Summary Report of the 3rd Project Coordination Meeting  
New Delhi, India – 31 May and 1 June 2016

Participants
EC Project Partners: Anu Bakhshi (WHO India), Nilesh Budh (WHO India), Ibadat Dhillon (WHO HQ), Jabulile Dlamini (AHIHLD South Africa), Patrick Kadama (ACHEST Uganda), Hamsadvani Kuganatham (WHO India), Percy Mahlati (AHIHLD South Africa), Robert Odedo (ACHEST Uganda) Prakin Suchaxaya (WHO India), Aisling Walsh (RCSI Ireland), Pascal Zurn (WHO India)

External: Ved Prakash Mishra (Medical Council of India), Kavita Narayanan (Director Human Resources for Health, Ministry of Health and Family Welfare), Krishna Rao (Oxford Policy Management)

Summary
The objective of the 3rd Partner Coordination meeting was to assess progress and challenges encountered during the 2nd year of projection implementation, as well as to facilitate learning across countries. The meeting had a specific focus on reinforcing partner understanding of the project financial frame, with the aim to improve financial and technical implementation.

The meeting included presentations from project partners on progress in Year 2; open dialogue across partners and countries around challenges, lessons learned, and opportunities; detailed discussion around finances and reporting; as well as initial discussion around Year 3 planning, sustainability, and strategic communication. Additionally, two important presentations from the Ministry of Health and Family Welfare and the Medical Council of India enabled learning across countries, with important relevance to ongoing work of partners. The Medical Council of India described their work towards development of “live” registers, while the Ministry of Health and Family Welfare spoke to the focus of soon to be established Human Resources for Health Unit.

Significant progress has been made in Year 2. Data collection and data related-support is ongoing in all countries. Case studies on General Practitioners are expected to be ready in all five countries by the end of August 2016. Specific support has been provided by project partners to improve the quality of data at country level. This includes support to linking datasets in Ireland, support to the routine utilization of available data in Ireland, utilization of the WHO Minimum Data Sets to support the transition to ‘live’ registers planned by the Medical and Nursing Councils of India, and support to Cross River State in Nigeria for data management. There has also been progress with respect to advocacy of the WHO Global Code and associate policy environment at country level. Notably, all five countries have designated national authorities to report on the Code, with four of the five submitting national reports during the 2nd Round of Code reporting. Moreover, across countries, partners reported the level of dialogue to be maturing, with a consistent and increasingly informed group of stakeholders. The establishment of a National HRH Cell with the Ministry of Health and Family Welfare in India, and project support towards reviving the HRH Technical Working Group in Nigeria are, in particular, important both as fora for policy development and longer-term sustainability of existing support.
Project partners identified areas of individual and common challenges. Key challenges included weak information systems and particularly weak data on emigration; poor coordination amongst stakeholders; complexity in relationship between national and decentralized levels of governments; and political uncertainty in some of the partner countries. Differences in definitions and registration processes were also identified and discussed.

Approaches to addressing existing challenges have included greater focus on engaging with provincial level actors (where much of the need and demand resides); seeking synergies with other actors participating at country level; and afore mentioned capacity support where possible. The project partners additionally pointed to specific opportunities that could be better leveraged. Better capturing of immigration (entry) data and sharing across countries (via the WHO Global Code), was identified as a realistic approach to compensate for consistent weaknesses in emigration data. All project countries would aim to fully capture emigration data. Moreover, partners felt that the WHO HQ brand and representation at country level added important weight to ongoing policy dialogue. The WHO MDS and communication materials have been valuable at country level. An initial idea around the development of a video, with focus on international migration within Africa, was also discussed. Moreover, the recently established High-Level Commission on Health Employment and Economic Growth, with its strong focus on health worker migration, was identified as an opportunity to give further visibility to partner efforts at country level.

The detailed description and explanation of the project and partner budget, as presented to the EC, was very much appreciated by partners. Frank discussion took place on the timing of funds released to partners and the associated responsibilities of project partners in relation to quarterly technical and narrative reporting to WHO. There is a renewed commitment to timely reporting by all partners; with the end of May marking the end of Quarter 3, Year 2. Partners are expected to provide reports for the first 3 quarters, where still outstanding, by end of July. ACHEST (Uganda and Nigeria) sought specific support from WHO HQ to aid in the process towards improved financial reporting for Year 2.

WHO India country office raised the issue that due to the mechanism of financing, effort at country level is not appropriately being recognized. Due to staff turnover at WHO India CO, it is especially important that effort at country level be fully recognized. Suggestion that at a minimum, WHO HRH Director speak with WR India to ensure that the TOR of staff reflect work on the project. The ideal situation, from WHO India CO perspective, would be for funds to be directly transferred to WHO CO.

There was limited time to discuss issues of sustainability; year 3 planning; and strategic communication. It was agreed that these areas would be further discussed during the next teleconference. Project partners also spoke to the need to start speaking beyond the three year life of the project; and the need to continue to build on the inter-sectoral engagement of stakeholders. Building strong relationships with WHO country offices and capacity was identified as one important mechanism to ensure sustainability.

Presentations

1. Welcoming remarks were presented by Dr. Prakin Suchaxaya the Deputy WHO Representative for India. Dr. Suchaxaya highlighted the important opportunity for cross country learning provided by the meeting.

2. Ibadat Dhillon from WHO HQ also welcomed the meeting participants and identified the expectation for the meeting. He followed with a presentation on the progress related to the 2nd Round of WHO Global Code reporting, including submissions of project countries; on activities at the global level; and links to the recently launched High-Level Commission on Health Employment and Economic Growth. Of note, during discussion, it was highlighted that the High-Level Commission could be leveraged to make further prominent partner efforts at country level.
3. Percy Mahlati presented on Year 2 progress in South Africa. The year 2 case study will be informed by quantitative data collected at provincial level (4 out of 9 provinces in South Africa have reported thus far); membership information from the South Africa Medical Association (largest membership base in Africa); and qualitative information from a survey of approximately 700 physicians. Highlights from early results, include a discrepancy between stock of medical offers and placements of medical interns with resignations occurring over a five year period, particularly amongst those under 30. Of the four provinces that have reported thus far, The Western Cape province, with Cape Town as its capital city, is the most attractive in terms of medical intern placements and has the largest stock of medical officers. At the same time, it also has the highest proportionate, by considerable measure (nine fold greater than the next highest), incidence of resignations from service over a five year period. Moreover, in 2015, over half of all resignations from service took place amongst those under 30. In absence of quality data on emigration, there is a strong suggestion that many are migrating internationally. A suggestion was raised that only those who are able to access the few slots for advanced training remain in the system. This finding for Western Cape is strikingly different from the other three provinces where placement in rural areas is less coveted but retention seems to be higher. Data on immigrant medical professionals was also presented. Limpopo and Northwest Province, perhaps due to difficulty of attracting South African medical personnel, rely much more heavily on immigrant medical officer. Initial results from a qualitative survey of 754 medical personnel were also presented.

4. With respect to advocacy, Percy Mahlathi pointed to improvements in Year 2 engaging with a consistent group of stakeholders, including the National Human Resource Committee, Statutory Health Councils, and Professional Associations. At the national ministry level, a major achievement was assistance with information to include in the 2nd round of Code reporting. A workshop on Health Personnel Migration was held in May 2016, with strong participation from provincial health departments. The meeting aimed to sensitize participants on the WHO Global Code, as well as relevant national HRH policies (e.g. Foreign Medical Professionals Act). Envisioned next steps in year 2 include a one day meeting with the National Human Resource Committee and potential presentation of the Year 2 Case Study at the annual meeting of the South Africa Medical Association.

5. Discussion included suggestion of comparing provincial data with posts available; getting more information on foreign nationals working in South Africa (as better data on this); and more information on existing policies in place, as well as impact. South Africa also spoke to current challenges in working, and supporting, the national government given the overall political climate. The stronger focus on engaging with provincial level health departments at the technical level, where much of the need and demand reside, was a mechanism to overcome this challenge. South Africa reported as the main countries of origin for foreign physicians as DRC, Nigeria, Uganda, Zambia, and Swaziland.

6. Aisling Walsh presented on Year 2 progress in Ireland. With respect to informing the Case Study for Year 2, Aisling pointed to ongoing work on linking medical workforce datasets; collection of data on general practitioners; qualitative review of the International Medical Graduate Training Initiative; and findings from the RCSI COSECSA Graduate survey. With RCSI support, datasets from the Medical Council of Ireland (MCI Annual Retention Application Form) and the HSE National Doctors Training and Planning department (Medical Practitioners System and National Employment Record) were linked. Initial results point to 90% of Non-Consultant Hospital Doctors (NCHDs) holding Irish citizenship. This stands in stark contrast to earlier findings of approximately 40% reliance on International Medical Graduates in Ireland, a substantial proportion of whom
would serve as NCHDs. The data linkage exercise has the potential to point to existing gaps in using Medical Council data alone. Additional information was presented on General Practitioners, as well on emerging results from the IMGTI program, and the COSECSA graduates survey.

7. Aisling’s presentation led to considerable discussion amongst meeting participants on the definition of ‘General Practitioner’, with definition varying by country. It was agreed that it was important that each case study explicitly define ‘General Practitioner’ as used in the country. Moreover, Ireland was encouraged to provide further information on Non-Consultant Hospital Doctors, whose functions are more akin to the definition of GP used in other partner countries. With respect to stakeholder engagement and capacity building, RCIS has strong relationship with both HSE NDTP and the Medical Council of Ireland; is a member of and participates actively in the DoHC Strategic Review Group; and hosted RCSI HWRG policy dialogues. Specific capacity building support in year 2 include real time contribution of findings to national policy makers, and support of RCSI biostatistician to HSE and MCI.

8. Robert Odedo provided an update on Year 2 progress in Nigeria. Specific highlights included ongoing data collection on General Practitioners; completion of Year 1 data on the Surgical Workforce and initiation on Year 3 data collection on Nurses & Midwives; Nigeria’s appointment of a Designated National Authority; and the project partner facilitating submission of Nigeria’s national report as part of the Second Round of Code Reporting. Moreover, the project has ensured high level stakeholder engagement at both the Federal and State Level including the Federal Minister of Health, Senior Management of the Federal Ministry of Health, the WHO Representative in Nigeria, and Senior Ministry of Health staff Cross River State. Specifically, all key stakeholders in Cross River State were engaged in a workshop to sensitize them on the work of the project. Focused effort is now in place to revive the Federal Working Group on HRH and to support the Federal Ministry of Health to convene a first national convention on HRH later in 2016. It is hoped that such a convention will result in the HRH policy development in Nigeria (currently it was reported that there are none). The relevance of these activities are particularly important as the lack of stakeholder coordination was identified as one of the key challenges with regard to implementing the Code, as reported in Nigeria’s 2nd round of Code report. Select challenges identified included lack of data on private health practitioners in Cross River State; complexity of relationship between federal and state levels; limited data on external migration; weak state level mechanisms for data capture and management. Maximizing synergy with a Canadian funded project on frontline Health Workers was identified as one specific opportunity to advance the goals of the project. Robert also pointed to the importance of engaging with the WHO Country office to ensure sustainability of current efforts.

9. Krishna Rao and Nilesh Budh presented progress on Year 2 in India. Oxford Policy Management has been contracted to capture quantitative data on the domestic and international migration of GPs, with a focus on Kerala and Bihar states. Methods will include desk review; sample of medical schools (40% in each state, public and private), as well as extraction of data from primary and secondary sources (health and medical education departments; regulatory councils; medical schools/batches; and overseas medical associations). Results are expected by July 2016 and an advocacy/dissemination meeting is planned in August 2016. The WHO Country Office convened a stakeholder meeting, bringing together the Ministry of Health, Ministry of Overseas Indian Affairs, Ministry of External Affairs, the Ministry of Home Affairs, the Ministry of Commerce and Industries, Academia, UN, professional associations, and the private sector to inform and discuss the WHO Global Code. Successes included use of the minimum data set for the forthcoming establishment of live registers by the Medical Council of India and the Indian Nursing Council and formal designation by India of a
National Designated Authority for reporting on the Code. Relevant challenges include weak information systems, weak coordination amongst concerned ministries, and expected turnover of project staff. Establishment of a National HRH Cell within the MOHFW, in coordination with development partners and WHO, is an important step to build on existing efforts and long term sustainability.

10. Patrick Kadama presented on Year 2 progress in Uganda. Data collection is underway, methods and tools have been adjusted to make them more relevant for the Ugandan context. Data is being assembled from annual register update. Project is specifically assisting Councils to transition from manual to web based and real time registers. Moreover, have sensitized stakeholders on compliance requirements of the WHO Global Code. Similarly, national stakeholders, were sensitized on the role and rationale for a Nationally Designated Authority. Initially, a very junior person was identified as the Nationally Designated Authority. Project intervention allowed for the designation of a more senior individual. The project additionally supported the facilitated of reporting by the NDA to the second round of Code reporting. An additional stakeholder meeting is anticipated for July 2016. Patrick Kadama additionally cautioned on how stakeholders are sensitized is important; with group to group and peer learning more effective than standing lectures.

11. Kavita Narayanan spoke to the HRH challenges and opportunities in India, particularly in light of the expected establishment of the HRH Unit. She spoke to ongoing reforms in medical, nursing and allied health professional education, with strong focus on social accountability and rural retention. She spoke to the development of a new Allied & Healthcare Professionals’ Council of India to strengthen regulation in the area. She additionally spoke of collaboration between the MOHFQ and the Ministry of Skills Development and Education for a skilling initiative in healthcare, aimed at creating 100,000 skills health professionals per year. Ved Prakash Mishra provided the historical and current context on the Medical Council of India register; its relationship to state registers; and the process towards making it live (full running account of individuals). It is expected that the register will be live by 31 March 2018. He also spoke about the potential in the future of the 13 Medical Councils in the WHO SEARO region exchanging information. Medical Council of India is also looking to have certificates of good standing being linked to the Indian Medical Register. Ved Praksah Mishra also provided data on the fast growth of medical education in India. In 2015/2016, India has 412 medical schools with 53,000 admitted students. Currently there is higher intake in government schools than in private schools (27,000 vs 26,000). Moreover, over a ten year period, annual registrations have increase from 20,000 to 40,000 medical practitioners annually.

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