

## The Belgian development cooperation stakeholders'

### ***Charter on the recruitment and support to the development of human resources for health in partner countries***

In this fifth newsletter of Be-cause health, we present an outline of the workshop organised on the first of June to discuss the draft of our human resources charter. The workshop has been attended by about 30 people, representing about 25 members of the platform. During the workshop we tried to clarify the concepts and to finalise the wording of the draft charter. But, in the first place the workshop has strengthened the commitment of the represented members to take up the promotion of health workers seriously in our international cooperation work.

We are very grateful to Elisabeth Paul, from the University of Liège, Grap-pa Santé and the ever dedicated chairperson of the Human Resources for Health working group, who did the big job to put this newsletter together and to offer you a very readable overview of the presentations and discussions.

*Dirk Van der Roost, Institute of Tropical Medicine and Secretary of Be-cause health*

## What 's it about?

Human resources are one of the main pillars of health systems. It is necessary to strengthen the former in view of enabling the latter to respond to essential health needs, especially in view of reaching universal coverage. Unfortunately however, there is an estimated shortage of several million health workers complying with the qualifications required at global level; several low income countries are suffering from a severe shortage. In low income countries, this global crisis of human resources for health (HRH) is also expressed through an inequitable distribution of existing health workers, mainly affecting rural and difficult regions and at the expense of clinical functions, as well as through bad quality training and insufficient alignment between the needs and health workers' competences.

Conscious of that important problem, the World Health Organisation (WHO) developed on behalf of its members a Code of Practice (CoP) on the International Recruitment of Human Resources for Health which was approved at the 63<sup>rd</sup> World Health Assembly in May 2010. This is a voluntary, non-binding Code which does not limit migrations, but rather acknowledges the workers' right to migrate and even recognises that brain circulation has positive effects. But as at the same time, it reckons that populations of all countries have the right to have access to health services. Thus the CoP recommends finding a fair balance between both these rights.

Belgium supported the development and approval of this Code of Practice. Moreover, the 2008 policy note "The right to health and to health care" identifies the shortage of HRH in terms of numbers, competences and motivation, among the principal challenges to be addressed. As such, the note recognises that these problems are caused by external and internal migration, by problems in the countries of origin, and that there are repercussions on the quality of services and programmes. In addition, the Belgian medical NGOs prepared a document at the beginning of 2005 aiming to set up a dialogue with DGD to take up the question of "rethinking the human capital", and pleading for DGD to have a free and open dialogue on this question, not excluding the possibility of co-funding salaries and/or performance fees for local health workers.

Considering the above, and inspiring from the Charter on drug quality developed in 2008 by Be-cause health, its working group on human resources (WG-HRH) took the initiative to develop a ***Charter aimed at better harmonising and increasing the equity and effectiveness of Belgian cooperation stakeholders' practices in the field of recruitment and support to health workers coming from partner countries***. This is considered as an essential aspect in the efforts towards universal health coverage, to the promotion of which Be-Cause Health is very much committed. As the Charter aims to encourage the implementation of the WHO CoP in Belgium, it translates several of its orientations into

concrete commitments. It is voluntary and it encourages respecting a number of principles with regards to partnerships and harmonisation, HRH policies and development plans, training, recruitment, as well as in our environment in Belgium. As a first step, it targets the « Southern » elements of the CoP. Nevertheless, this is not an end and the expected next steps are to reach similar commitments with Southern partners, as well as to develop the « Northern» elements of the CoP's commitments in Belgium.

The Charter development process was participative. The WG-HRH prepared a first draft and circulated it among all Be-Cause Health members for comments and suggestions. A second draft, prepared after integrating the results from the electronic consultation round, was then deeply debated during a workshop organised on June 1<sup>st</sup> at BTC headquarters (Espace Jacquemotte). The workshop, the main messages of which are synthesised hereunder, aimed at three objectives:

1. To present what some organisations are doing with respect to the Charter's commitments to other Be-Cause Health members;
2. To reach a definitive consensus on the Charter's commitments;
3. To discuss how the Charter shall be implemented.

The final Charter prepared after the workshop has been circulated among all Be-Cause Health members, and it should be signed during a ceremony organised during the next General Assembly on 27<sup>th</sup>, November 2012. The expected signatories are member organisations from Be-Cause Health that adhere to the principles and have the ability to sign it. Even if they cannot sign the Charter, the Belgian federal ministries of Cooperation and Health support the process.

It should be noted from the start that by signing the Charter, the organisations commit to respecting a number of principles that aim, on the one hand, to actively support capacity building of health workers and reinforce sustainable systems; and on the other hand, to limit the negative consequences that international recruitment of health workers from partner countries may have on local capacities. However, not all organisations might be in a position to perfectly respect all of the Charter's commitments.

## Synthesis of the June workshop's presentations and debates

The workshop comprised two general sessions and then a debate aimed at reaching a consensus on the Charter. Some transversal conclusions were then drawn by Dr Karel Gyselinck, president of Be-Cause Health. The main messages from the sessions are presented below.

### Background presentations

In his welcome speech, **Karel Gyselinck** recalled the conceptual framework developed by Monique Van Dormael, Guy Kegels and Bruno Marchal for the Be-Cause Health annual seminar of 2005 on HRH, according to which a full time equivalent health worker depends on availability x competences x motivation. He also paraphrased the idea that « there are five critical variables in health system strengthening : people, people, people, people and people ».

**Wim Van Lerberghe** from WHO then recalled the context of the HRH crisis and the history of the CoP. Even if WHO already worked on HRH in the 1980s, it is only in the 2000s that the HRH crisis came to the forefront, notably thanks to the WHO Report of 2006. Some fundamental change occurred in the past decade as it started to be viewed not as a "Southern" issue (South-North brain drain) but as a common, global issue. The first draft CoP was elaborated in 2008 but it took many rounds of consultations to get a consensual version that could be approved by the Executive Board in 2010, and then at the World Health Assembly.

He recalled the various articles of the CoP and emphasised that it is voluntary and calls for ethics and health systems strengthening. A fundamental objective of the CoP lies in the promotion of a global dialogue and information sharing, notably over migration, in order to better plan the health workforce. Each Member State must elicit a designated national authority (DNA) in charge of following up the migration issue and CoP implementation through a simplified information collection tool comprising both qualitative and quantitative data. Mostly European countries have designated a DNA, but capacities to deal with HRH issues are lacking in Africa. A baseline survey is being processed and should be presented to the Executive Board Fall meeting.

Wim concluded by raising the point that the HRH vogue is already starting to become outdated and replaced by a new vogue for universal health coverage (UHC). Thus, if we want to keep the HRH issue alive, we should surf on the wave of UHC. Moreover, voluntarism is not sufficient, and should be complemented by watchfulness and continuous lobbying. This presentation raised a lot of questions from the public. In his answers, Wim stressed the fact that it is important to extract the CoP and more generally HRH thinking from its isolation (e.g. in Africa, sometimes there is a trend to focus on HRH plans and commissions that are separated from the global health system; in Europe as well, there is a risk that the debates around the CoP limit to migration issues, while it is much wider). Note also that other countries have done a work similar to ours, but it is to be expected that the Charter will reinforce the Belgian position in international debates.

**Ignace Ronse** from DGD started by presenting, on behalf of the Belgian Ministry of Health (MoH), the Joint Action on Health Workforce Planning and Forecasting launched by Belgium during its presidency of the European Union. It intends to create a cooperation platform gathering European MoHs to provide information and share best practice on HRH planning methodologies, as well as to estimate future needs in terms of skills and competences. The second part of his presentation dealt with the Belgian cooperation. He first recalled the nine pillars of the Health Policy Note of DGD. One notices that HRH compose the first pillar of the part on healthcare system, but are actually dealt with indirectly in all other pillars. Several aspects of the Charter are dealt with in the Policy Note (e.g. the importance of developing international partnerships and promoting healthcare integration), so that Ignace could analyse the two in parallel. He stressed the fact that DGD does not recruit internationally, but intervenes in several ways which are in line with the Charter's spirit, such as: fostering sector-wide approaches and country Compacts, participating in country and global policy dialogue, providing support to health system strengthening and especially training, etc.

**Johan Wets** from HIVA (KULeuven) presented the results from a study its research centre conducted on behalf of King Baudouin Foundation on the recruitment of HRH of foreign origin in Belgium. Indeed, the context (population ageing) lets foresee an HRH shortage in our country, so that international recruitment might be a solution. However, the existing data are not coherent and do not clearly indicate a shortage. The Belgian policy to respond to a potential shortage rather focuses on reinforcing the attraction of healthcare professions and recruitment within the existing unemployed (possibly foreign) workforce, but very little on international recruitment. The study, based on administrative data from 2007 (which is not a perfect indicator for foreign origin, yet), shows that the number of foreign origin HRH in Belgium goes on growing but is still not very large (about 8,000 physicians or 18%, but 70% of them have a Belgian diploma; about 9,200 nurses or 6%, but most of them have a Belgian diploma). They are mostly European (Dutch, French, German), and quite few of them come from outside Europe (mostly Lebanon and Morocco, 15% from Africa). It should be noted that there are a lot of migrant HRH whose diploma is not recognised in Belgium, so that they cannot work in line with their skills. There are a few examples of active recruitment abroad, notably in the Philippines, Romania and Poland, but the situation of Belgium cannot be compared to that of other countries (USA, UK, Canada...) counting many foreign HRH and/or training many foreign students. The report also discusses ethical issues as some countries from the South face very large shortages, and it already suggests that the CoP could inspire policymaking. It notably proposes to compensate international recruitment by a transfer fund benefitting Southern countries and encouraging them to better train and retain health personnel.

**Lieve Daeren and Annelien Poppe** (UGent) then presented their research project called "Human Resources for Primary Health in Africa" (HURAPRIM). It is an international collaborative research project that aims to develop and assess policies and key interventions to address the personnel crisis in the health sector, especially in Africa. Indeed, Africa faces a major disease burden while concentrating few HRH, especially in rural areas and with respect to specialised services. The project is led by the University of Ghent with partners in Austria, Botswana, Mali, South Africa, Sudan, the UK, and Uganda. It runs until the end of February 2015. It is designed around several work packages, among which assessing the scope and analysing the causes of the deficit in HRH, and designing interventions to address the human resources crisis in African Primary Health Care. A specific research is being done through qualitative interviews of African health workers who immigrated to Belgium, notably to investigate their push and pull migration factors. Provisional results indicate that there seems to be a number of obstacles for remigration but also reasons to return. Many interviewed persons are not sure yet, but the majority think they will not return permanently, even if they consider returning for short term periods ("circular migration").

## The experience of several organisations with respect to the Charter's commitments

The second set of interventions aimed to present the experiences of various organisations with respect to the Charter's commitments. **Stefaan Van Baestelaere** (BTC) started by recalling that even if HRH are correctly planned at national level, individual aspirations may jeopardize the investment in people (for example, if a qualified surgeon decides to shift to public health). He also recalled some components of the HRH crisis, among which systematic under (/over) production in some countries, poor or absent HRH planning and monitoring, as well as resistance to change and insufficient focus given to clinical tasks. For BTC, it is essential to support HRH planning in partner countries. Solutions encompass a number of elements, among which the CoP and reinforcing self-esteem. Stef then presented four cases of BTC support to HRH in partner countries: Burundi where BTC supported the design of the HRH development plan and implements an institutional support programme; Senegal where it implements a 3-component programme, among which one on governance with some support to the HR department; the shift from individual grants to an institutional capacity building programme aligned on the indicative cooperation programme and the national health strategy; and the performance-based financing programme in Rwanda, which enabled to increase health workers' revenues, leading to very encouraging results.

**Paul De Munck** (Return to Care Foundation) started by recalling the very rudimentary working conditions facing African physicians when they go back to their country of origin after their specialisation. Indeed, HRH who were trained in Europe often do not receive sufficient support for exerting their new competences when they go back home. He also recalled the diverse symptoms and causes of the HRH crisis which have been much studied and debated in the past years. He then presented the RTC Foundation ([www.returntocare.be](http://www.returntocare.be)), which gathers three francophone Belgian universities (UCL, ULB, ULg) and aims to improve working and living conditions of some physicians from the South who are ready to invest themselves over the long term in their country after their training in one of the three universities. The idea is to support those students who specialised in Belgium and go back to their country with a project for returning to care (e.g. improvement of their service), in partnership with their institution of origin, the university where they studied, and RTC.

Three NGOs then presented their HRH policy in DR Congo. **Tine Demeulenaere** explained that Action Damien interacts with several types of personnel with various statuses. In addition to Action Damien's employees (medical officers, direction and other administrative staff), it works with many Congolese health staff, whom they compensate for their services: State agents in the provincial and district teams who act as chief medical project officers, receiving premiums of about 1000 Euros per month; State agents in charge of implementing the TB and leprosy projects, receiving various premiums; and general health staff who are entitled to small performance premiums. Moreover, it offers many training grants.

**Vincent Litt** explained that CEMUBAC works nearly exclusively with local staff, whom are offered very competitive salaries (as much as 2000 Euros net of taxes for senior medical officers) as well as long-term career perspectives with a number of training and research opportunities. Staffs are hired through a Congolese interim agency. CEMUBAC collaborates over the long run with local partners (district teams) and offers interventions aimed at improving working conditions, premiums to complement the basic salary (about 200-300 USD per month) and training opportunities. For instance, over the past ten years, 41 training grants have been granted to 39 Congolese officers, of whom only 4 have left the country and 8 joined international agencies or NGOs acting in DRC. Moreover, CEMUBAC also leads short-term collaborations with usual targeted performance premium and per diems.

**Frank De Paepe** illustrated the HRH crisis as observed in DRC by MEMISA, comprising inequitable staff distribution, under-remuneration of clinical functions (for instance, as many nurses divert patients, it has been observed that public health centres were more frequented during nurse strikes!), inadequate competences, etc. He then explained how MEMISA already respects the Charter's commitments in terms of partnership and harmonisation, support to HRH development policies (especially with respect to good governance, deontology, focus on care functions, professional environment and higher remunerations), support to initial training and curricula development, and recruitment (most of its staff are State agents who are detached for a short period), so that MEMISA will not encounter any problem in signing the Charter. Especially, the commitment to share information and advocate the HRH cause will be implemented through the participation in the WG-HRH and a joint European project with MMI/AMREF/WEMOS – the Belgian contribution of which is provided via MEMISA.

Those interventions gave rise to many questions and debates that are too numerous to synthesise here – all the more since we want to arouse your interest to participate in our next workshops. Some recurrent conclusions are that a mix of incentives are necessary to contribute to reducing the brain drain – some are financial (e.g. the policy of salary increase in Ghana) but improving working conditions and reducing isolation may even be more powerful. Reinforcing training is also part of the puzzle, and supporting quality improvement in private training institutions should not be excluded, provided they have some public interest. Moreover, the South-North brain drain is definitely only the top of the iceberg; the HRH issue is much larger, and global policies are necessary to solve it, notably to increase HRH production in the North as well.

The last two presentations underlined the importance of making people more responsible for their actions so as to better motivate them to commit to their job and perform. **Marc Le Moine** (Erasmus Hospital, ULB) presented a project of *in loco* training in therapeutic endoscopy led at the CHU Aristide Ledantec in Dakar, Senegal. It was a real success and shows that it may be very profitable to decentralise specialised training in the South, provided a number of prerequisites are met, notably: assessing need and local resources, trust building, pursuing realist objectives, involving local universities, and preparing for local and regional autonomy by favouring South-South cooperation. Then, **Anne Fromont** (ULB / GRAP-PA Santé) explained how much self-esteem is important and has direct and indirect effects on health and work quality. She developed a model of organisation-based self-esteem (with determining factors belonging to the environmental structure, other variables and direct individual experiences; consequences on job satisfaction, performance, commitment / ownership and citizenship; and in turn, impacts on healthcare quality), and used it to assess the impacts from a Quality Contest in Morocco. The latter had very positive effects on stakeholders in the first two years but after, many problems occurred: competition was badly perceived by losers, knowledge and competences were insufficiently valorised, the process was perceived as exogenous, the audits as controls, the process was judged as unfair and lacking transparency. At the bottom line, the Quality Contest generated un-satisfaction, a weak impact on performance, and little ownership. As a conclusion, the self-esteem approach is valid both in the North and South, but it is important to use it in a systemic approach, without any vertical determinism. It is promising to develop a new logic based on trust, autonomy, recognition, transparency and justice – that is, people's self-esteem – to engender satisfaction, commitment and behaviour change, which are powerful leverages for health sector reforms.

## Towards a consensus on the Charter

A plenary session moderated by Ignace Ronse enabled to discuss the draft Charter. He recalled that the Charter targets the Southern aspects of the CoP, even if we acknowledge that the Northern ones should be dealt with in the continuation of this process. Furthermore, some fundamental actors – those of the South – are not supposed to sign it. Hence, it was decided to precise that the Charter was that of “the actors from the Belgian development cooperation”. Vivid debates took place, notably about how strong the commitments should be, because some organisations have diverging approaches to, for instance, recruitment and motivation – hence the need to harmonise practices. Moreover, not all organisations are concerned by the various proposed commitments. Thus the final draft may seem quite generalist as it targets a large variety of organisation, and it does not commit to results but only to respect a number of principles. Yet, this should be viewed over the medium term as a way to foster debate: indeed, even if not all organisations respect all commitments by now, signing the Charter may bring in questioning within those organisations so that they can improve their practices. At the bottom line, a number of amendments have been done in the draft so as to reach a consensus on terms and commitments. The final draft is presented in the annex of this Newsletter.



A concentrated audience - Nathalie and Karel, part of the reporting team

## Conclusion

Karel Gyselinck concluded the workshop by summarising the main messages from the various presentations and debates of the day, as well as a number of paths for the future. The HRH issue should definitely not be isolated but to be tackled globally – that is, worldwide, over the long term, through a systemic approach, in conjunction with other aspects of health systems strengthening (e.g. health financing), and in the perspective of reaching universal coverage. The “human” aspect of HRH should also be better promoted, notably through reinforcing self-esteem, trust, recognition, learning and links between people.

At developing country level, various interventions have been identified as important to promote HRH, particularly raising the attraction of healthcare functions through improving working conditions and substantively increasing salaries, and improving the quality of initial training in public and private institutions alike. But at the global and Belgian levels as well, action is still necessary, especially to advocate the case for HRH and improve information and experience sharing. The CoP and Charter are very good entry points to foster political dialogue about HRH. Other on-going experiences of WG-HRH members also have a good potential to be valorised.

## The commitments of the Charter

### ***The organisations adhering to this Charter,***

Taking into consideration that each patient has the right to be taken care for by qualified, available and motivated health workers where he/she lives,

Recognizing that the recent situation of shortage in qualified HRH and non-ethical recruitment of HRH is preoccupying,

Taking into account that the Code of Practice of the WHO is voluntarily and non-binding,

Taking into consideration that HRH from countries in the South have the right to benefit from a just and fairly managed system and be motivated to put into practice their competences to the benefit from their populations,

Recognizing that in the framework of development cooperation, partner countries can call on the Belgian cooperation to support the implementation of an effective development framework for their HRH, and more broadly to achieve universal coverage in health care and services,

### ***Take on the following engagements within the limits of their respective missions:***

*With regard to partnerships and harmonisation:*

- To integrate our interventions in the national structures and organisations (from the public sector as well as from the civil society) and to support the reinforcement of the health systems in the partner countries;
- To participate in each country in the consultation with the actors supporting the implementation of the development plans for HRH in order to harmonise progressively the support;
- To raise the predictability and the long term vision of our support to HRH.

*With regard to policies and development plans for HRH:*

- To promote within the partner countries the development of national qualified HRH, good governance and respect for ethics and deontology in the medical and paramedical functions – in especially the respect for patients and their socio-cultural identity and the fight against corruption;
- To support, if the demand exists, the conception and the implementation in the partner countries of development plans for qualified HRH, respecting values as equity and the dimension of “gender”, including through the promotion of measurements reducing inequities in the geographic distribution of health workers in these countries;

- To implement measurements aiming at strengthening considerably the professional motivation and at raising the attractiveness of the caring function for the national health workers, notably by promoting more valorising professional environments in terms of confidence, recognition, learning and self-esteem;
- To create a social and salary advantageous environment for the HRH.

*With regard to training:*

- To support the initial, permanent and complementary training of health workers coming from partner countries, according to the needs expressed in the national development plans of HRH if these exist and/or according to the relevance of the solicited trainings;
- To privilege as much as possible the national and the regional capacity strengthening in training.

*With regard to recruitment:*

- To respect the ethics of the Code of Practice of the WHO during the international recruitment of HRH coming from poor countries;
- To compensate the potential negative consequences on the local health systems caused by the recruitment of HRH in the partner countries.

*In our environment in Belgium:*

- To inform and to raise awareness with the actors of the public and the private sector who might recruit HRH coming from the South using the principles of the Code of Practice of the WHO, in especially with regard to the welcoming of these persons and the implications of their recruitment on their countries of origin;
- To reinforce the collaboration with the diaspora and the universities in Belgium;
- To capitalize and to share our experiences with regard to the support of development of HRH.



Paul (Return to care), Stefan (BTC) and Anne (ULB) - Wim (WHO), Karel and Paul (BTC), Elisabeth (ULg) and Dirk (ITM) - The current and former DGD team: Francis, Ignace and Philippe

## Announcements

Du 23 au 26 Octobre 2012 : Atelier de capitalisation à Kinshasa 'Financement et qualité des soins et services de santé : renforçons ensemble la santé en RDC'

27 November 2012: general assembly of ITM, with the signature of the 'Charter on the recruitment and support to the development of human resources for health in partner countries'

29 November 2012 : 8th Annual seminar of Be-cause health, at ITM-Antwerp: 'People centered care: A paradigm for the promotion of individual and collective wellbeing'