of skills, confidence, and independence;
- South Africa's natural beauty;
- But mostly, to deliver healthcare to the poor and under-served.

South African doctors are attracted to working in the rural areas for the same reasons, and also because of:

- Research and innovation potential; for example, they view Kwazulu-Natal as the epicentre of rural health and HIV/AIDS knowledge, and with support and encouragement believe they have much to add to evidence-based medicine;
- No lawsuits;
- No traffic.

What doctors need:

- FQDs will come if they're "wanted".
- FQDs would feel encouraged to work in South Africa if the application process were streamlined and made as easy as possible. RHI can process applications in 2–4 months, with others it takes 6 months. The reduced approval period decreases the cost, the workload on the DoH, and ensures access to healthcare for the rural patient.
- RHI assistance is akin to "hand holding" – helping FQDs through the process, making it easy, supplying handbooks, and augmenting the orientation system. It is currently replicating the system that has been set up in Kwazulu-Natal in the rest of the country, especially the North West. However, each province has different procedures for approval and the more decentralised it is, the better it works. RHI has working relationships with provincial and national DoHs. It has developed relationships in the system, and has tried to address as many delays in the process as possible, for instance, in supplying the HPCSA with more staff. It has someone who works in the UK to expedite the visa application process.
- Training, including palliative and work ethics, and especially on the impact of ethics on patients and colleagues. Mid-career doctors are important because they can facilitate the training of others.
- Some supervision and a bit of leadership.
- Trained, motivated nursing staff and decent records.
- Modest, but available, living space.
- The salary, which includes the rural and scare skills allowances, is acceptable to doctors.

South African doctors need to be told that they are pillars of society and rural doctors need to be treated with respect and to feel like their work is valuable. They display a large amount of mutual respect and admiration of each other's work. In this way they become rural health practitioners who develop and identify with their communities and their provinces. RHI is the mechanism to help them achieve this.

## Presentations by Participating Organisations

A number of participants at the meeting were asked to give short presentations on their organisation or institution. Specifically, they were asked to cover the following areas:

- What their organisation does;
- The resources and/or expertise (not only financial) it has; and
- The ways it could contribute to a campaign to recruit and place foreign healthcare professionals in South Africa.

### Rural Doctors Association of South Africa (RuDASA)

Dr. Bernhard Gaede, the chairperson of RuDASA, presented on the organisation.

The vision of RuDASA is for all rural people in Southern Africa to have access to quality health care. Thus, it is not necessarily an "employee organisation" for rural doctors. Instead, it sees itself as an organisation for rural people.

RuDASA strives for the adequate staffing of rural health services by appropriately skilled medical staff and to be a voice for the rural doctor regarding training and working conditions.

Its strategic areas of work are:

- Inspiring others and publicising the rural areas;
- Lobbying and advocacy;
- Influencing change by assessing whether government policy is appropriate for rural areas ;
- Strengthening links to rural communities;
- Promoting student interest.

RuDASA is a "virtual organisation" of rural doctors with full time jobs. It meets roughly once a year. Thus, the areas to which it can contribute are the following:

- Networking and managing the context of rural healthcare;
- Hosting an email discussion list;
- Partnering with academic rural units and recruitment project, for example, the RHI;
- Linkages within the Department of Health;
- Advocacy;
- Partnerships with other organisations which work in the field of rural healthcare.

The members of RuDASA have a wealth of experience, commitment, ideas, and knowledge of issues on the ground. There is an enormous amount of intellectual

capital which RuDASA generates which could be harvested and used in a campaign to recruit and place foreign healthcare professionals in South Africa.

## American International Health Alliance (AIHA) and the Voluntary Health Corps (VHC)

Mr. John Capati, Country Director for the AIHA, gave a presentation on the organisation.

Since its inception in 1992, AIHA has managed more than 150 partnerships in 30 countries spanning the globe. These partnerships have engaged some 150 US hospitals and health systems and 55 schools of the health professions in international health systems development. It started working in Africa in 2004.

The Twinning Center at the AIHA was set up to strengthen human and organisational capacity to expand or scale up HIV/AIDS prevention, care, and treatment services through volunteer-driven activities, namely twinning partnerships and the Volunteer Health Corps (VHC).

The VHC places healthcare providers and other skilled professionals in volunteer placements at PEPFAR-supported sites overseas. It wishes not only to fill gaps, but also to address the gap so that is remains filled when the volunteer leaves.

- Assignments range from three months to two years.
- There is a focus on technical assistance through onsite knowledge transfer, teaching, and mentoring.
- Recruitment is conducted through existing organisations, professional associations, and related networks, as well as the Twinning Center website and advertisements in targeted publications.
- Volunteer support includes transportation, housing, living allowance, and emergency evacuation/travel coverage

To date the VHC has placed 28 volunteers in Ethiopia, South Africa, and Tanzania, with more placements pending. The 28 past and current volunteers have contributed 160 months of service to date, with the average volunteer placement lasting over 5 months in duration. Three Ethiopian Diaspora volunteers have returned to their home country to take permanent paid positions.

Volunteers have filled the following positions or areas of work: Clinical Mentor, Nursing, Nutritionist/Dietician, Pharmacist, Mental Health, Social Work, HIV/AIDS Stigma, Palliative Care, Laboratory, Prevention of Mother-to-Child Transmission (PMTCT), Infection Control, Information Technology, Health Planner, Monitoring and Evaluation.

Challenges to the programme thus far have been recruiting people with clinical expertise and tapping into networks of potential volunteers.

## Southern African Health Capacity Development Coalition (SA-HCD)

Dr. Fikile Sithole, Quality Assurance Advisor at SA-HCD, gave a presentation on the organisation.

SA-HCD is a coalition of independent NGOs who have different activities within health work, namely:

- Intrahealth (the lead partner);
- Council for Health Service Accreditation of Southern Africa (COHSASA);
- Foundation for Professional Development (FPD);
- ESCA Health Community; and
- Management Sciences for Health.

Thus, the coalition brings together the strengths of these different organisations.

The mission of SA-HCD is to be the regional leader in building sustainable local capacity in human resources for health systems to deliver comprehensive HIV and AIDS services.

The main areas in which SA-HCD works are:

- Policy and planning: with regard to human resource-related policies, advocacy, policy implementation, and HIV/AIDS standards. ECSA is the lead partner and has the ability to influence Southern African policy.
- Quality Improvement Programme: involving capacity building of the National Quality Assurance Team; performance improvement using standards and/or indicators and accreditation.
- Training Systems: with regard to curricula development; trainer development and mentorship, programmes and materials support.
- Human Resource Systems, which includes human resources gap analysis; leadership and management; recruitment, deployment and retention strategies; review of job descriptions; performance management; organisational structure review; placement; Human Resource Information Systems and data management.
- SA-HCD has had an impact on recruitment through placement of foreign healthcare professionals through its partner, FPD. The SA-HCD partnership supports recruitment to move from numbers to making an impact in service delivery through its different focus areas.

The challenge for SA-HCD is the quality of service in health care facilities. SA-HCD attempts to improve the standard of care which is delivered through appropriate leadership.

## Migration Research

Dr. Sally Peberdy, researcher at the University of the Western Cape (UWC) and previously a member of the Southern African Migration Project (SAMP), presented on the current status of migration research in South Africa. She provided a description and contact details of research units working in the field of health worker migration.

SAMP (http://www.queensu.ca/samp/) is still in existence. The project has published two reports on migration of health professionals, including one on South African professionals in South Africa wanting to migrate. Institute for Democracy in South

Africa (IDASA: http://www.idasa.org.za) is a SAMP partner and also has a migration research programme. The University of the Witwatersrand (Wits) has a Forced Migration Studies Programme (http://migration.orag.za) which conducts research in Acornhoek, Limpopo. Other organisations working in the field are advocacy groups, such as Lawyers for Human Rights, Centre for Applied Legal Studies (CALS) at Wits and the Refugee Law Clinic at the University of Cape Town (UCT). Dr. Peberdy is also undertaking migration research at the University of the Western Cape (UWC).

Some key research concerns are:

- Researchers must be concerned with the effectiveness and implementation of their studies.
- Research must be conducted on the premise that a basic human right is freedom to move and that people have right to work where they want, so long as they follow legal procedures.
- The Immigration Act: doctors and nurses are not on the quota list.
- Recruitment: engaging the Department of Home Affairs, NDoH and Department of Labour.
- How we can facilitate the accreditation process of foreign healthcare professionals?
- A focused discussion on Europe and the nationalities of foreign doctors in South Africa at the moment.
- Xenophobia and recruitment.

## The Centre for Development and Enterprise (CDE)

CDE is a business-funded think tank on policy issues. It has research and policy analysis experience in the migrant sector. It has published 14 reports on the issue, the latest of which are:

- Immigrants in Witbank (2006);
- Skills, Growth and Migration (2007);
- Migration from Zimbabwe: Number, needs and policy options (2008).

It is in the final stages of completing a new research report, focusing on migration, skills availability, xenophobia and the economy. The final report will make recommendations on an immigration policy or strategy for South Africa, in this way looking into the contribution that foreign healthcare professionals can make to South Africa's public health services.

At this stage, the preliminary findings of the report are:

- There is limited infrastructure to recruit and register foreign professionals.
- There is limited capacity at health professional registration councils.
- There are ethical challenges to recruitment from other developing countries.
- There may be insufficient regulation and assessment of bilateral agreements.

The views of the CDE are that:

- There is a global market in health skills.
- As long as individuals have freedom of movement and there are disparities between societies, markets will be powerful.
- Regulations which attempt to deny or ignore these basic conditions are likely to have unforeseen consequences and perverse incentives.
- Smart management rather than prohibitive regulation is what is needed.

CDE's key strength is its advocacy through the following activities:

- Extensive distribution of its research, targeted at key decision-makers in business and government.
- Increase the public profile of issues through hosting events and workshops and publishing articles in the mainstream media.

During group discussion after this presentation, it was pointed out that the current status of HRH in South Africa is similar to having a "Help not Wanted" sign on one's door. What is needed is to, firstly, attract FQDs to South Africa, and secondly, retain local healthcare workers in South Africa. Advocates and campaigners to address health worker migration should lobby and put pressure on politicians to make them understand that we need a competitive environment. Government-to-government agreements with regard to FQDs are naïve and bureaucratic. Instead, all that is needed is a good screening system – the FWMP's equivalent in Australia is a web-based application. It should also be recognised that the responsibility for exporting South African healthcare professionals has shifted from foreign governments to private recruitment agencies – a lucrative business. Another area of advocacy should be around the policy that prevents healthcare workers from other developing countries working in South Africa.

It was agreed that the FWMP needs to move from "paper" into an electronic format, or it needs to be better staffed. Either of these two improvements will speed up the process. It was pointed out that the policy regarding healthcare workers from other countries has exceptions. The phrase "not usually" (see Ms. Pienaar's presentation below) means that foreigners who are refugees, married to a South African citizen, or others, on a case by case basis, may be allowed to work in South Africa.

The issue of staff shortages in the provincial Departments of Health (DoH), which slows down the process considerably, was raised. In order to address this problem government need to have a similar unit to the FWMP, with the same name and function, in every provincial DoH. It was also noted that the NDoH is currently working on bilateral agreements with Russia and the Ukraine. The RHI added that it has offered to place staff, at its expense, in the FWMP to alleviate staff shortages.

## Foreign Workforce Management Programme (FWMP)

Ms. Larissa Pienaar, Senior Administrative Officer at the FWMP, gave a presentation on the FWMP, which is now known as Sub-directorate: Foreign Workforce Management.

What does it do?

- Screens all foreign health professionals that want to work in South Africa;

- Approves those who qualify for employment in South Africa;
- Issues all documentation required as part of registration and work permit applications;
- Assists in placement in rural institutions.

What is the process?

- Evaluation of file:
    - Should the applicant write exams?
    - If not, where will they work? FWMO assists in placement.
    - If so, they first write the exam, and then FWMP assists in placement.
- When placement is confirmed, FWMP issues the final endorsement letter for the work permit application.

Considerations during this process:

- Individual applicants from developing countries are *not usually* supported.
- The FWMP mandate is to place in rural provinces.
- Appointments are on a suitable level according to experience.
- It takes 4-6 weeks to process any application.

FMWP has the following resources:

- Unit staff with a specific job description and specialised experience.
- Higher level staff who have superior knowledge of Immigration legislation.
- Contacts in all Provincial DoHs; Professional Councils; and in the Department of Home Affairs.

It can contribute to a campaign to recruit and place foreign healthcare professionals in the following ways:

- Try and make the approval process as quick and painless as possible.
- Evaluate files fairly.
- Send candidature of applicants to provinces for consideration.
- Assist foreign employees with specific problems if they cannot be resolved on a provincial level.

## Health Professions Council of South Africa (HPCSA)

Professor Jannie Hugo, a board member at HPCSA, gave a presentation on the organisation.

The HPCSA's main remit is to accredit medical practitioners, who constitute the most accreditations, as well as dentists, clinical associates, South Africans who study abroad and other health professionals.

In the early 1990s HPCSA was mostly concerned with the registration of returning exiles. In 1999 the government issued a six year moratorium on the registration of FQDs. The statement of the then-Director General of Health was that “No foreign qualified doctors will work in South Africa other than government-to-government agreements”. The approach of government at that stage was that if South Africa needed FQDs, it would bring them from Cuba. The Cuban programme was spearheaded by Professor Kerneels Nel.

In 2001, the HSPCA established a Board Examination. Since then it has accredited 1,601 candidates from 70 countries. Candidates from Nigeria, the DRC and Cuba constitute the highest number of accreditations of FQDs to date. The pass rate for the exam is 45% for the first attempt and 32% for subsequent attempts. The exams are written and practical and cover clinical knowledge, ethics and law, and language. There are currently three examinations per year and the cost is more than R3000 per examination.

Avenues for registration are as follows:

- Public service registration, which is permanent. This is achieved through a board exam or non-exam.
- Independent Practice: University or College examination.
- Volunteer: 1 year.
- Post Graduate Study
- Academic.
- Medical Practitioner and Specialist.

The HPCSA has a dedicated office for the accreditation of FQDs. They are accredited through the following process:

- Examinations Subcommittee Medical.
- Liaison with FWMP.
- Application.
- Examination.
- Registration.

Government-to-government agreements work in the following ways:

- Assessment of qualification.
- In-country peer review and selection.

Currently government-to-government agreements are in place for Cuba, Germany, Iran, Tunisia, and Russia.

One of the biggest challenges to this process is selecting a doctor who can work without orientation. The HPCSA is involved in selection and can make proposals about orientation, but this is a real challenge. For one, disease profiles are different. Sometimes FQDs do not function well. One cannot pick up everything in an exam, so this is where a strong orientation programme must play a role. It is also necessary to attempt to expand the number of institutions which accept non-exam candidates.

There are many available FQDs from Eastern Europe but most of them are specialists and need to work in a specialist domain so this may not be ideal.

Some of the new ways of accreditation are:

- A specialist public service process where a FQD would register as medical practitioner in domain and review in practice after one year.
- A two year internship.

## Association of Nurses in the UK (ASANUK)

Ms. Thoko Mlungwana, a member of ASANUK and a South African nurse who formerly worked in the UK, gave a presentation on the organisation.

South African nurses have been in the UK for decades. ASANUK is a voluntary organisation set up by South African nurses in the UK in October 2001. The organisation provides professional support for South African nurses in the UK, and a link with health service development in their home country.

Over the period from 1998 to 2001, the then United Kingdom Central Council (which was replaced by the UK Nursing and Midwifery Council [NMC] in 2002) registered 3,145 nurses from South Africa. South African nurses who came to the UK were highly clinically qualified and experienced professionals, although they were not trained with some equipment.

ASANUK assists such nurses with adjustment to the UK, as well as with further study. A survey among South African nurses in the UK showed that they were interested in engaging in initiatives that contributed to health service provision in their home country. The experience of those who had been in the country for many years suggested that newly arrived nurses experienced isolation, loneliness and lack of support. Those who wished to develop their careers needed guidance and information regarding their career paths.

The aim of ASANUK is to:

- Enable health services in South Africa to benefit from the knowledge, skills, and participation of South African nurses who are in the UK.
- Help South African nurses in the UK achieve career goals.

Its objective is to establish a working partnership with relevant organisations in South Africa and the UK, in order to facilitate achievement of its aims.

Membership of ASANUK is open to all South African nurses in the UK, including those who have retired. Registration fee is £30 per year, which is reviewed annually. Management and administration is by the Director and Deputy; Treasurer and Deputy; Chairperson; Chairperson Professional – Working Group; Chairperson Education – Working Group; Secretary and Deputy Secretary.

The education working group works in partnership with professional organisations in the UK and South Africa. It organises joint seminars and exchange visits in the UK. This group promotes professional development. It assists members in identifying

career pathways and mentors to assist in career advancement. It also enables them to access information on accreditation of South African qualifications in the UK and recognition of UK qualifications in South Africa.

The professional support working group facilitates peer support whenever necessary for those experiencing workplace challenges, and it provides advice and information on access to statutory and voluntary labour relations services. This working group also runs "Working in the UK" orientation workshops for newly arrived nurses.

ASANUK works in partnership with relevant organisations in the UK and South Africa to achieve its goals. In the UK it has achieved sponsorship from Community Health and Reconstruction Training (a UK based voluntary organisation contributing to capacity building in South Africa), the Royal College of Nursing, UNISON (the UK's largest public sector union) and MoneyGram International (a financial service to wire funds between source and destination countries). The link with the South African government is facilitated by the first officer at the South African high commission in London.

In South Africa, ASANUK supports projects in the School of Nursing at Medunsa and has established a working partnership with DENOSA.

One of the challenges facing South African nurses when they came home was the "them and us" attitude of nurses in South Africa. There has also been a difficult relationship between the NDoH and nurses that work abroad, demonstrated by the comments made by the Minister of Health to a meeting of nurses in the UK, in which she said that her priority was nurses who stayed in South Africa and not those who had left.

### Democratic Nursing Organisation of South Africa (DENOSA)

Mr. Ephraim Mafalo, president of DENOSA, gave a presentation on the challenges of and lessons learned from health worker migration. He highlighted the human capacity crisis in healthcare with the following quote: "While Africa has 11% of the world population and carries 24% of the world's disease burden, it has only 3% of the world's health workers – and many of these workers continue to be lost to migration" (NDoH, 6 March 2008).

He also pointed the different forms of migration – being rural to urban areas; public to private sector; nursing to non-nursing and South Africa to developed countries. According to a World Health Organisation (WHO) fact sheet, one in four doctors and one in 20 nurses who were trained in Africa have migrated to developed countries. Some of the challenges pushing healthcare workers include an unsafe work environment, a high workload due to disease burden, and lack of economic remuneration. The number of nurses either dying of AIDS or having to deal with the illness of AIDS is almost equal to the number of nurses leaving South Africa.

There is also a disjuncture between cut-backs on public health spending by the International Monetary Fund (IMF) and the World Bank and an increased need and demand for nurses.

The way forward is to:

- Reach agreements with the recruiting countries (since the 2001 Code of Practice signed with the UK, registration with NMC decreased by 55% from 2,114 in 2002 to 933 in 2005).

- Improve conditions of service and remuneration of health personnel (by adherence to the Occupational Health and Safety Act 85 of 1993 and proper implementation of occupational safety).

- Invest in nursing education in developing and developed countries.

- Implement the Human Resource Health Plan of South Africa.

- Create multiple recruitment initiatives.

The presentation concluded with a quote from Kingma, which states that "Nurse migration would not be such a big issue if there wasn't a shortage. Migration is and will continue to be part of our lives, especially with increasing globalization. If we deal with the need to migrate, we'll address the nursing shortages, and migration will not be an issue, it will be an enrichment."

## Jhpiego

Ms. Lunah Ncube, Country Programme Manager for Jhpiego, gave a presentation on the organisation.

Jhpiego is an affiliate of Johns Hopkins University (Baltimore, USA). It enhances the health and saves the lives of women and families in limited-resource settings. For nearly four decades, it has put evidence-based health innovations into everyday practice to overcome barriers to high-quality health care services for the world's most vulnerable populations. From its origins as technical experts in reproductive, maternal, and child health, Jhpiego has grown to embrace new challenges, including prevention and treatment of HIV/AIDS, malaria, and cervical cancer – reflecting the increasing interconnectedness of global health.

Jhpiego empowers front-line health workers by designing and implementing effective, low-cost, hands-on solutions that strengthen the delivery of health care services, following the household-to-hospital continuum of care. It partners with organisations from the community to the national level, building sustainable, local capacity through advocacy, policy development, and quality and performance improvement approaches.

It strengthens the performance of health workers and health systems to provide quality health care services for women and families by:

- Building service delivery and health workforce capacity through global and local partnerships;
- Working with doctors, midwives, nurses and health educators;
- Performance and quality improvement and human resources for health; and
- Translating research to practice.

## The Network on Equity in Health in Southern Africa (EQUINET)

Dr. Yoswa Dambisya, a member of the EQUINET steering committee, gave a presentation on the organisation.

EQUINET is a network of professionals, civil society members, policy members and state officials in East and Southern Africa that aims to advance and support health equity and social justice through:

- Sharing information and experience;
- Research;
- Building critical analysis and skills;
- Networking and building strategic alliances.

The University of Namibia specifically works on retention and the Health Systems Trust (HST) in South Africa works on issues of migration.

It is involved in the following areas of work:

Process work:

- Parliaments
- Policy work
- Health civil society
- Information and publications
- Capacity building

Theme work:

- Fair financing
- Governance and participation
- HRH
- HIV/AIDS and health systems
- Economic policy, trade and health
- Health rights
- Food security and nutrition
- Monitoring and surveillance

Country work>

- Equity analyses in Zambia, Malawi and Tanzania
- Networking in Zimbabwe, Tanzania, Malawi and Uganda

The following organisations support EQUINET's work: the EQUINET Secretariat (the Training and Resource Support Centre, TARSC), Steering Committee and the University of Limpopo, in cooperation with ECSA, IOM and WHO. It has links with

SADC, institutions in Canada, UK, and Australia, with support from the Swedish International Development Cooperation Agency (SIDA).

Its recent research includes:

- Mapping and sharing of evidence on current incentives for retention of HRH in five countries: Uganda, Kenya, Tanzania, Swaziland, and Zimbabwe.
- Assessing retention strategies in the context of HIV/AIDS (with University of Limpopo and WHO).
- Assessing impact migration on health systems in Kenya (with TARSC and IOM).

Work being implemented 2007 to 2009:

- The need for sound evidence to inform policy and practice: effects, benefits, costs of healthcare worker migration.
- Strategic planning, leadership and management capabilities backed by clear guidelines.
- Country-specific approaches to managing migration, for example, through bilateral agreements and engagement of Diaspora healthcare workers.
- Reclaiming resources for health: a regional analysis of equity in health in East and Southern Africa

**Plenary discussion: Roadmap of short and long term activities and identifying key role players**

Mr. Saul Kornik of RHI facilitated the plenary discussion in the afternoon, the purpose of which was to formulate a very specific plan on how the participants could work together on a campaign to recruit and place foreign healthcare professionals in South Africa. The group began the session by brainstorming a set of expectations for the afternoon session. These were to:

- Formulate the beginning of an agreed model and approach to a campaign: what are the key components and who are the key partners within these components?
- Address the culture of how South Africa deals with FQDs;
- Plan for better communication among stakeholders;
- Discuss one day processing of FQDs: how to address bottlenecks and how to streamline this process?
- Pinpoint key priority areas, set targets and timeframes for achieving them;
- Coordinate the activities of FQD recruitment agencies;
- Address the challenges of marketing;
- Find ways of information sharing of existing research so that people's motivations of why they stay and go and barriers to why people are not recruited and retained may be better understood;
- Formulate an overall government advocacy strategy ;
- Begin to form an orientation plan and retention strategy
- Think about who else could be pulled into the process, for example, the Department of Home Affairs.

A brief discussion ensued on the drivers and recent changes in South African HRH. It was agreed that the HIV epidemic has made the need for HRH more urgent in the last five years and that there is now an awareness of the value of FQDs.

## Advocacy Campaign

The first issue discussed was how to take forward an overall advocacy campaign to facilitate the recruitment and placement of foreign healthcare professionals to work in the public health sector in South Africa.

### *Who are the major players in the campaign?*

It was agreed that the following organisations or institutions constitute the major players:

- National and Provincial Departments of Health and local health managers
- Health Committee of Parliament

- Regulatory councils, such as HPCSA, SANC, South African Pharmacy Council (SAPC), Traditional Health Council and South African Medical Association (SAMA)
- Department of Home Affairs, the Presidency, New Partnership for Africa's Development (NEPAD), and SADC
- Training institutions
- Nursing organisations like DENOSA and ASANUK
- Donors
- Civil Society
- Media

***How to engage with key players***

The importance of assessing the willingness and ability of each of these key players was pointed out – if one or both are lacking, it needs to be addressed.

It is important to make what is already available function better, including identifying where the bottlenecks are and having the provinces much more keenly involved. There is also a need to ensure that FQDs function better and have a better experience while in South Africa. Furthermore, there needs to be a change in the perception that FQDs are "stealing jobs" in the rural areas.

It was suggested that perhaps there needs to be an advocacy campaign similar to the one for the rollout of antiretroviral therapy (ART) and that it needs to be targeted at politicians. Such a campaign needs to be a systematic one that may disseminate information, create partnerships, and ensure that the issue is on the agenda of every big conference and that people talk about it at every opportunity. It was agreed that where there is political will, the logistics will fall into place.

One suggestion was to take up the current obstacles that FQDs face when wanting to work in South Africa to the Human Rights Commission (HRC) or other similar human rights bodies since such obstacles impede access to healthcare for ordinary people. In other words, obstacles that inhibit FQDs from working in underserved areas of South Africa actually lead to people living in the underserved areas not accessing health care. It was also suggested that in order to create a conducive environment for policy change, counter-xenophobia should form part of an advocacy plan.

***How to engage the Department of Health***

It was agreed that the NDoH needs to be a key player in a systematic campaign. One of the problems within the NDoH is that it is not allowed to recruit directly. One of the participants asserted that there is no culture of recruitment in the NDoH and that it is not proactive – he pointed to the way in which adverts for positions are worded. The NDoH does not treat human resources as a *resource* – however, people need to be treated as a valuable commodity and rural areas need to be perceived as a place that FQDs want to go to.

Government needs to change its mindset from "combating migration" to "managing migration", in other words, how to make the process more efficient. It was suggested

that the time to engage the new government on this issue is now. The justification one starts with is that it is an access to healthcare issue – in other words, one starts from a position of needs and works from there. The issue of recruitment from developing nations needs to be addressed, specifically engaging FQDs from those countries who are already in South Africa. Perhaps it should be pitched to government using a quota system, brokering an agreement between SADC and the NDoH.

### *Which partners are willing and able to coordinate the advocacy plan?*

It was agreed that a working group needs to be established in order to address the key questions being raised and coordinate the campaign. RuDASA is considering employing someone to do advocacy work and the AIDS Law Project (ALP) could also be called upon to assist. There are some US organisations which do this kind of work and could be used as models. Advocacy requires broad-based support. The dissemination of information on this campaign in other countries could occur through the IOM offices abroad, and the RHI agreed to be the central clearing house for information sharing.

## Road map for the facilitation of the recruitment and placement of foreign health care professionals to work in the public health sector in South Africa

This session consisted of a focused discussion of the abovementioned roadmap (see Appendix 3). Each stage of the roadmap was discussed to identify the gaps and possible future actions and identify lead actors.

### *Assessment*

The purpose of the assessment is to gauge the interest and availability of healthcare professionals in selected developed countries.

This component includes identifying potential partners in different countries. One participant wanted to know whether there was a way of recruiting Indian doctors. Another responded by saying that it is complicated, as there are many sub-standard educational institutions in India and South Africa would not want to recruit FQDs from those. He suggested that we need to classify two types of developing countries – those which are chronically undersupplied and oversubscribed. We should select from specific institutions rather than countries.

### *Information campaign*

The purpose of the information campaign is to provide information to attract foreign healthcare professionals to apply for vacancies.

It was confirmed that foreign volunteers for a government post can be employed. It was said that would be helpful to have a best practices recruitment model.

The following was agreed:

- IOM can work with people from the South African Diaspora who would like to return.

- The RHI can use the IOM offices, capacity and networks in recruiting countries in order to disseminate material, market and recruit potential candidates.
- RHI is going to meet with ASANUK later this year to recruit South Africa Diaspora nurses to return.
- SA Partners/MassMed should be drawn into the process.
- RHI can be used as a central contact for recruitment.

***Identification of potential candidates***

The purpose of this stage of the process is to identify potential candidates based upon agreed procedures.

This step of the process is all about where one markets. It must be remembered that candidates need minimum two year's experience to work in the South African public health care.

It was agreed that organisations which place volunteers should be drawn into the process, namely:

- VHC
- Voluntary Service Overseas (VSO)
- International Centre for Equal Healthcare Access (ICEHA)

Xoliswa Lukhalo from RHI is going to liaise with John Capati about engaging with voluntary organisations.

***Recruit, Match and Place***

The purpose here is to recruit and match candidates with vacancies in provincial public sector health institutions, based on their expressed field of interest.

There was a very long and detailed discussion on this issue, which centred on the challenge of FWMP approval and registration at HPCSA and SANC. Bottlenecks, in terms of issuing work permits at the Department of Home Affairs, also need to be addressed. The following are key players that need to be involved in facilitating the recruitment, matching and placement process.

**FWMP**

Firstly, FWMP needs more staff and/or an electronic database that generates documents automatically. With regard to the former, the RHI has already submitted a proposal to the FWMP to place and fund more staff for the FWMP. Some participants were worried that this may create a dependency and preferred an IT solution. It was suggested that, in addition to the current proposal to capacitate the FWMP, a proposal needs to be written and submitted to supply the FWMP with an adequate electronic system. There are also ethical issues to consider and the RHI acknowledged these and promised to maintain independence at all times.

Secondly, it was agreed that each provincial DoH needs to be engaged. What is needed is a unit similar to the FWMP in every province. Provincial work on FQD

approval needs to be decentralised. The main challenge to the process of approval seems to lie in the fact that provinces are slow to give the FWMP a job offer. If provinces could supply the FWMP with a vacancy list and blanket approval to fill those vacancies, this challenge could be addressed. The RHI said that a similar proposal to the one currently under consideration is submitted to place and fund staff for a FWMP at a provincial level. It was agreed that the system in Kwazulu-Natal works well and should be used as a best practices model.

**HPCSA**

The question was raised of how to speed up the process registration at the HPCSA. It was agreed that currently the process is faster than it has been, owing to the fact that the RHI has supplied staff to the HPSCA. However, documents have been getting lost. A number of potential solutions were discussed.

Firstly, the HPCSA said that it is installing a new software system which should be functional by September. The RHI and FPD offered to support the HPCSA to achieve this goal.

Secondly, the issue of exams was raised. It was agreed that it may be possible to increase the number of exams which are currently offered from three times a year to monthly. The cost of the exams is high and sometimes prohibitive for FQDs, especially refugees. A proposal needs to be put forward to subsidise the cost of these exams. It was not clear who would carry this out. It was suggested that a way to attract academics to facilitate the exam process and mark exam papers was to offer Continuing Professional Development (CPD) marks in exchange for their services. Representatives of the HPCSA at the meeting promised to raise these issues at the upcoming HPCSA board meeting on 7 May 2008. It was decided that the idea of setting up exams overseas is not feasible.

**SANC**

It was agreed that there is a major problem of bottlenecks at SANC. A number of potential strategies to deal with this were suggested.

Firstly, the group should develop an advocacy project which tries to work with SANC, in which the challenge of human capacity is also addressed. There is currently no registrar at SANC, which may be part of the problem. However, a new council is to be elected shortly and it was agreed that the group should attempt to engage and educate it on the issues of recruitment and find ways to work with it to improve efficiency. It is unclear to the group whether the problems at SANC are owing to inefficiency or xenophobia, or a combination of both. What is clear is that xenophobia needs to be part of an advocacy strategy. DENOSA agreed to take an active role in this project, as it would be useful to have it speak publicly against xenophobia and engage its members on the issue.

Secondly, if the advocacy campaign proves unsuccessful then the group should embark on a more vigorous legal campaign, using the ALP, to get SANC to carry out its duties.

In addition, it was agreed that there are more qualified nurses in the private sector or working outside of the profession than those that are working overseas. Thus

there should also be a campaign to attract them to the public sector. RHI already has a project which deals with this issue.

In terms of attracting South African Diaspora nurses back to South Africa, RHI has developed a close working relationship with the South African Embassy in the UK. The IOM has a relationship with many other embassies overseas and is willing to facilitate relationships between them and recruitment agencies on a case by case basis.

**Department of Home Affairs**

It was decided that the NDoH needs to engage the Department of Home Affairs on an agreement to fast-track the issuing of visas to FQDs. Such an agreement needs communication on national and local levels. The group decided to pursue a number of routes:

- Larissa Pienaar of the FWMP and Jannie Hugo of HPCSA will personally talk to Hennie Groenewald of FWMP about pursuing such an agreement.
- The group could use the services of a pro-bono immigration lawyer, or train a paralegal, to assist with the fast-tracking process.
- Should neither of the above bear fruit the Department of Home Affairs could be taken to court in order to get it to perform in this area.

***Pre-departure orientation***

The purpose of pre-departure orientation is to arrange orientation for selected healthcare professionals in their respective countries.

Material and training is needed. FPD is going to help design a course which can help FQDs learn local health issues before they arrive in South Africa. Clinical courses and distance learning also need to be explored.

However, both clinical and social orientation is needed. It was decided that in the future the issue should be referred to as “orientation and mentoring”, as the latter is just as important as the former. FQDs require mentorship and a buddy-system after they arrive. We need to broaden the number of institutions that offer training and expand orientation to include areas like language training and support programmes.

It was agreed that the NDoH needs to give orientation a bigger budget. RuDASA is having a meeting with Percy Mahlati, Deputy Director of Human Resources in the NDoH, where orientation could be discussed. FPD offered to brief RuDASA on the complexities of orientation before that meeting.

Calvin Thomas from RHI is currently designing an orientation programme.

***Travel arrangements***

The purpose of this stage of the process is to provide assistance to selected healthcare professionals in their travels to South Africa.

Young doctors who have study loans in their home countries find it difficult to travel. It was agreed that recruiters could:

- Send a proposal to source governments to request that they cover the cost of the candidate's return flight.
- Approach the IOM on a case-by-case basis for its reduced-cost flight arrangement.

There was a brief discussion about orientation for FQDs once in South Africa. RuDASA wondered whether it could offer support in any way. It was agreed that provincial government should take responsibility and be more open to FQDs. The group must explore whether there is human capacity development money which could be used or training institutions which could assist with funding, for example, South African Institute of Health Care Managers (SAIHCM). The challenge of adequate housing for FQDs must be addressed. It was agreed to approach local charities that work on housing issues, such as Habitat for Humanity and community-based programmes.

## Conclusion

The meeting was adjourned with the mutually-agreed upon commitment that once the workshop report was finalised the decisions made and agreements reached during the meeting would be followed up.

In terms of its objectives, the stakeholder meeting was a great success. Firstly, the early morning presentations gave presenters an opportunity to share with the participants some of the lessons learned and good practices from the IOM assessment report and the experiences of FQDs in Kwazulu-Natal from the research conducted in Kwazulu-Natal. This session also presented an opportunity to contextualise health worker migration within the human resources health capacity crisis in South Africa.

Secondly, the mid-morning presentations by representatives from various organisations in attendance gave participants a deeper understanding of the key components of existing interventions in the field of health worker migration. Challenges were also discussed in some detail.

Thirdly, it was useful to have participants from many different organisations come together in this manner as it allowed for extended networking and coordination between stakeholders. Each stakeholder had the opportunity to explore the role that his/her organisation could play in an ongoing campaign.

Finally, the afternoon plenary discussion was a very productive, outcomes-based session in which an advocacy plan with regard to the "roadmap" was discussed in great detail. This discussion provided an excellent blueprint for the way forward in terms of running a sustained campaign for the recruitment and placement of foreign healthcare workers to work in the public health sector in South Africa.

**Appendix 1: Workshop programme**

| **Workshop Programme**<br>**Thursday 17 April 2008** | | | |
|---|---|---|---|
| **REGISTRATION: 08h00–08h30** | | | |
| 08h30–<br>08h50 | 20 min | Welcome<br>Introduction to IOM & RHI | International Organization for Migration (IOM)/ Rural Health Initiative (RHI) |
| 08h50–<br>09h00 | 10 min | Workshop Objectives, Expectations & Outcomes | IOM/RHI |
| 09h00–<br>09h20 | 20 min | IOM Assessment Report | Reiko Matsuyama (IOM) |
| 09h20–<br>09h30 | 10 min | Q&A | |
| 09h30–<br>09h50 | 20 min | The context of human resources in healthcare in South Africa | Saul Kornik (RHI) |
| 09h50–<br>10h00 | 10 min | Q&A | |
| 10h00–<br>10h20 | 20 min | The successes and challenges of recruitment & placement of health care professionals in Kwazulu-Natal | Therese Hansen (RHI) |
| 10h20–<br>10h30 | 10 min | Q&A | |
| **10h30–11h00** | **BREAK (30 minutes)** | | |
| **Description of participating organisations, resources & contribution to campaign to recruit and place foreign health care professionals in South Africa** | | | |
| 11h00–<br>11h10 | 10 min | Rural Doctors Association of South Africa (RuDASA) | Bernard Gaede |
| 11h10–<br>11h20 | 10 min | American International Health Alliance (AIHA)/Volunteer Healthcare Corps (VHC) | John Capati |
| 11h20-<br>11h30 | 10 min | Southern Africa Human Capacity Development Coalition (SA-HCD) | Fikile Sithole |
| 11h30–<br>11h40 | 10 min | Migration research | Sally Peberdy |
| 11h40–<br>11h50 | 10 min | The Centre for Development and Enterprise (CDE) | Robin Leslie |
| 11h50–<br>12h00 | 10 min | Foreign Workforce Management Programme (FWMP) | Larissa Pienaar |
| 12h00– | 10 min | Health Professions Council of South Africa | Jannie Hugo |

| **Workshop Programme**<br>**ay 17 April 2008** | | | |
|---|---|---|---|
| 12h10 | | (HPCSA) | |
| 12h10–<br>12h20 | 10 min | Association of South African Nurses in the UK (ASANUK) | Thoko Mlungwana |
| 12h20–<br>12h30 | 10 min | Democratic Nursing Organisation of South Africa (DENOSA) | Ephraim Mafalo |
| 12h30–<br>12h40 | 10 min | Jhpiego | Lunah Ncube |
| 12h40–<br>12h50 | 10 min | The Network on Equity in Health in Southern Africa (EQUINET) | Yoswa Dambisya |
| 12h50–<br>13h00 | 10 min | Discussions | |
| **13h00–14h00 Lunch** | | | |
| 14h00–<br>15h00 | 1 hour | Plenary Discussion: Roadmap of short term and long term activities and identifying key role players | Saul Kornik |
| **15h00–15h15 BREAK (15 minutes)** | | | |
| 15h15–<br>16h00 | 45 min | Plenary discussion ctd.<br>Recommendations | Saul Kornik |
| 16h00–<br>16h30 | 30 min | Summary of the way forward<br>Evaluation and closure | IOM/RHI |

**Appendix 2: List of participants**

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|---|---|---|---|---|---|
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**Appendix 3: Stages in the recruitment and placement of foreign healthcare professionals to work in the public health sector in South Africa**