

# HEALTH WORKFORCE MIGRATION IN SUB-SAHARAN AFRICA

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Malawi

by

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# Presentation Outline

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- Background/Introduction
  - The training of doctors in Africa
- Why health workers (Doctors) migrate from Sub-Saharan Africa to the wealthier countries
- Case examples of Migration in Africa
  - Kenya ,Ghana, Uganda, South Africa, Mauritius
- The Impact of the Migration
- What is being done and what has been done
- The Global response/WHO/WHA



# Background



- The migration of doctors from LIC to wealthy countries :
  - To further their careers , improve their economic , social or security situation
  - Doctors or health workers have a right of movement
  - The migration has several both positive and negative impacts:
    - A negative imbalance in the health workforce which has for a long time been recognized by WHO
    - Depletes the much needed workforce from the source country
    - Weakens an already weak Health Systems



# The investment in the training of Doctors in SSA

- Medical Education started in Africa as early as 1918 in Dakar Senegal
- With Independence in the SSA in the 60s and the 70s more schools were established
- In the 70s to 90s turmoil affected the schools
- During the last three decades there has been tremendous increment in the establishment of Medical schools in the Public sector, Private for profit and Faith based for non-profit

# Samples of Medical schools



## Sub Saharan Africa Medical Schools as at 2004

1.	47 Countries	87 Medical Schools
2.	11 Countries	No Medical Schools
3.	24 Countries	1 Medical School each
4.	12 Countries	More than 1 medical school

## Comparison Physician Population Ratio

1.	Sub Saharan Africa	13: 100,000
2.	United Kingdom	164:100,000
3.	United States of America	279:100,000

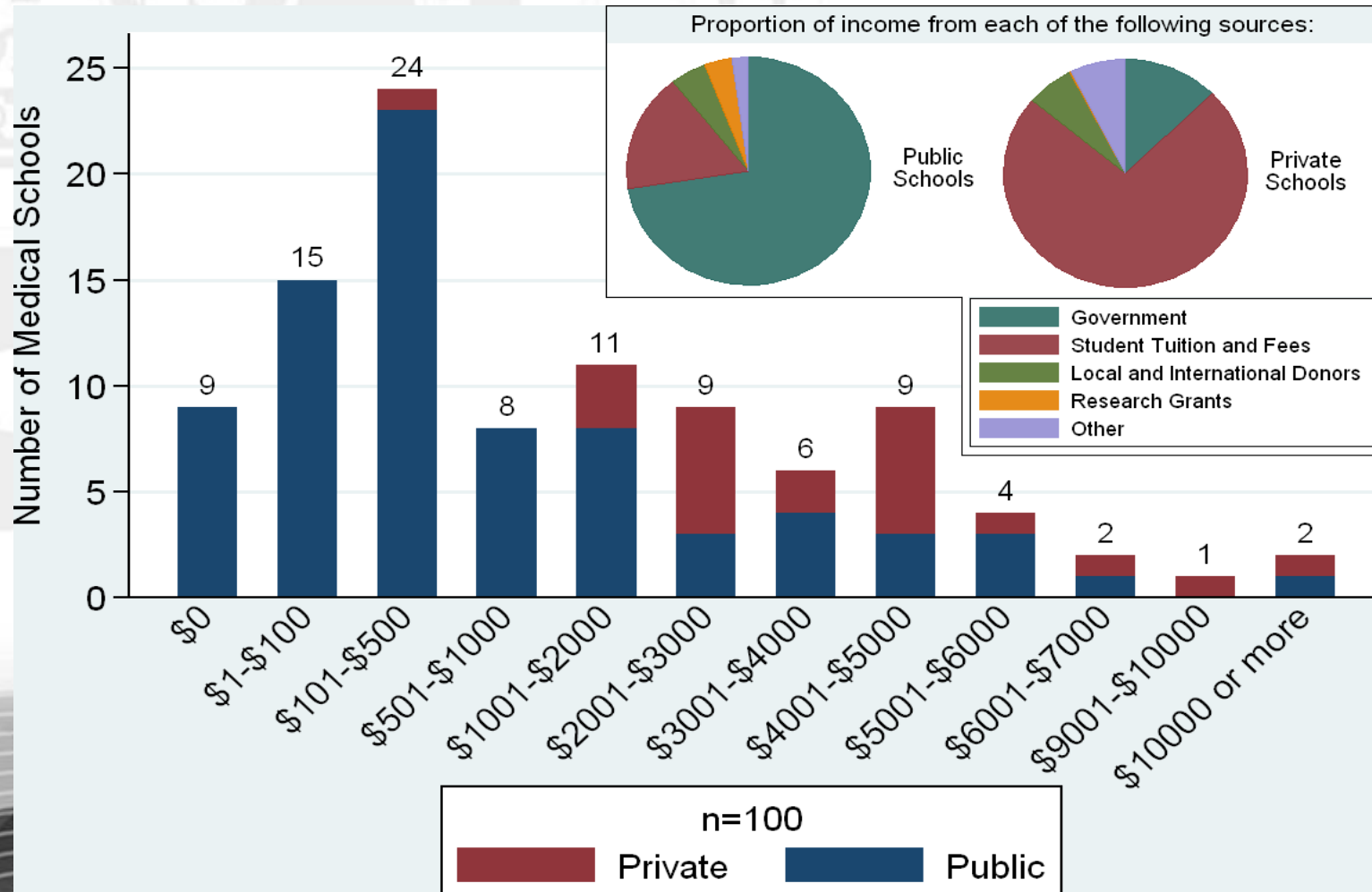


## Estimated tuition fees for the first year of a Bachelor of Medicine (MBBch) degree in some schools in RSA 2015

	Medical Schools	Cost in First Year
1.	University of Cape Town	R64,500
2.	Wits University	R58,140
3.	Stellenbosch University	R51,326
4.	University of Pretoria	R51,270
5.	University of KwaZulu-Natal	R44,220
6.	University of the Free State	R41,260



# The Investment in Medical Education in SSA



# SSA Physician workforce and burden of disease compared to the rest of the world

Burden of disease		
	Sub Saharan Africa	12% of world population
	Sub Saharan Africa suffers	27% of the world burden of disease
	Sub Saharan Africa	Has 3.5% of world health workforce
	Sub Saharan Africa has Sub Saharan Africa has	1.7% of the World health physicians 1% of Global economic resources



# Some examples of Comparative Doctors Salaries a From a few select SSA countries a decade ago



	COUNTRIES	Average monthly wage (US \$)	
		Doctors 2004	Doctors 2015
1.	Uganda	67	700
2.	Liberia	228	1500
3.	Kenya	250	(359)#1400
4.	Malawi	151	610
4.	Ghana	473	1200
5.	Zimbabwe	250	400 #Partner support
6.	South Africa	2836	7282
7.	UK	7676	12122
8.	Canada	8472	12918
9.	USA	10554	15000



# Why Doctors Migrate: Themes

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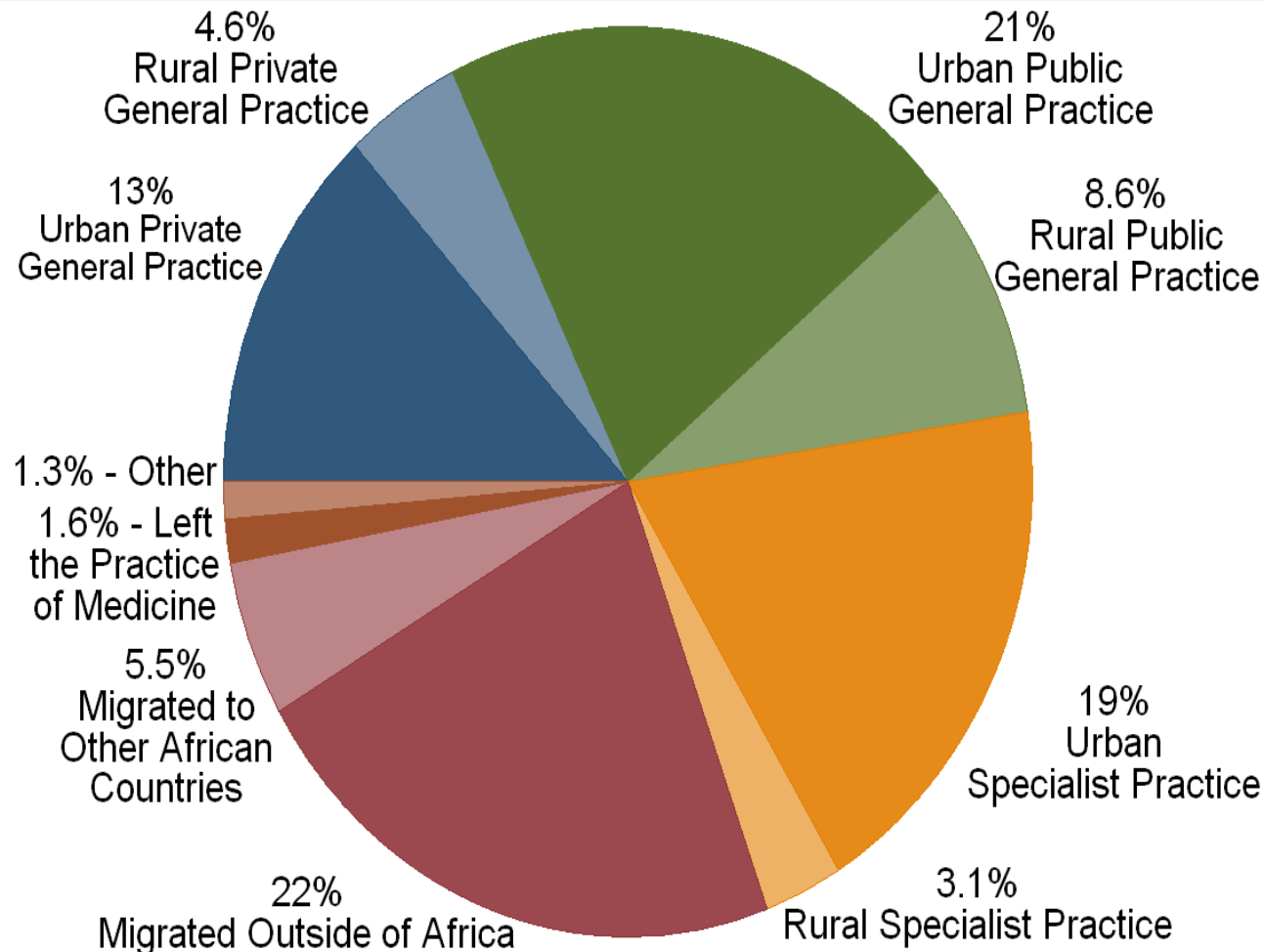


- Financial (in terms of salary or allowances)
- Career development (specialization & Promotion)
- Continuing education & CPD
- Hospital infrastructure ('work environment')
- Resource availability (equipment and medical supplies)
- Hospital management
- Personal recognition
- fringe benefits
- job security
- personal safety
- staff shortages and social factors



# Estimated location of doctors 5 years after graduation

Mean Reported Percentage of Graduates (n=62)



# Case Examples of Migration in SSA

- In a review in the USA of Physicians: 23% trained outside America of which 64% were from the LIC
- 5334 were from Africa which is equivalent to 6% of doctors practicing in Africa
- 86% of the doctors practicing in the USA are from : Ghana, Nigeria and South Africa
- Of the doctors in the USA from Africa 79% trained in 10 Medical schools !!

# Impact of the Migration

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- Lost Investment to the source country
- Financial remittance which does not benefit health sector
- Weakened Health Systems
- Weakened Quality of care
- Loss of confidence in the institutions that provide health
- Loss of confidence of institutions that train
- Specialists and subspecialists trained not available
- In Zimbabwe between 1991 and 2001 of 1200 physicians trained only 360 remained in the country





# What is being done and what has been done

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- Realistic remuneration packages to enhance retention of health workers
- Incentives: Car loans, housing loans , regular appraisal for promotion
- using a quota system to recruit students from rural and marginalized areas;
- shifting from bonding of student doctors for a year or two after their training and serving in remote government hospitals, towards incentive systems,





# What is being done and what has been done

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- Human Resource for Health Development
  - Reviewing curriculum for basic training to be responsive and innovative
  - For specialists training innovation in collegian system to accelerate the critical numbers and service delivery
  - HRH systems development
  - Task shifting and sharing examples
  - Strengthening the HSS
  - Strengthening the Quality Assurance
  - Strengthening Regulations



# Data on Physicians migration

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- Authentic and accurate data on Physician migration in SSA is challenging
- Sharing the data from receiving countries is also challenging
- Migrating physicians do not inform – They just resign from the public sector and move on
- There are also internal migration:
  - From the Public Sector to the private sector
  - From the public sector to the training Institutions Medical Schools
  - From the Public sector to the NGO programmes



# The Global Response

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- As early as 1996 the then Deputy President of the RSA raised the red flag on physicians migration from LIC.
- RSA legislated against immigration of Physicians and emigration of Physicians from OAU countries
- The Kampala Meeting in 2008
- During subsequent WHA meetings the subject was discussed.
- WHO mandated to develop a protocol to stem the migration crisis/ physician health worker crisis
- In 2010 the WHA adopted the WHO Code of Practice on the international recruitment of health personnel which had 10 articles



# The WHO Code of Practice on the international recruitment of health personnel

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- In 2010 the WHA adopted the WHO code of practice on the international recruitment of personnel as a global framework for dialogue and cooperation on matters concerning health personnel migration and health systems strengthening



# The Content ( Articles) of the WHO Code of practice on the international recruitment of the health personnel

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- Objectives
- Nature and Scope
- Guiding Principles
- Responsibilities
- Rights and recruitment practices
- Health workforce development and health systems sustainability





# The Content of the WHO Code of practice on the international recruitment of the health personnel



- Data gathering and research
- Information exchange
- Implementation of the code
- Monitoring and Institutional arrangements
- Partnerships, technical cooperation and financial support





# **Implementation of the CODE of practice on the international recruitment of Health personnel- A review from 2012 to 2016**



- Progress to date by countries
- Gains made
- Challenges
- Recommendations



# Implementation of the CODE of practice on the international recruitment of Health personnel- A review from 2012 to 2016



- Progress to date by countries
  - By 2012, 85 countries out of 193 WHO member countries had:
    - Designated a National Authority on the CODE out of which 13 were from SSA
    - Africa had the lowest responses to the Reported questions on the articles from the National Reporting instruments
- During the second round of reporting 2015/2016
- 117 countries reported
- 8 SSA countries reported



# Implementation of the CODE of practice on the international recruitment of Health personnel-

## A review from 2012 to 2016



- Gains Made based on the protocol:
  - Investment in Medical education
  - Investment in HSS
  - Dialogue and structured Migration between countries
  - Efforts at documentation
- Challenges:
- Poor documentation
- Poor reporting
- Inadequate involvement by all the stakeholders





# WHO GLOBAL CODE OF PRACTICE on the International Recruitment of Health Personnel

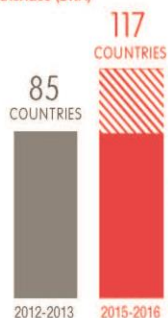
There have been major improvements in certain regions, including a **FOURFOLD INCREASE** in the number of designated national authorities in the Western Pacific Region.\*

## WHAT IS IT?

The Code, adopted by the World Health Assembly in 2010, aims to establish and promote voluntary principles and practices for the ethical international recruitment of health personnel and to facilitate the strengthening of health systems.

## HIGHLIGHTS

Number of countries that have designated national authorities (DNA)



85%

are based in health ministries

9%

are based in public health institutions

6%

are based in other institutions such as health authorities, health boards or human resources for health organisations

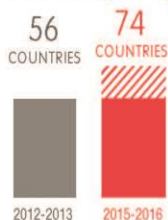


## 7 OF THE TOP 10

destination countries for international migrants took part in the second round of national reporting

- ✓ United States of America
- ✓ Germany
- ✓ United Kingdom of Great Britain and Northern Ireland
- ✓ France
- ✓ Canada
- ✓ Australia
- ✓ Spain

As of 4 March 2016, 74 of the 117 (63%) designated national authorities had completed and submitted a report.



Health workforce development and health systems sustainability is at the core of the Code.

The Code:



discourages active recruitment from countries with critical health workforce shortages

encourages countries to develop sustainable health systems that, where possible, allow, as far as possible, for domestic health services demand to be met by domestic human resources

focuses on policies and incentives which support the retention of health workers in underserved areas

emphasizes the importance of a multi-sectoral approach in addressing the issue

## IMPLEMENTATION OF THE CODE

The Code applies to both Member States and all relevant stakeholders. Both are called upon to implement the recommendations of the Code and report back every three years.

Of the submitted reports:



**70%** of Member States reported that migrant health personnel enjoy the same legal rights and responsibilities as domestically trained health personnel (Article 4)



**24%** of Member States reporting are considering action to introduce changes to laws/policies which conform with Code recommendations (Article 8)



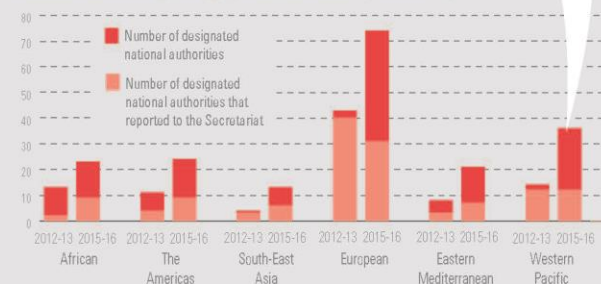
**67%** of countries are undertaking measures to educate, retain and sustain domestic health workforce (Article 5)



**58%** of countries are adopting measures to address geographical mal-distribution and improve retention in underserved areas (Article 5)

## PROGRESS BY REGION\*

First round of reporting by Member States (2012-2013) v. Second round of reporting by Member States (2015-2016)\*



## CHALLENGES

Reported by Member States in the second round

### AT THE NATIONAL LEVEL



incorporating the Code's provisions into national legislation and regulations



strengthening regulation



promoting intersectoral collaboration

### AT THE REGIONAL AND GLOBAL LEVELS



establishing a link between the regulations that have been put in place to guide their work at the national level and those that form part of bilateral agreements

### POOR QUALITY OF DATA



need to build capacities to standardize, collect and exchange mobility data



effective monitoring of the implementation and impact of the Code

## STRATEGY

Global strategy on human resources for health: workforce 2030

Member States have reported on their needs to integrate the Code implementation and its monitoring with broader national health workforce analysis and planning.

The draft global strategy on human resources for health: workforce 2030 reaffirms the need to utilize the principles and articles of the Code to inform solutions on health professional migration and ensure consistency with ILO's minimum standards for 'decent work'.



# Recommendations



- Given the plethora of activities towards the SDGs, the key role of doctors and other health workers:
- Requires continuous dialogue , education and follow up on its benefits
- The AMCOA member countries to adopt and domesticate the WHO CODE on Health Workforce migration;
- AMCOA countries to develop and adopt a Health worker migration protocol.
- AMCOA members country



**ASANTE SANA  
ZIKOMO KWAMBIRI  
THANK YOU**