

**Orientation to social dialogue for countries
participating in the Action Programme on
International Migration of Health Care Workers:
The supply side**

Final report

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1. Introduction and background

The launch of the ILO Action Programme on International Migration of Health Care Workers: The supply side was marked by a tripartite meeting for countries participating in the Action Programme, on 22 March 2006 at the ILO headquarters in Geneva. The Meeting was proposed in order to bring together the six countries nominated by the ILO Governing Body to participate in the Action Programme (hereafter referred to as the AP): Costa Rica, Kenya, Romania, Senegal, Sri Lanka, and Trinidad and Tobago.

All six participating countries attended the Meeting and were represented by tripartite delegations comprised of governments, employers' and workers' representatives. In some cases more than one government ministry or agency was part of the delegation, contributing to a broader debate from different government perspectives (please see the list of participants, Annex 1).

A number of interregional goals had been identified for the meeting:

- provide a common action programme blueprint for all six participating countries;
- share overviews of health care migration in each country with all participants;
- promote the role of social dialogue in addressing health care worker migration; and
- support information-sharing and cooperation among the participating countries.

In addition, key national goals were also set for the meeting, so as to strengthen each country's adherence to the AP:

- encourage coherence and promote coordination among participants from each national delegation;
- identify national opportunities and obstacles in addressing health care worker migration;
- clarify the roles and responsibilities of the key national players;
- establish National Tripartite Steering Committees;
- provide guidance in developing national plans of action; and
- determine appropriate time-tables for execution.

The Meeting was convened by the ILO Sectoral Activities Programme, in partnership with the Human Resources for Health Department, World Health Organization (WHO) and the Migration Health Department, International Organization for Migration (IOM). The Meeting was followed by the IOM Seminar on Migration and Human Resources for Health: From Awareness to Action, which was held on 23-24 March 2006 in Geneva, (in partnership with the ILO and WHO). This larger Seminar, which was part of the IOM series on International Dialogue on Migration, provided the opportunity for the delegations from the AP countries to gather additional information and to form part of a wider debate on the migration of health care workers.

2. Meeting proceedings

In the opening session, representatives of the ILO, WHO, and IOM, as well as the International Organization of Employers (IOE) and Public Services International (PSI) addressed the meeting participants with welcoming words.

Ms. Johanna Walgrave, Director, Social Dialogue, Labour Law, Labour Administration and Sectoral Activities Department at ILO, introduced the tripartite structure of the ILO, a unique characteristic among the United Nations agencies. Social dialogue was a key instrument used for advancing policy development and implementation, starting with information sharing and consultation. Through negotiation, social dialogue led to consensus and agreement among the social partners involved. It constituted not only an instrument but also an attitude to be applied in seeking solutions to challenges. Without information sharing and consultation, and even difficult negotiation, agreements could not be reached. ILO labour standards were examples of such agreements at the international level. With regard to migration she pointed to the collaboration with the ILO Migration Programme and the aim to harmonize the work of the AP within the recently adopted ILO Multilateral Framework on Labour Migration.

Mr. Ibrahim Awad, Director, ILO International Migration Branch, presented the ILO Plan of Action on Labour Migration, which had been adopted at the International Labour Conference in 2004. The Multilateral Framework was created as part of the follow-up to the Plan of Action. It was a unique compilation of principles, guidelines and best practices on labour migration policies. The Multilateral Framework was a non-binding and rights-based framework, and served as a valuable tool kit for countries formulating coherent and comprehensive migration policies, including those in the health sector.

Dr. Barbara Stilwell, Coordinator, WHO Human Resources for Health Department (HRH), welcomed the collaboration between the three organizations as a key component in advancing the work on health worker migration. The year 2006 was important as WHO celebrated the health workforce. The World Health Report was dedicated to the health workforce as was 7 April, World Health Day. Health worker migration was a reflection of the chronic under-funding of the health systems worldwide. After a period of research and information analysis, WHO was keen to move to action in partnership with other organizations. This meeting constituted an important step in learning how to move to action and how to address the very complex issue of health worker migration.

Dr. Danielle Grondin, Director, IOM Health Migration Department, provided a brief overview on the impact of health worker migration for health systems. Health workforce shortages constituted an increasing challenge for host countries and supplying nations, affecting health care providers as well as consumers. Developing partnerships between key players in the fields of health, labour and migration offered the opportunity to join forces in bringing together complementary expertise. This was an important strategy in order to advance the health worker migration issue.

Ms. Genevieve Gencianos, Coordinator, Women and Migration Project, Public Services International (PSI) pointed to the active cooperation between ILO and PSI on the subject of health worker migration and highlighted that PSI fully supported the Action Programme. PSI was in a position to offer punctual and practical support during the AP through their affiliates and regional offices in the field.

Mr. George James, Advisor, International Organization of Employers (IOE) state that the IOE considered labour migration an important issue, especially in view of the loss of skills in health systems, and supported the AP. IOE had also recently increased its collaboration with WHO, especially in the field of HIV/AIDS at work, and with the IOM on the subject of health and migration.

Ms. Susan Maybud, Health Services Specialist, ILO Sectoral Activities Programme, provided an overview of major issues facing the health services sector, especially international health care worker migration, and introduced the AP (please see Annex 2).

The action programme

Background

At its 292nd (March 2005) Session, the Governing Body of the International Labour Office approved the launching of an action programme on "International Migration of Health Service Workers: The supply side" for the 2006-07 biennium. Collaboration with the World Health Organization (WHO) and the International Organization for Migration (IOM) was secured so as to join inter-agency forces in implementing this action programme.

Aim

The overall aim of the action programme is to develop and disseminate strategies and best practices for the management of health worker migration from supplying nations' perspective.

Participating countries

The six participating countries have been identified along the following criteria: geographic and linguistic distribution; scope of health worker migration; impact on the national health system; position in the migration chain – receiving and supplying country; experience in social dialogue; particular issues of interest that merit specific research; and support from ILO, Who and IOM field offices.

The following countries have confirmed their participation: Costa Rica, Kenya, Romania, Senegal, Sri Lanka, and Trinidad and Tobago.

Major areas of action and objectives

(1) Social dialogue and stakeholder involvement

Objective: Establish and facilitate in-country social dialogue which promotes and includes the active participation of women among the government, employer and worker representatives with a view to:

- exploring the effects for health worker migration on national health systems;
- analysing existing migration policies and practices, including strategies for improved retention, with particular attention to women health care workers;
- identifying lessons learnt and best practices in order to develop acceptable policies and guidelines.

(2) Data improvement

Objective: Improve the quality of data on the movement of health workers by:

- supporting countries in developing their own data collection and analysis capacity, disaggregated by sex;
- capturing data related to changes as part of national health information systems; and
- using the findings for gender-friendly policy formulation.

(3) Specific research

Objective: conduct specific research of particular relevance to selected countries in order to assist in social dialogue and policy formulation. Particular attention will be paid to recruitment and retention issues, including strategies for attracting men into this female-dominated sector.

Duration

The action programme will be implemented over a two-year period, 2006-07.

Dr. Johannes Kinfu, WHO HRH Department, underlined the key message "health workers save lives" with global evidence on the role of health workers for population health. He provided information on how to measure the scope and impact of health worker migration by giving examples of potential data sources, such as registers of work permits and professional associations, household and labour surveys, population censuses and records of training institutions and in discussing their potentials and limitations. Possible indicators included inflows and outflows, unemployment of health workers in source countries and financial flows. The role of international organisations was proposed to focus

on the standardization, harmonization and support in the field of data collection as well as the facilitation of trans-national collaboration (please see Annex 3).

Following the presentations, participants were asked to break up into country groups in order to discuss the responses to the short survey they had received prior to the Meeting. The country delegations subsequently presented the national responses to the survey in plenary, generating a lively debate (please see point 3 below and Annex 4).

The afternoon session was dedicated to the development of Plans of Action at the country level. The country delegations discussed concrete objectives and activities to be undertaken as next steps in the action programme. They further identified the responsible stakeholders and established a timeframe for the planned activities. These meetings were considered to be the first National Steering Committee launches of the AP. The country Plans of Action were presented in plenary and discussed with all participants (please see Annex 5).

In the closing session, the participants expressed their positive evaluation of the Meeting. The active commitment of the country delegations and their knowledgeable inputs contributed to informed discussions and provided a promising start of the AP activity phase. The next steps were very much dependent on the national delegations. The actions taken by them after their return would shape the progress of the AP, while taking into account their specific country situations. Delegations were encouraged to turn towards the ILO in case of questions or problems and were assured of the Organization's active support of national activities. The WHO and IOM and PSI representatives reiterated their readiness to provide information and practical support to the delegations through their field offices.

3. Meeting outcomes

Country information – survey responses

Participants had been asked to provide country specific information in response to a short survey that had been distributed prior to the Meeting. The survey addressed three major aspects: data, policies and practice.

Data

Data collection showed similar patterns involving various data sources in the countries. In general, information is mostly partial and data is incomplete. Where data is available it is held by different sources and agencies. In most countries, there is lack of common sharing of the available data between the agencies. While health workforce data is routinely available and mostly held by the ministries of health, other relevant data for health worker migration can be obtained from the following main sources: population census, labour and economic surveys, registries of professional associations and authorities, immigration/emigration data. Major agencies holding such data include Ministries of Health, Ministries of Labour, public statistical offices, immigration/emigration authorities, professional bodies and associations, universities and training institutes. Romania also mentioned recruitment agencies as a potential data source.

Policy

- (1) The overall picture with regard to policies that could potentially impact on health worker migration was quite diverse. While Costa Rica stated that there were no

national policies in this regard, Kenya noted that its national employment policy had facilitated free movement. In Romania, legislation on migration had been developed since the 1990s and was currently in the process of harmonization with EU laws. Sri Lanka remarked that human resource policies such as the opportunity to engage in private practice or a proposed increase in bond fees could have effects on health worker migration.

- (2) Little information was available on the impact of trade agreements. In Costa Rica, discussion turned around multi-lateral and bilateral trade agreements, and a potential negative effect of liberalization on the health labour market was of concern for professional organizations. Kenya mentioned some recent bilateral agreements on health worker migration had been concluded with Namibia and the East African Community.
- (3) All countries provided examples of human resources policies addressing the work environment. Trinidad and Tobago and Romania mentioned general collective agreements. In Costa Rica, Trinidad and Tobago and Senegal there were different employment status and contracting systems. Concern was voiced regarding the increasing flexibility in contracting. Employment conditions were often precarious for nurses in Costa Rica and Trinidad and Tobago. New standards were being developed in Senegal. Kenya and Sri Lanka tried to improve the working conditions in the health sector by salary increases and opportunities to engage in private practice. While training opportunities were one aspect of retention strategies, Kenya stated losing many of its qualified professionals to other occupations and to international migration.
- (4) Country specificities emerged regarding the unemployment of health workers. In Kenya, unemployment among nurses and clinical officers was of major concern. Workforce planning mismatches, recruitment freezes and retrenchment in the public health sector were cited as reasons. In Senegal, unemployment in the health professions was seen as “voluntary unemployment”, reflecting low salaries and poor working conditions; this situation caused shortages in the health services. In Costa Rica, the employment of nurses was not adequately matched to their qualifications (under-utilization) was cause for concern, while unemployed doctors worked in the private sector. Romania reported a low unemployment rate, with primarily new nurse graduates not finding entry-level positions. In Trinidad and Tobago, there was no major unemployment – on the contrary, nurses were recruited from Cuba. In Sri Lanka there was no unemployment as all graduates were absorbed by the health system.

Practice

- (1) Common views surfaced in listing the major stakeholders with an interest in health worker migration. Within governments, all countries named the ministries of health and the ministries of labour as major stakeholders, and most of them also included the ministries of education. Workers’ representatives, employers’ organizations and professional associations were considered primary partners. Additional stakeholders were named in academic institutions (Romania, Trinidad and Tobago), NGOs (Senegal, Kenya, Trinidad and Tobago), the general public (Sri Lanka), recruitment agencies (Romania). The participants agreed that the international organizations had a role to play at the national level as well.
- (2) An active private health sector existed in all countries, but the public-private mix varied. While in Romania the private sector was in early stages representing only a small proportion of health care, in Sri Lanka and in Trinidad and Tobago the private sector constituted 50 per cent of the health sector. In Kenya, 52 per cent of facilities

were publicly run and 48 per cent privately run, and in Costa Rica the public – private mix was 70 to 30 per cent respectively. In Senegal, the private sector proportion in the health sector was 10 per cent.

- (3) There were differences in the public-private mix in terms of the provision of medical education as well. In Costa Rica, one public medical school produced 100 doctors per year, and 7 private schools showed an additional annual output of 400 graduates. In Kenya two public universities educated doctors, while nurses were trained in two public universities and three private institutions. Romania reported 10 universities and 10 colleges for nurses. Many private nursing schools existed in major cities, but the quality of the education was of concern. In Senegal, most of the schools were public, however, one private school for doctors and dentists existed and five private schools for nursing and midwifery. In Sri Lanka, all six medical schools were public, producing 800 doctors per year, and there were 11 public nursing schools. While nurses were also trained in private institutions, those graduates were not registered nurses. In Trinidad& Tobago all medical education was publicly funded.
- (4) The six countries reported private recruitment agencies operating in their countries, but under different regulations. A common trend was increasing recruitment through media advertisement and especially via the internet. In the case of Senegal, there were no private recruitment agencies operating in the country but advertisements were placed in the press by foreign agencies. Similarly, recruitment activities in Trinidad and Tobago were undertaken by foreign agencies not based in the country, running campaigns through the media and sending “scouts” to conduct interviews in hotels. In Sri Lanka, the proportion of health workers recruited by private agencies was small; however, some foreign agencies recruited during temporary visits to the country. In Kenya, private agencies functioned as local representatives for foreign recruitment agencies, and there were a number of foreign agencies recruiting through the media and the internet. In Romania, the case of one private recruitment agency was mentioned, placing 100 nurses annually abroad. Recently the Ministry of Labour had established its own recruitment and placement agency of Romanian workers abroad. In Costa Rica, there were four foreign agencies operating also through press and internet and known to charge fees for preparation and training.

Development of country action plans

The major outcome of the Meeting was the discussion and development of proposals for plans of action by the country delegations. For this purpose a template was provided with a structure for the action plan. Delegates were asked to agree on a limited number of very concrete and practical objectives and break them down into activities (what), indicating also the responsible bodies (who) and the time frame (when). Additional comments completed the action plan structure.

This section provides an overview of the country objectives. The complete plans of action are attached as annex 5.

Action programme objectives of the participating countries

Country	Objectives
Costa Rica	<ol style="list-style-type: none"> (1) Establish a tripartite National Steering Committee in the health sector for managing migration. (2) Realize an inter-sectoral workshop to identify problems related to health worker migration in Costa Rica.

Country	Objectives
	(3) Define an action and intervention platform for the development of health worker migration management policies.
Kenya	(1) Initiate in-country social dialogue. (2) Improve the quality of data on health worker migration. (3) Conduct impact analysis of health worker migration. (4) Development of effective management strategies.
Romania	(1) Encouraging return migration of health care workers by Readapting and recognizing their professional experience abroad. (2) Monitoring of the migrant health workers and their issues in destination countries. (3) Information and advice on migration for health worker candidates.
Senegal	(1) Improved management of health worker flows, internally (rural-urban) and externally (international).
Sri Lanka	(1) Establish a mechanism for a social dialogue between key stakeholders for the action programme. (2) Establish a Management Information System for monitoring of migration of HCWs. (3) Ensure effective international migration of HCW through enhanced social dialogue.
Trinidad and Tobago	(1) Improve the existing data collection mechanisms (2) Promote social dialogue on migration of health workers

Discussion

The broad scope of objectives and activities proposed by the country delegations inspired a spirited discussion among the participants, underlining the complexity of health worker migration as well as its close correlation with working conditions in the respective health systems.

Addressing and advancing health worker migration issues in the countries required the involvement of various stakeholders and an ongoing dialogue between the parties involved. It became clear in the discussion that, for example, at government level different agencies needed to be involved in addition to the ministries of health and ministries of labour, such as the ministries of education, ministries of interior, immigration authorities, or statistical institutes. The delegations demonstrated their recognition of the importance of strengthening social dialogue and building mechanisms for information exchange and consultation in all the national plans of action. All six country delegations also considered the appropriate partners and procedures for their activities, thereby ensuring the legitimate basis for the action programmes.

The scope of measures to be initiated varied between the six countries, reflecting the specific environments and needs that had to be addressed.

Kenya, for example, put a strong emphasis on creating an evidence base, in improving data collection, in reviewing and in analysing the impact of health worker migration on the health system. The delegation noted that at present there was no clear information available in the country. The members were of the opinion that an impact

assessment was important for developing strategies and formulating policies. This approach represented a learning opportunity on how to monitor migration.

Similarly, Sri Lanka reported a scattered data situation with several data sources from which partial information could be obtained. In general, information was difficult to get. As an example, one Sri Lankan delegate mentioned that he had heard about the PSI programme in his country, but it had been impossible for him to get the country report. It was only during the current meeting that he had received it directly from PSI. He pointed out that existing initiatives in his country should be included in the AP, and therefore information flow was very important.

Mr. Piyasiri Wickramasekara, Senior Migration Specialist, ILO International Migration Branch, noted that no country had a perfect information system in tracking migrant workers. Common problems, such as the comparison of data, derived from the fact that different agencies were gathering data using different definitions and methods. Labour supplying countries needed to collaborate with recruiting countries in data collection in order to verify data. He also stressed that information was only available on documented labour migration. Ms. Maybud added that information on migrant health care workers who went abroad on student visas yet worked practically full-time also skewed statistics.

The delegation from Trinidad and Tobago stressed the need to integrate existing initiatives into the AP. In their country, there were no data collection mechanisms in place for specific subjects such as health care worker migration. However, the Ministry of Labour had recently started to build up a national human resource information system. For the objective of improving the data situation they proposed to use this new infrastructure.

The delegation was asked whether they wanted to share the Caribbean experience with their Nurse Retention Programme. The Ministry of Health delegate reported that in her view the programme had been unsuccessful, as not enough nurses had been trained. As a result, the Ministry of Health in Trinidad and Tobago re-launched the programme in order to generate more trained nurses.

The Costa Rican plan of action brought into the discussion the inter-sectoral approach. The delegation planned to organize a workshop in order to better identify the problems related to health care worker migration. The outcomes of the workshop would lead to the development of comprehensive strategies. The aim was to raise awareness on migration issues at high levels in order to garner political will, and to formulate a national policy in order to mitigate the negative effects of migration. Assistance from the PAHO Observatory on HRH in the process would be requested.

The Romanian plan of action focused on the migrant health worker's need for and access to information. One important aspect was the integration of returning migrant health workers into the domestic health labour market. According to the delegation, experience had shown that returnees were re-integrated poorly. It was difficult for them to find jobs that corresponded adequately to their skills and often they were not socially accepted because of their experience abroad. Many gave up and migrated again, which constituted a loss of highly qualified staff. Another issue to monitor was the repatriation of illegal Romanian health care workers from receiving countries who were subsequently forbidden to go abroad again.

Ms. Gencianos highlighted that proper information for migrant health care workers was a crucial component in decision-making and in protecting their rights. A Kenyan delegate added that incomplete or misleading information often caused misunderstandings. For example, information on standards and costs of living in receiving countries was needed in order for migrants to realistically assess proposed salaries.

Dr. Stilwell stated that according to WHO research almost all workers would prefer to stay home if they had proper working and living conditions. WHO was currently looking at the life course of health workers and their needs, such as housing, pensions, etc. These needs would shape the retention strategies. She further recommended the mobilization of the diaspora for temporary return.

Mr. Wickramasekara proposed that rather than temporary return migration there was a need for circulation friendly policies, so that migrant workers could move back and forth. This included the requirement in receiving countries to ease permit restrictions in order to allow the return of the foreign workers.

The Employer delegate from Costa Rica stated that the reinsertion of migrant health care workers was very difficult. This involved the question of trust between the population and the health care worker. Sometimes returning migrant health care workers were not trusted by either colleagues or patients, and this impeded their re-integration into the workforce. Therefore it was important to consider how to encourage migrants' return and what incentives to offer without offending others.

Dr. Davide Mosca, Senior Migration Health Physician, IOM Nairobi, said that the success of reintegration would reflect the history of what had brought a person to migrate. The retention of qualified people was also a crucial aspect in managing health worker migration.

The Senegalese delegation proposed that a networking mechanism among the AP participants be set up in order to further exchange information and experiences beyond the current meeting and for easier access to good practice examples.

Consideration of important issues and suggestions for the way ahead were noted in order to map the next the steps both at national and international levels.

Annex 1

List of participants

Liste des participants

Lista de participantes

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