Commonwealth Secretariat

Commonwealth Foundation

CMA COMMONWEALTH MEDICAL ASSOCIATION

COMMONWEALTH MEDICAL ASSOCIATION

A Report On

Commonwealth Asia Symposium

On the theme

"Migration of Health Workers"

Atrium Hotel, Faridabad, New Delhi, India

November 16-18, 2008

The Commonwealth Foundation

The Commonwealth Foundation is an intergovernmental organisation, resourced by and reporting to Commonwealth governments. Established in 1965, the membership of the Foundation is open to all members of the Commonwealth. The Foundation's mandate is to strengthen civil society in the achievement of Commonwealth priorities namely; democracy and good governance, respect for human rights and gender equality, poverty eradication and sustainable, people-centered development, and to promote the arts and culture of its peoples.

Commonwealth Medical Association

The Commonwealth Medical Association was established on 1969. The role of the Association is to promote, assist, and strengthen the capacities of the composite national medical associations of countries within the Commonwealth and provide leadership and services for the benefit of the health and welfare of the people within the Commonwealth. The CMA is an independent civil society organization associated with national medical associations of countries within the Commonwealth as its members. It is governed by the Council of the Association. The Association is administered by the Executive guided by the decisions of the Council and it is committed to an open and transparent relationship with its stakeholders. In carrying out its constitutional mandate the Executive works closely with a diverse group of people and organizations including other health professionals and social services providers, private and voluntary providers nationally and internationally. The Commonwealth Secretariat and its funding agency, the Commonwealth Foundation remain the key stakeholders

Background

Recent trends in the international migration of health workers have resulted in a greatly uneven distribution of health workers. Limited domestic health workforce planning and the unregulated international recruitment of health workers are key causal factors. National, regional and now global policy responses to international migration of health workers have included the introduction of policy instruments such as codes of practice for the international recruitment of health workers which seek to balance the interests and rights of all actors – source countries, destination countries and migrants.

The Commonwealth Code of Practice for the International Recruitment of Health Workers, introduced in 2003, was the first policy instrument of its type, and a forerunner for the World Health Organisation's Global Code which is currently in development. Given the diversity of Commonwealth membership – encompassing high income, low income, source and destination countries, it can be viewed as a microcosm of global society, and therefore parallels in the development and implementation of the Commonwealth Code and the Global Code can be expected.

The introduction of codes of practice has not been without criticism, or problems. Given the ongoing process of developing the Global Code it is timely to consider the concerns

surrounding existing codes to inform discussions on the development of the Global Code to ensure that this latest policy instrument builds on the experiences of its predecessors.

About the Symposium

The symposium was funded by the Commonwealth Foundation and organised in partnership with the Commonwealth Medical Association as the main executing agency. It was held from November 16-18, 2008 at the Hotel Atrium, Faridabad – New Delhi, India. Commonwealth health professional associations for medicine, pharmacy, nursing, dentistry, mental health, the handicapped and developmental disabilities were represented by member associations from India, Sri Lanka, Pakistan, Bangladesh and Malaysia. Representatives from the Ministry of Health and Family Welfare, India, World Health Organization, Indira Ghandi National Open University of India, Centre for Trade & Development, India were among other participants. The symposium discussed issues relating to migration of health workers in the commonwealth countries, its impact on the health care systems of the source and destination countries and to make relevant recommendations to address the challenges and problems due to such migration.

Aim

The symposium aimed at developing recommendations to the Council of health ministers of member states of the Commonwealth based on the framework of the W.H.O Code of practice being developed for the migration and international recruitment of health workers**.**

Objective

The core objectives were to;

1. Address the issues relating to migration of health workers in the Commonwealth countries,
2. Assess the challenges and impact on the individuals and health care systems of the source and destination countries within the existing system of Migration and
3. Make relevant recommendations to address the challenges and problems due to such migration.

Participation

Participation in the important symposium included representatives from all major Commonwealth civil society or professional associations concerned with health issues. Also present were representatives of the Commonwealth Foundation, Commonwealth Secretariat and other health institutions. See Appendix A for the full list.

Programme

The symposium was held over two days from, November 18-19, 2008 with the residential participants arriving a day earlier. See Appendix B for the detail programme.

Day One; Monday, November 17, 2008

Welcome Address; Dr. S. Arulrhaj, President, Commonwealth Medical Association
Dr Arulrhaj in his welcome address highlighted the aim of the symposium **"Development of Recommendations to the council of health ministers of member states of the Commonwealth based on W.H.O Code of practice for the migration and international recruitment of health workers".**
He stated that among the member states, the issue of health workers migration from Africa and Asia is critical with the ever widening gap between supply and demand. According to Dr Arulrhaj, it is imperative that the participants focused on the following;

- Reasons for migration
- Existing codes of practice
- Crisis is in the quality of services
- Vital strategies that can help attain the millennium development goals

Opening Remarks - Dr. Elizabeth Marsh, Senior Programme Manager, Commonwealth Foundation

Dr. Marsh in her remarks to officially open the symposium briefed participants on the status of migration of health workers in the commonwealth.
She stated that as per WHO statistics over 4 million health workers are needed to address the issue of shortages within Commonwealth countries. Dr Marsh disclosed that Africa which accounted for 63% of global shortages leads in the gravity of the situation that calls for immediate crisis management as a matter of urgency before the damage and decimation resulting from this became almost irreparable.
She appreciated the overall representation of NGOs at the Symposium and said it provided a real opportunity to effectively address the objectives of the symposium.

Presentations;

1. "Health Workforce Migration in the Commonwealth"

Ms Peggy Vidot, (Health Adviser, Commonwealth Secretariat)

Ms. Vidot stated that delivery of quality healthcare services is an increasing challenge in both developing and developed countries. She disclosed that in the last three decades, migrant population has doubled of which 49% are females.

The acute shortage phenomenon as described above calls for increased density of healthcare professionals if the millennium development goals are to be achieved.

She indicated that though interventions at different levels are a must, the real need is a global approach for synergy and cooperation.

Of the total shortage – *2.9* are healthcare givers and 1.9 support staff

In the commonwealth countries, migration is a critical problem for small states with low density of healthcare workers.

Ms Vidot spoke of the imbalance between the push and the pull factors influencing the problem

Push Factors: Difficult working Conditions, Diminished opportunities for professional advancement, Poor salaries, Impact of HIV/AIDS, Personal security (conflicts) and Economic instability

Pull Factors: Improved working Conditions, Opportunities for professional development, Better incomes, Better career prospects and Personal safety

Summary of Discussion and Remarks on Ms Vidot's Presentation

***** There is little information available regarding Dental schools in India and most other developing countries that adversely affect the corrective actions of planning to meet the demand.

***** In India, despite the presence of 284 medical schools producing around 31,000 new doctors yearly, the number still remains short of requirements on account of a) Migration and b) higher numbers needed in chronically deprived specialties and geographical areas.

* The above data also include the training of a large number of medical Professionals for other countries. This accounts for 15% of medical school admissions each year.

***** India still has the problem of not having appropriate and official channel or process for health workers wanting to migrate and thus complicates finding solution for the problem.

***** Among other reasons, in Ghana some migrate because they want to get married to loved ones who are already migrated.

***** It was noted that migration started from India, Pakistan, Bangladesh and Nepal in large numbers and this migration of doctors has been likened to a global conveyor belt. Amazingly, it has been described that there is one Indian Doctor for every 1325 Americans in USA as compared to one Indian doctor in India for over 2400 of the population in India.

* Despite the challenges India has the largest number of healthcare workers in the region and it also attracts lots of patients from overseas.

* Migration from government health services to the private sector within a country is a major issue coupled with migration to non-health sectors of the economy.
* There is also the concern for the sudden increase in the number of medical schools with the increased risk of compromising the quality of training.

* It was agreed that migration as a challenge to availability and quality of health services is only the tip of the ice-berg; it is more of a symptom of greater malaise of the healthcare system namely bad local and socio-cultural issues, poor resource allocation, poor incentives.

2. **Cluster Focal Point Health System Development**
   - **Presentation by Dr. Sunil Nandraj** WHO,-India.

Dr.Sunil Nandraj stated that on one hand there is a shortage of nurses, doctors etc while on the other hand there is the fact of brain gain from those who migrate to improve their knowledge and skill to return. He emphasized on the need for a formal, reasonable and effective management of migration. He said the effects of migration depended on the needs of a country and the roles of the available skills.

"The loss of human resources through migration of professional health staff to developed countries usually results in a loss of capacity of health systems in developing countries to deliver health care equitably".
Relativities- 50 nurses from Malawi to UK; this is about half the annual number trained in the country
Skills- A National quality assurance coordinator in a sub Saharan African country becomes a clinical staff nurse in Manchester.

Why the migration? Poor countries have a rather high rate of migration of nurses, majority of whom are females and they migrate for very varied reasons. In India there are some hurdles that professionals face such as recognition of degrees. There is also the paradox of statistical and health workers distribution inadequacies and while the country produces over 30,000 doctors annually, it is unable to employ them all.
Health workers will continue to be interested in crossing national borders to access the "pull" factors which may include better remuneration, professional development and enhanced career opportunities, or the opportunity to experience life and work in a different culture.
The major cause of the current relatively high level of migration is workforce shortages in developed countries, combined with the existence of "push" factors of low remuneration, poor career prospects, unsafe work environments and political instability in some developing countries.
The migration of health workers is often a symptom of more deep-seated problems in country's workforce imbalances in the labour markets.

Summary of Discussion:

* Despite improved HR capability in India few years ago, the current situation with the mushrooming of institutions indicates that by 2012 the required numbers could be

achieved. However the quality of the products may be compromised and this calls for effective regulation and monitoring.

* The migration of nurses is a symptom of deep seated socio-economic problem in each country. For most developing countries there is no reliable data. The cause is not always poor remuneration but also due to problems with recognition, career progression opportunities and specialization.

* In some cases degrees and other qualifications are recognized on bilateral agreements and such arrangements may compromise the rights and negotiating power of the migrants involved.

* The migration from Government to private medical colleges due to higher salary attractions may adversely affect tuition in state institutions.

* The variation between countries and regions leads to difficulty and different national responses. Commonwealth Asia has a relatively better outlook of healthcare workers as compared to Africa.

3. **The Status of Female Health Workers in Asia**
    - **Jill Iliffe** Executive Secretary, Commonwealth Nurses Federation.
    -

Jill Iliffe started with a note;
The world has 191 million migrants – half of them are female. More are in developed countries.

WHY WOMEN?
Women are unfortunately more vulnerable with less power and more likely to be subject to intimidation and violence. They are more likely to be subject to sexual exploitation, attracted to particular type of work, unskilled and semi-skilled such as in health care, domestic work, garment and textile industries, responsibilities for bearing and rearing children and caring for older family members.
She intimated that there is an urgent need for Governments to act swiftly by;

- ratifying relevant UN Protocols and Conventions
- implementing accurate data collection measures
- increasing expenditure on anti trafficking and labour exploitation strategies and
- increasing the criminal penalties for labour exploitation.

Summary of Discussion
* There is a growing complexity in the migrating of nurses; from USA to Australia, from the UK and Ireland for adventure and also from other regions for further education.

* In the areas of funding of training institutions and maintenance of trained personnel in developed countries, it is becoming increasingly clear that over time, these are gradually

dwindling in terms of national resource allocation. Unethical recruitment was rather encouraged, covertly and overtly.

* The issue of regional imbalances; equal work and unequal pay. For example in the EU.

* All countries confronted with the challenge should consider having regulatory bodies with transitional agreement programmes.

* In some cases quick transfers of nurses, doctors without adequate planning tend to become a disincentive to either learning or professional satisfaction or both.

* Endemic migration from government to private sector of both the trainee and the trainers with respect to nursing has taken a heavy toll on proper distribution of health workers in many developing countries.

* In Pakistan similar problems have been controlled by regulatory bodies at federal level to manage the training and movement of personnel.

* Career progression opportunities should be actively developed to act as incentive against migration to other country.

* Skill training and knowledge development of nurses should be considered as vital instruments to enable nurses contribute more effectively in the health care team and also a critical means of earning respect and the appropriate recognition in their countries and among other professionals.

PANEL DISCUSSION- Chaired by Prof. Bimla Kapoor.

The Panel discussion started with presentation/comments by each panelist

A. Health Workers Migration and Unethical Recruitment

Most health workers migrating end up being recruited into jobs much lower their qualifications. Generally, temporary engagement of physicians is useful. Adequate number of physicians is a requirement in improving and maintaining standards of health services therefore there is the need for adequate projections.

The flow of international migration of physicians is generally from poorer to wealthier countries. The poorer countries bear the expense of educating the migrating physicians and receive no recompense from the beneficiary countries.

Every country should do its utmost to educate an adequate number of physicians, taking into account its needs and resources. A country should not rely on immigration from other countries to meet its need for physicians.

B. **Migration of Pharmacists**

-**Ms. Manjiri S. Gharat,** Commonwealth Pharmacists Association -CPA)

The United States of America was the most common destination country with 14% of overseas pharmacists, half of which are working in industry or academia where formal board registration is not required.

United kingdom:

Year	2001	2002	2003	2004
Foreign Pharmacists	554	741	777	655
New Graduates	1302	1643	1671	1722

The number of pharmacists migrating to the United Kingdom has increased since 2000. The migrating pharmacists are mainly from Zimbabwe, New Zealand, Australia, Ghana, Spain, Nigeria and Ireland. What is unknown is whether the migration is temporary or permanent. For most pharmacists registering in the United Kingdom from New Zealand and Australia, it is suspected to be temporary. The effect on these source countries may not be as great compared with countries where migration is more likely to be permanent, such as Zimbabwe, Ghana.

Ireland: Foreign pharmacists constitute almost half of the number of registered pharmacists in the country. At the same time, Ireland loses a significant proportion of its workforce to migration each year. Between 2001 and 2005, the number of pharmacists from Ireland that registered in the United Kingdom was 113 constituting over a third of the number graduating in the same period.

Ireland thus represents both a source country as well as receiving country

Dr. Vijay Prakash Mathur

Dental auxiliaries and dentists – Among these cadres a major issue of concern is lack of job satisfaction; the technology they have learnt in their graduation and post graduation is most often not available for their work. In some countries such as India, infection control protocols are not being followed and there is general lack of supplies.

Unethical Issues– These dental qualifications are not recognized in developed countries and this leads to different levels of appointment resulting in unequal pay for equal work. Non EU workers get lower pay.

Racial Bias: There is racist bias for Indian and other foreign doctors going for lower consultation charges.

Training fee is different for citizens from Asian countries. For the professional qualifying exams, the fee is very high and the pass percentage is higher for migrants.

Ms Susie Kong, Singapore Nursing Association

Ms Kong gave an outline of the experiences of nurses who had migrated to developed countries especially the UK. She said the Association was in the process of collating information on working conditions for migrant nurses from Singapore and accordingly adopt a white paper suggesting remedial measures.

Dr. Srajul Islam, Medical Association of Pakistan

He disclosed that there is a discrepancy in the number of doctors produced as against those the country could employ. This has led to a situation of having significant unemployment of health workers though staffing of health institutions is inadequate. There is also the challenge of what he called 'fungal' growth of health institutions affecting the quality of the graduates. Most of them are targeted to migrate to 'greener pastures'. The UK alone is noted to be deficient of 4700 doctors and especially in the anesthetist, radiology and psychiatry faculties. This has led to unethical recruitment from Pakistan which produces 4000 doctors a year.

Summary of Discussion

* The UK immigration laws are targeted for south Asian immigrants as EU country migrants like those from Poland are easier to immigrate.
* Incentives to doctors and other professionals in rural areas are now being made mandatory to curb migration. Pakistan produces 1000 nurses per annum but 500 migrate annually as some remain unemployed.
* A lot of the issues are addressed by the existing code(s) and it is important professional associations highlight these to their membership.
* ASEAN countries plan to adopt a protocol in 2015 to opening up and allow free movement of manpower professionals.
* Currently, countries in ASEAN have their own restrictions, though they have signed a mutual agreement to enhance the free movement of professionals.
* Support to allow free movement of people through trade is under discussion in Australia. Though there is a need for individual legislation from countries. Language can be a useful barrier.
* The regulation of migration is a necessity if the world was a good chance to achieve the millennium development goals on health. Unethical recruitment is a major danger.
* It is important to stress that for most situations today a lot of professionals are beginning to realize how much they have lost and continue to lose socially through migration- detachment from family relations, broken marriages, bringing up of children in different environments. Therefore some significant positive changes in other push factors have a huge potential to stem the tide.
* In India owing to the fact that availability of doctors is not a major problem nothing much has been done to stop the migration.
* Developing countries must critically examine the push factors with particular attention to country-specific challenges such as; HR management issues, incentive packages generally and those specifically targeted at positively influencing redistribution of personnel to serve in critical and needy communities or regions.
* Politicians have to be lobbied and influenced by the professional associations and not the secretariat and foundation.

Remarks for adjournment by Dr. Arulrhaj, CMA President

Migration, whether domestic or international is a Human rights issue. It calls for a concerted effort at the global level to regularize the phenomenon with a view to checking the imbalances of Surplus and Shortage, Usage and exploitation, and universal curriculum for global recognition of a minimum standard of training and knowledge.
Migration with respect to Physicians and Nurses remains critical while that of pharmacists is either less or not officially documented.
Migration being a basic human right can not be banned however conducive conditions leading to utilization of potential and appropriate human resource would be in the right direction.

Day Two: Tuesday, November 18, 2008

"The Commonwealth Code of Practice for International Recruitment of Health Workers" Presentation by **Ms. Peggy Vidot**

Adopted in 2003, it is the first multilateral political agreement: CW as a 'safe political space' for 53 source/destination countries to negotiate contentious issues, not legally binding and discourages migration/targeted recruitment from vulnerable countries with

shortages. It's not about migration or country bans; it supports retention and returns policies and effective workforce planning and safeguard the rights of migrating health workers, and promote professional practice conditions. It is also about the set of codified principles for international recruitment of health workers. The Code contains guidelines for ethical recruitment of health workers.
The code is a policy option for addressing unethical recruitment of health workers; it looks at supporting retention policy and return policy. Ethical recruitments talks of acceptable recruitment practice. Not targeted active recruitment. It requires a balancing act.
She spoke on accountability among all stakeholders; according to Ms Peggy recruiters must provide information to potential recruits – contractual requirements, nature and requirements of jobs, country conditions, their rights.
She further added the mutuality of benefits to both source and recipient countries as a result of migration and that is possible only if a mutually agreed code is adopted. Codes are instruments which need to be operationalised. Their effectiveness will depend on how it is done.

Summary of Discussion
* On the question of compensation a lot of doctors migrate to western countries. USA have 50,000 Indian Doctors and for educating them the Govt. had to spend about 10.5 Billion USD. Will the USA compensate this amount of money to the Indian Govt. and therefore this is an example that migration in general is not mutually beneficial.

* Sri Lanka has established a Government Agency for migration of health workers with an objective of facilitating the migrant, the basic human rights.

* The document of code of conduct of migration is more for moral policing rather than having binding principles. Migration will take place as said and interference with migration will actually be interference on human rights. To speak of vulnerable countries with shortage of healthcare personnel, migration may lead to depletion of health workers in those countries to a great extent. On the other hand surplus health workers in some countries are a misnomer.

* Who monitors how to monitor? It may be better for Commonwealth organizations such civil society bodies to do the monitoring since Ministers will come and go.

* Professional associations / universities should have a migration checklist and code on their websites.

* The code and the companion has been adopted in May 2003 by all Commonwealth countries, but still it has not been effectively implemented or executed in real terms by most of the Commonwealth countries. Is there any attempt on Commonwealth Foundation / Commonwealth secretariat or by the Commonwealth Medical Association to monitor the implementation? Can this be a part of the review meeting during the WHA May 2009?

* Mechanism for monitoring the effectiveness of code must be defined as there is no coordinated group that looks into the monitoring. The Sri Lanka example is good.

* Nurses recruitment is still unethical – Some agencies keep the certificates of nurses till they pass the exam and that is what, at times leads to exploitation.
* If there are codes that have shortcomings in terms of effectiveness, then professional associations have to take the initiative. Diverse needs of different commonwealth countries – each country will implement it differently. Whose responsibility is to monitor the code? Countries need to develop Good HR plan for health workers as also draft bilateral agreement. Professional associations should provide information to potential migrants on their websites.

* Issue of compensation – contentious issue and needs to be discussed by professional associations with their governments.

The session continued with **Small Group Discussions on**

- Suggestions on Global Code
- Recruitment practices
- WHO code of Practice

The outcome of the discussions were

Group A
Suggestions on Global Code

- There is the need to form a Commonwealth Health Alliance to have a strong advocacy on this and other related issues.

- Each professional association should adopt a resolution condemning unethical recruitment.

- Migration checklist should be made available on websites – e-journal or journal

Group B
Recruitment practices

- Mechanism of providing information to migrant health workers must be made available on websites of associations

- Before migrating, health workers must be given copies of existing codes.

- There should be transparency in recruitment practices.

- If healthcare workers take a lower job, should that be allowed in the codes?

- Practicality of implementation of the codes is different in different member states

- There must be a Complaint mechanism
- There should be Institutions to coordinate for both recipient and source country.

- National Health workforce Sustainability

  - There should be strategies to attract and keep HCW in their jobs.

  - Governments should be encouraged to play an increasing role in ensuring effective measures are in place.

- Data gathering and research
  - Recipient and donor countries to provide for monitoring of HCW
  - The challenge is on collecting information at country level
  - Emphasis on workforce planning
- Information exchange
  - It should be mandatory for countries to give data update on flow of HCW.
  - Facts and figures to be made available yearly
  - Establish database or register
- Implementation of code
  - Code is not legal
  - There is the need for strategies to regulate recruiting agencies.

Group C

The WHO Code of Practice

- The WHO code of practice is a comprehensive document hence calls for implementation in totality
- Recruitment based on principles of transparency, fairness and mutuality of benefits
- Information gathering, monitoring and dissemination to be mandatory and not voluntary
- Associations should be mandated to address the issue related to transparency

•

Following the group presentations the meeting debated and resolved as follows;

- **There is a strong need for all five different Commonwealth bodies related to health workers to work on a common platform and present a cohesive group for a strong and emphatic voice for the relevant Ministries to accept and implement**

Second Group Discussions

The Second group discussion was on Fair Recruitment Practices which was conducted with two group discussion on Fair Recruitment Practices for;
Health Professionals- (Pre-Recruitment/Post Requirements)
Donor Country /Government

The outcome of the discussion were

Group A
In their discussion on Health Professionals recruitment the group categorized the issue into
Health Professionals-Individuals (Pre-Recruitment/Post Requirements)
Health Professionals-Professional Association (Pre-Recruitment/Post Requirements)

1. Health Professionals-Individuals
a. Pre-Recruitment Requirements shall include the consideration of
Language
Culture
Standards
Registered/Non Registered
Comprehensive Information
Meets contractual arrangements in own country
Memorandum of Understanding (reciprocal agreement between source and recipient countries)
Regulatory framework for recruiting agency

b. Post-Recruitment
Orientation and support, mentoring, supervision
Social support for integration
Same employment conditions and legislation
Access to further education
Grievance process

Safe working environment
Freedom of association

2. Health Professional Association
a. Pre-recruitment
Lobbying Government
Memorandum of Understanding with relevant agencies and stakeholders
Pursue regulatory Framework
Provide information to potential migrants
Alliances with other professional associations

b. Post – Recruitment
Monitoring
Professional associations in recruiting country to reach out to migrant workers

HCW Migration Process Cycle

1. Recruitment
2. Decision Making
3. Pre Departure
4. Departure
5. Arrival
6. Employment
7. Integration – Return - Reintegration

Group B
Fair recruitment practices – Donor Country

Discussions focused on the role and actions at the Government and Private sector level.

Government:
Show sensitivity towards migrating HW issues
Should adopt adequate manpower planning
Establish monitoring agency
Ensure returns with respect
Transparency of the recruitment procedures
Ensure equality, Protection and Fairness of Migrants
Wages – Minimum & Gold Standard
Encourage professional associations to represent interest of migrating Health workers.

Private Sector and recruiting agencies
All should work within regulatory framework
Should be registered
Ensure defined grievance handling mechanism
Ensure transitional developmental or training programs
Draft a document related to responsibilities and liabilities of agencies.

RETENTION STRATEGIES

There were four case presentations on retention strategies that have been executed and in some cases with evaluations conducted. The presentations were made by;

1. Dr. Oheneba Owusu-Danso, Commonwealth Medical Association
2. Ms. Chinta Abayawardana, Commonwealth Pharmacists Association
3. Dr. Suresh Shanmuganathan, Commonwealth Dental Association
4. Ms. Ramziah Bt Ahmed, Commonwealth Nurses Federation

The full text of each presentation is attached/submitted.

Afterwards the session broke into three groups to discuss retention strategies to form broad guidelines which could be adopted and adapted by Professional Associations and Countries.

Group A

- There is the need to have reliable database on the extent of migration and its implications for the health services system of the source country.
-
- Strengthening the health services system through proper planning, adequate budget allocation, incentives and proper promotional strategies for the workforce etc.
- Compulsory rural service for professionals for getting registration and with appropriate remuneration for such services
- Measures should be taken to ensure efficient management of human resources and this shall include; in-service training, prompt appraisal and promotion of staff, incentive packages.
- Ensuring adequate staff availability
- Effective migration management policies shall make all the difference to the quality of migration and impact thereof on both donor and recipient countries.
- Generally, the problems vary for countries and thus recommended measures should be adapted appropriately.

Group B

- The associations should sustain advocacy on the Commonwealth to continuously commit to work on the retention strategies.
- It is essential for the different associations to provide effective leadership and form strong alliance to lobby their Governments.
- Professional Associations should consider specific interventions to improve the circumstances of their membership as exemplified by the Ghana Medical Association; Pension Fund Scheme, Hire Purchase Car Facility with Government Guarantee, Continuing Professional Development Programmes.
- Websites, newsletters, career guidance seminars should be targeted as important sources of reliable information knowledge for future migrants.

Group C

Retention strategies to be adopted for health professionals must be evidence based and these include work of the following:

1. Exiting health professionals – what will keep them in their service or profession
2. Migrant workers – what will keep them to stay on or renew their contract

3. Those who migrate from health to the non-health sectors– how to bring them back.

There is the need to research on all these categories, as stated above and the results analysed thoroughly. The outcomes shall be implemented accordingly.

Adoption of recommendations

After an interesting debate following the presentation by a special team the symposium concluded with the adoption of the following recommendations;

Recommendations and The Way Forward

- That the Symposium recommends to the Commonwealth Health Professional Associations that they take an active role in disseminating the Commonwealth Code of Practice for the International Recruitment of Health Workers and in the development of the WHO Code of Practice on the International Recruitment of Health Personnel.

- That the Symposium recommends to the Commonwealth Health Professional Associations that they form an alliance of Commonwealth Health Professional Associations in order to have a strong and united voice at the Commonwealth level on issues of mutual interest and concern.

- That the Symposium recommends to the Commonwealth Foundation and the Commonwealth Secretariat that research be commissioned to collect data on the extent of health professional migration in Commonwealth countries and include research on the experience of and outcomes for health professionals who have migrated and the impact of migration of health workers on health outcomes for countries.

- That the Symposium recommends to the Commonwealth Health Professional Associations that they take a supportive role in providing appropriate information to their members who may be considering migration around the migration process so they are in a better position to make an informed decision and take responsibility for the commitments made and the decisions taken

- That the Symposium recommends to the Commonwealth Health Professional Associations that they urge the governments through CHOGM to cooperate with and engage with the health professional associations of their countries in addressing the challenges posed by health professional migration.

- That the Symposium recommends to the Commonwealth Foundation and the Commonwealth Secretariat that research is commissioned across the

Commonwealth targeted toward health professionals currently in health systems; health professionals who have left health systems (public to private or left altogether); and migrant health professionals; to provide evidence for the development of effective retention strategies to inform best practice.

Concluding Remarks

The President of CMA, Dr S. Arulrhaj, expressed his deep appreciation to the Commonwealth Foundation for hosting such important conference, the topic for which he said was very crucial for developing Commonwealth countries. He congratulated all participants for their intellectual debates and analyses which he said contributed in making the symposium a huge success. He disclosed that the Commonwealth Foundation through its senior programme officer, Dr Elizabeth Marsh, has indicated that a similar symposium for the Africa region would be held in the first quarter of 2009.

Appendix A: List of Participants

Commonwealth Foundation

Dr. Elizabeth Marsh, Senior Programme Manager

Commonwealth Secretariat

Ms. Peggy Vidot, Health Adviser
Ms. Victoria Hall, Research Assistant

Civil Society Representatives

Commonwealth Medical Association

1. **Dr.Sundaram Arulrhaj MD.**
   President
   Commonwealth Medical Association
   Sundaram Arulrhaj Hospitals.
   145/5B, Jeyaraj Road,
   Tuticorin - 628 002 Tamilnadu, India
   Tel : -91-0461-2322661/2320061 Fax : -91-0461-2338661
   M : +91-9994580001
   Email : drarulrhaj@gmail.com, drarulrhaj.cma.uk@gmail.com

2. **Dr. Oheneba Owusu-Danso**
   Secretary
   Commonwealth Medical Association
   Buhrfeindhaus
   Elise-Averdieck Strasse 17

27356 Rotenburg (Wumme)
Germany
Tel: +49 426 177 3643
M : +49 152 2795 5905
Email : oheneba111@yahoo.com ; ooheneba @hotmail.com

3. **Dr. N. Arumugam**
Vice-President for S. E. Asia Region
Commonwealth Medical Association
Malaysia
Email: aarrum.n@gmail.com

4. **Dr. A. Pubudu de Silva**
Sri Lanka Medical Association
Mobile- 94- 0718150908
e-mail- pubsy@sltnet.ik

Commonwealth Nurses Federation (CNF)

1. **Ms. Jill Iliffe**
Commonwealth Nurses Federation
Royal College of Nursing
20 Cavendish Square
London W1G ORN
Tel: + 44 438 647 252
Email: jill@commonwealthnurses.org

2. **Ms Irshad Begum**
Director General Nursing, Punjab
Directorate of Nursing,
24 Cooper Road
Lahore, Pakistan
Fax: + 92 042 9200966
Email: dgnpunjab@gmail.com

3. **Ms Ramziah Bt Ahmad**
President, Malaysian Nurses Association
GPO Box 11737
Kuala Lumpur 50756
Malaysia
Tel: + 60 3 7957 6173
Email: mramziah@yahoo.com

4. **Ms Susie Kong**
Immediate Past General Secretary
Singapore Nurses Association
Unit A 4-6 Jalan Desa Bakti 2
1 Desa Residence, Taman Danau Desa

Kuala Lumpur 58100
Malaysia
Tel: + 60 6 017 632 3282
Email: susie.kong1@gmail.com

5. **Dr.W.A. Keerthiranthne Podimahathmaya**
285/3, Kanatta Road
Boralugoda
Athurugiriya
Colombo, Sri Lanka
Tel: + 94 11 256 1029
Email: kwanasekara@yahoo.com

Commonwealth Pharmacists Association (CPA)

1. **Ms. Chinta Abayawardana**
370/1, Ahugammana, Demalagama
Sri Lanka
Telephone: +94-11-2402518 /2402843
Mobile: +94-777-656133
E mail: chinta@whosrilanka.org

2. **Mrs. Manjiri S. Gharat**
Vice- Principal
K.M.Kundnani Pharmacy Polytechnic
Ulhasnagar-3
Maharashtra, India ,
Phone: +91 251 2554163
Email: symghar@yahoo.com

Commonwealth Dental Association (CDA)

1. **Datin Dr Norain Abu Talib**
Malaysian Ministry of Health
Blok E1, E6, E7, E10, Komplex E
Pusat Pentadbiran Kerajaan Persekutuan
Putrajaya 62590,
Malaysia
Telephone: +603 8883 3888
Email: drnorain@moh.gov.my

2. **Dr. Ayyaz Ali Khan**
Pakistan Dental Association
PDA Headquarter, Surgimed Hospital
1-Zafar Ali Road
Lahore 54000
Pakistan

Telephone: +92-42-5714411
Email: ayyaz@riphah.edu.pk

3. **Dr. Vijay Prakash Mathur**
Assistant Professor
Pedodontics and Preventive Dentistry
Centre for Dental Education and Research
R. No. 4055, Teaching Block
All India Institute of Medical Sciences
New Delhi 110029, India

4. **Dr. Suresh Shanmuganathan**
38 Beddagana Road,
Pitta Kotte, Sri Lanka
Mobile: +94 77 7774764
Telephone: +94 11 2883337
Email: suresh1965@hotmail.com

Commonwealth Association of Mental, Handicap and Developmental Disabilities (CAMHADD)

1. **Dr. Uday Bodhankar**
Secretary General CAMHADD UK
Ramdaspeth,Nagpur. 440012 M.S, INDIA
Telephone: +91- 712- 2425020 / 2445554 (R)
+91 -712- 2459090 / 2422505 (H)
Fax : +91- 712- 2428145 \ 2421017
Email : ubodhankar@hotmail.com

2. **Dr. Sirajul Islam**
President CAMHADD
6 Green Square,
9/2 Green Road,
Dhaka 1205,
Bangladesh
Telephone. +88-02-9668448
Mobile: +88-01819220580
Email - msiraj46@gmail.com

Other Delegates

1. **Mrs. Sheila Seda**
Secretary General
L-17 Safdarjung Enclave
New Delhi- 110016
Tel- +91 26566665 / 262534765
Mob: +91 981862445

2. **Ms. Anns Issac**
Centre for Trade and Development,
Safdarjung Enclave A1/ 304
New Delhi
e-mail- annsissac@gmail.com
Mobile- +91 9868019184

3. **Prof. (Dr) Mangal Kohli**
Assistant Director General
D.G.H.S & Ministry of Health and Family Welfare
Nirman Bhawan
New Delhi
Tel- +91 230619707/ 23062493
Mobile- +91 9868920586

4. **Dr. Ashwani Kumar**
Medical Council of India
Dwaraka New Delhi
Mobile- +91 9810281993

5**. Mr.Sunil Nandraj**
Cluster Focal Point
Health System Development
537, 'A' Wing, Nirman Bhawan
New Delhi- 110011

6. **Dr. P Rajan MD DMRD DMB** (Member MCI)
Associate Professor
Dept. of Radio Diagnosis
Medical College Calicut
Kerela
Mobile- +91 9847228359

7**. Dr. Bimla Kapoor**
Director School of Health Sciences
IGNOU
New Delhi
Phone- +91 29533078 / 29532965
Fax- +91 29534935
e-mail- bimlakapoorr@hotmail.com bkapoor@ignou.ac.in

8. **Dr. Hariharan**
C-005 Agrasen Apartments,
66 I.P. Extension
Delhi- 110092
Mobile- +91-9810197049
e-mail- drhariharn@rediffmail.com

9. **Mr. Atul Ghandotra**
E- 170, East of Kailash
New Delhi
Mobile- +91-9899000201
e-mail: atulgandotra@yahoo.com

10. **Dr. Anand Sethi**
A.104 East of Kailash
New Delhi
Mobile- +91-9999209957
E mail- drsethi@emediscene.com

Appendix B: Programme

Time	Session / Activity	Facilitator / Resource Person
	Day 1 – Monday – November 17	
08:30	Registration	
09:00	Inauguration	
09.00 – 09.20	Welcome Address	Dr. Sundaram Arulrhaj President Commonwealth Medical Association
09.20 – 09.40 09.40 – 10.00	Opening Remarks	Dr. Elizabeth Marsh Senior Programme Manager Commonwealth Foundation Ms. Peggy Vidot Health Adviser Commonwealth Secretariat
10.00 – 10.30	Keynote Address	Dr. Anbumani Ramadoss Minister of Health & Family Welfare India (*invited)*
10.30 – 11.00	**Refreshments** (Press conference for invitees only)	
11.00 – 11.30	Presentation – Putting health worker migration in context: describing migration patterns in Commonwealth Countries and the resulting health workforce crisis	Ms. Peggy Vidot Commonwealth Secretariat
11.30 – 12.00	Discussion	

12:00 – 12:30	Presentation - The status of the female health care worker in Asia	Ms. Jill Iliffe Executive Secretary Commonwealth Nurses Federation
12.30 – 13.00	Discussion	
13:00 – 14.00	**LUNCH**	
14.00 – 15.30	Panel discussion on health-worker migration and unethical recruitment, focusing on priority issues for each organisation.	Dr. N Arumugam, Commonwealth Medical Association; Mrs. Manjiri Gharat, Commonwealth Pharmacists Association; Dr. Ayyaz Ali Khan, Commonwealth Dental Association; Ms. Susie Kong, Commonwealth Nurses Federation; Dr. Sirajul Islam, Commonwealth Association of Mental, Handicap and Developmental Disabilities (CAMHADD)
15:30 – 16.00	**Refreshments**	
16.00 – 17.00	Chaired discussion – Priority areas for the region and for the Health Commonwealth Associations working in the region.	Professor Bimla Kapoor Indira Ghandi National Open University
17.00 – 17.30	Discussion	
17.30 – 18.00	Evaluation of the day	Led by Dr. Sundaram Arulrhaj

Time	**Session / Activity**	**Facilit**
	Day 2 – Tuesday – November 18	
09.00 – 11.30	Session 1: Ethical Codes of Practice as an approach to managing recruitment	Speak Comm
09.00 – 10.00	Presentation – The Commonwealth Code of Practice for the International Recruitment of Health Workers and issues with the codes	Chair - Resea Comm
10.00 – 10.45	Small group discussion (3 mixed groups) on the role of Health Commonwealth Associations in implementing the Commonwealth Code of Practice for the International Recruitment of Health Workers	3 spea 10 mir
10.45 – 11.30	Presentations of group work and discussion	
11.30 – 11.45	**Refreshments**	

11.45 – 13.00 11.45 – 12.30 12.30 – 13.00	Session 2: Fair recruitment practices Small group discussion on the role of organisations in: - protecting health worker migrants - protecting health systems in source countries - regulating private recruitment firms Discussion on group work action points	Chair - Comm
13.00 – 14.00	**LUNCH**	
14.00 – 16.20 14.00 – 15.00 15.00 – 15.40 15.40 – 16.20	Session 3: Retention Strategies Case study presentations on successful retention strategies Small group discussion: - Appropriate retention strategies - The role of Health Commonwealth Associations in encouraging better retention strategies Discussion on small group action points	Ms. Vi Comm Dr. Oh Comm Chinta Pharm Shann Assoc Comm Chair - Comm
16.20 – 16.40	**Refreshments**	
16.40 – 18.00	The Way Forward Chaired discussion on: • Developing strategies for each Health Commonwealth Association to address the issues discussed • Promoting knowledge and expertise sharing between attending Health Commonwealth Associations	Dr. Eli Comm Ms. Pe Comm
18.00	**End of Symposium**	