

BRAIN DRAIN TO BRAIN GAIN
HEALTH WORKFORCE MIGRATION EXPERIENCE FROM UGANADA
Co-funded by the European Union and NORAD &
coordinated by WHO

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Project Aim

In General the project aims at Supporting WHO Code of Practice on International Recruitment of Health Personnel for Better Management of Health Worker Migration” at Country level.

The Brain Drain to Brain Gain project is implemented by ACHEST in the Africa Region in two countries - Uganda and Nigeria:

- to contribute to building capacity for HWF stock and flow management
- as well as to inform policy dialogue on HWF development

Regulation framework for the Labour Work Force Export Market in Uganda

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Regulation is in its infancy

**The Employment, (*Recruitment of Ugandan
Migrant Workers Abroad*) Regulations, 2005 no. 62
provisions:**

- 1. Licensing of Recruitment Agencies**
- 2. Inspection (*supervision of Recruitment Agencies*) and its scope**
- 3. Accreditation of Recruitment Agencies, criteria, procedures, sanctions etc.**

Labour Work Force Export Market infrastructure in Uganda

- 1. The National Administration is vested in the Ministry of Labour**
- 2. Legal Frame still weak and narrow**
- 3. Currently there are 25 licensed private overseas recruitment companies in Uganda as of 12th January 2015**
- 4. THE CODE ASSUMES THAT ALL THESE CAPACITIES EXIST FOR THE EXPECTED TASK for Member State (MoH) TO UNDERTAKE**

▶ Member States should, to the extent possible, and according to legal responsibilities, **MAINTAIN A RECORD, UPDATED AT REGULAR INTERVALS, OF ALL RECRUITERS AUTHORIZED BY COMPETENT AUTHORITIES** to operate within their country.

THE HEALTH WORKFORCE STOCK IN UGANDA

Health Work Force Stock

Uganda Health Sector Performance Report 2014/15,

Uganda had a total of 81,982 health workers employed in the health sector.

A total of 42,530 (52%) were employed in the public sector; at least

9,798 (12%) in the PNFP sector, while about

One-third (29, 654) either in private practice or unemployed or emigrated.

Medical doctors estimated at 4,811 (6%)

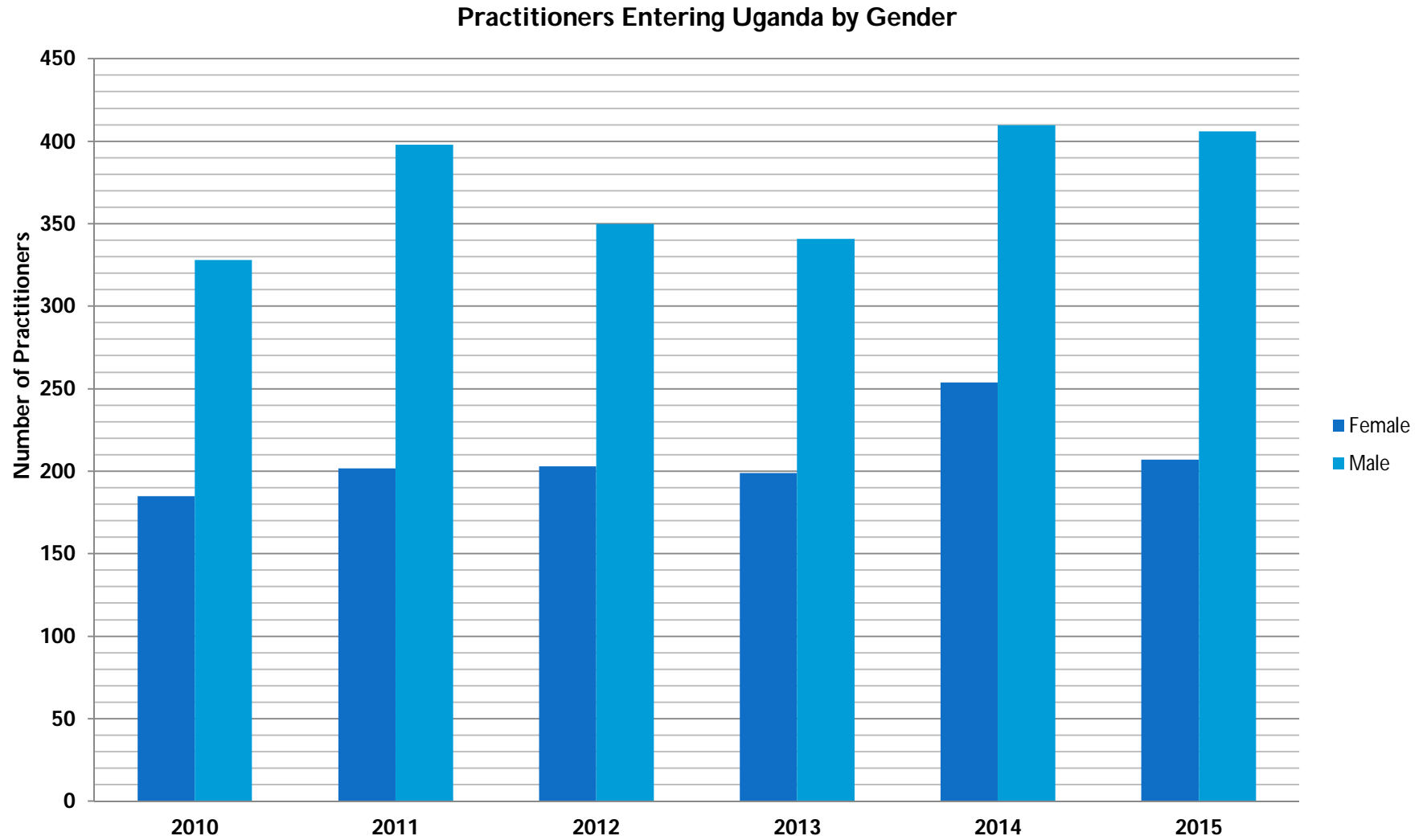
GPs alone estimated at 3,849 (80%) of doctors

THE HEALTH WORKFORCE GROWTH

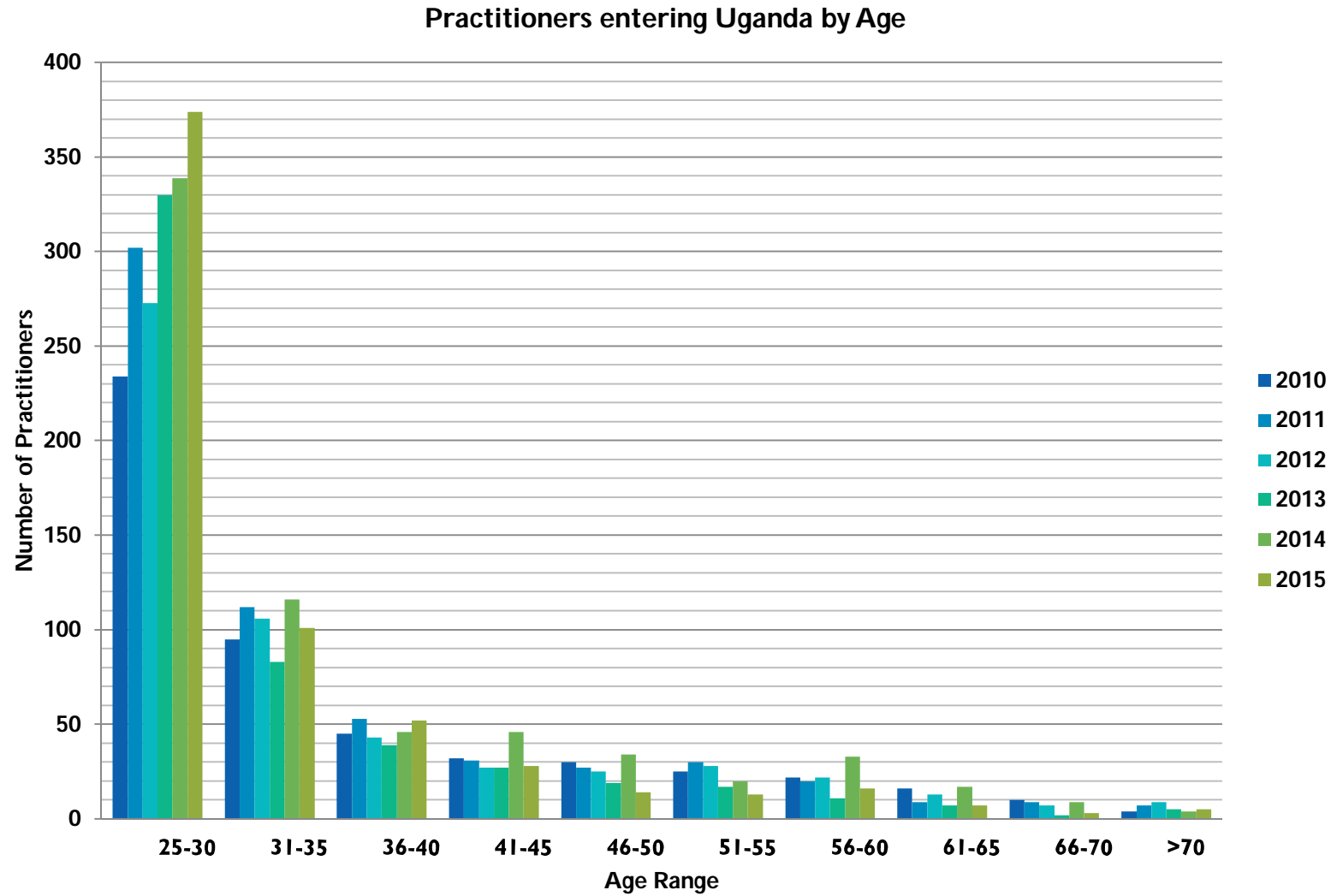
IN-FLOWS

ENTRIES TO THE STOCK

IN FLOWS BY SEX (GENDER)

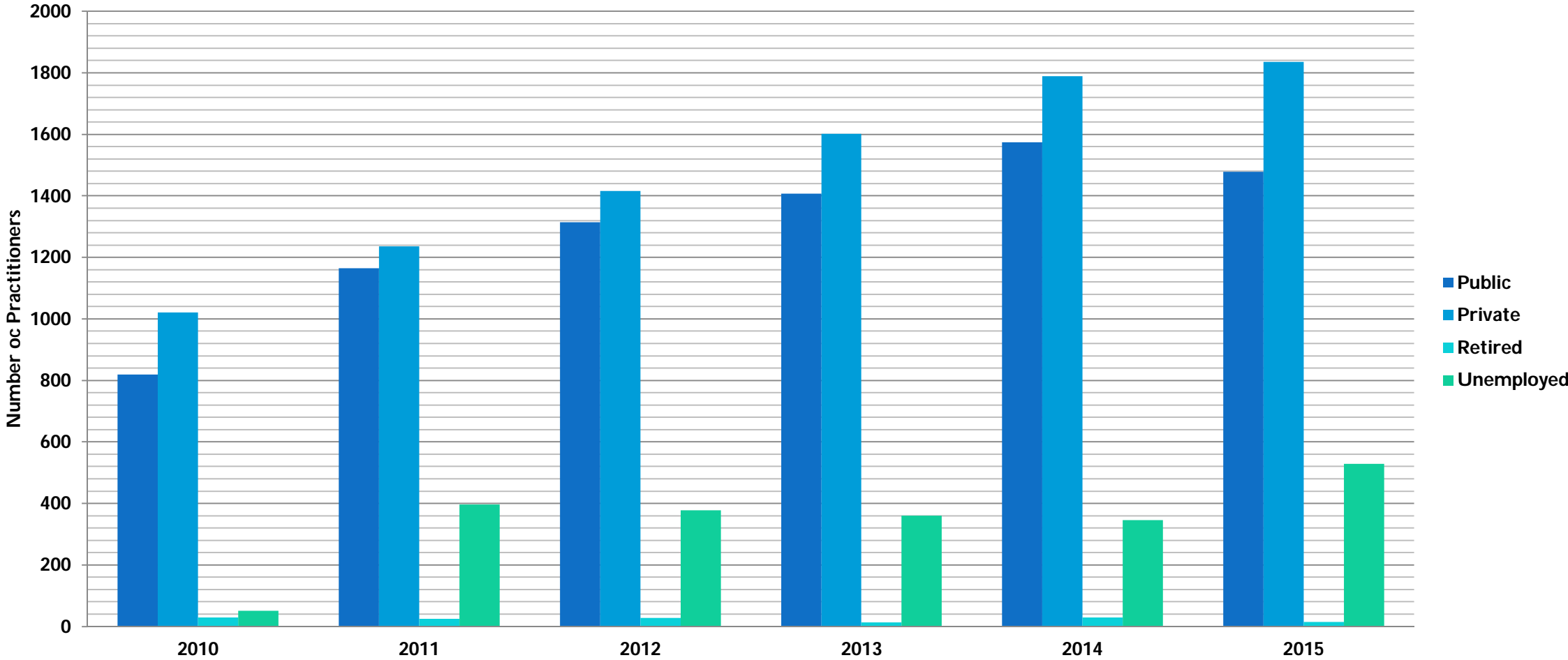


AGE DISTRIBUTION OF INFLOWS TO THE STOCK



IN-FLOW DISTRIBUTION TO SUB-SECTORS (Public/Private)

Practitioners entering Uganda Stock by employment status



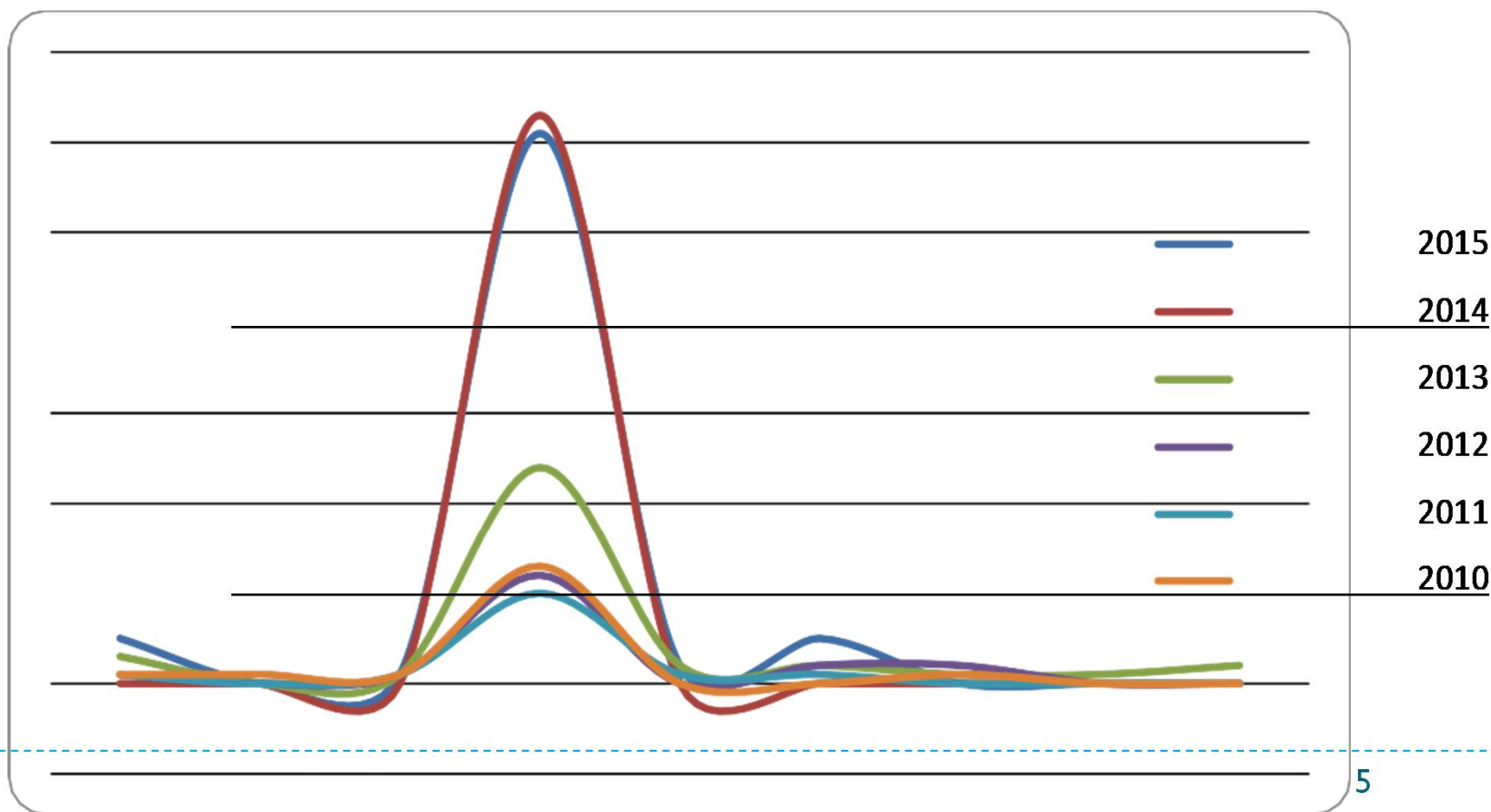
THE HEALTH WORKFORCE

OUT-FLOWS

ENTRIES TO THE STOCK

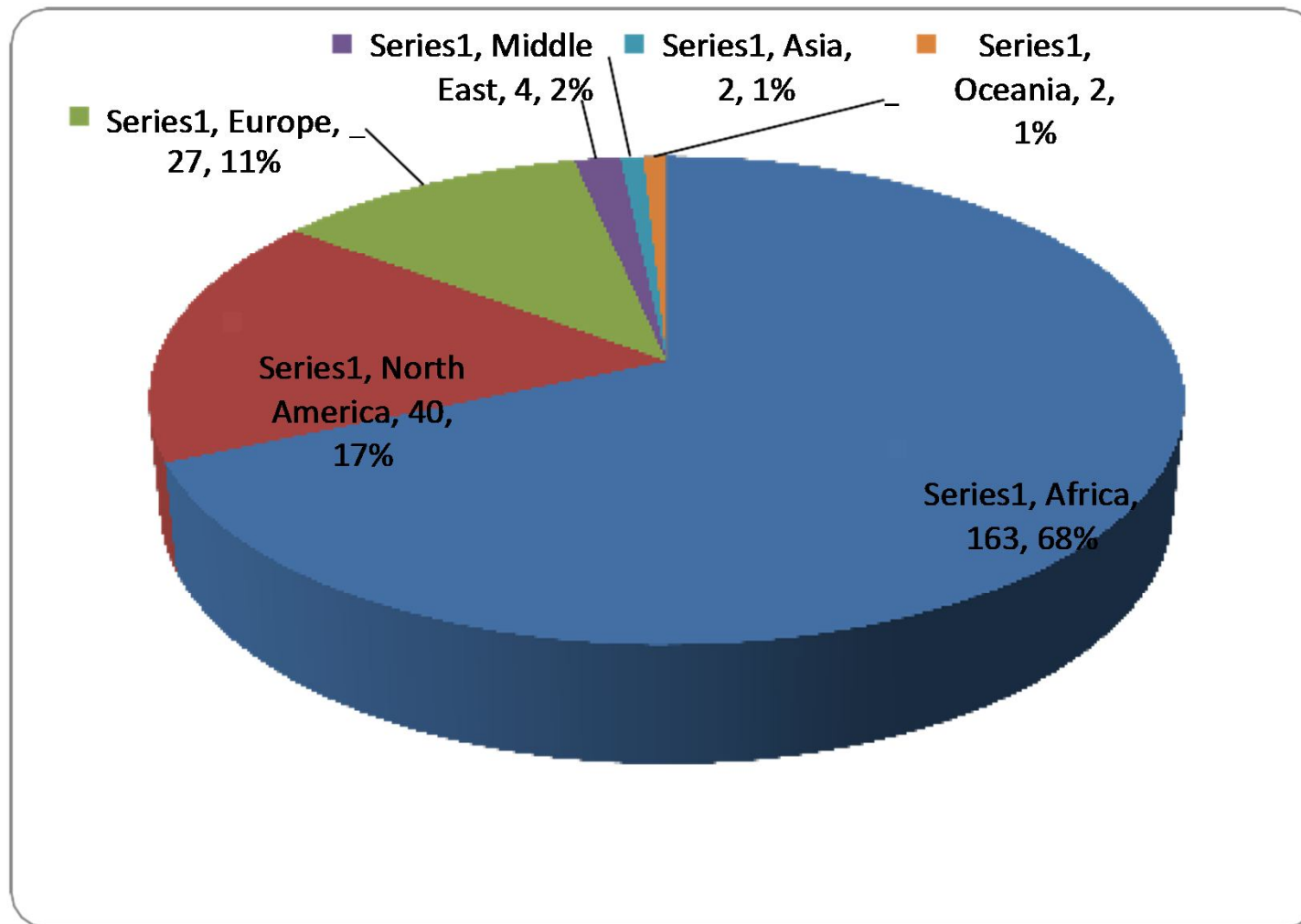
EXITS: A migration trend analysis reflects a peak in migration between 2013 and 2014 when the highest number of medical practitioner health cadres indicated intentions to migrate.

Figure 1. Distribution of migrating surgical workforce by cadre, 2010–2015



WHERE ARE THEY GOING? – Destination Countries

Figure 2. GLOBAL Distribution of migrating cadre by destination



- ▶ **A higher than usual influx of medical practitioner personnel from Uganda into the Republic of South Africa was recorded during that period.**
- ▶ **Most of the migrating medical practitioner health workers (68%) were destined to African Countries most notably Botswana and South Africa.**
- ▶ **North America accounted for 17% of the destinations with Canada alone accounting for 13.6% which was notably greater than intended migrations to all European destinations combined which accounted for 11%**
- ▶ **IN GENERAL THERE IS A NET OUT - FLOW**

"The Trinidad and Tobago Case" HWF Export proposal in Uganda

1. The Government of Uganda, through the Ministry of Foreign Affairs, had tentatively agreed to send around 300 skilled health workers to Trinidad and Tobago in exchange for oil and gas industry training and financial support for its police.
2. The proposed agreement generated negative reactions from national civil society because of health workforce shortages and mal-distribution in Uganda.
3. Several development partners also raised concern and Belgium's Cooperation Minister proposed to put on hold the disbursement of development assistance to the Government of Uganda
4. In light of concerns, Parliament requested for further consideration and broader stakeholder dialogue on the matter & it is on hold.
5. Regrettably - Little use has so far been made of the available provisions of the Code in resolving dissent to the proposed arrangements

CONTEXT AND CAPACITY DEVELOPMENT

- ▶ **CAPACITY DEVELOPMENT FOR DATA ASSEMBLY / ANALYSIS**
 - ▶ **Peer learning through group and person to person interactions**
 - ▶ **Hands on approach in small working groups with various Council technical staff for:**
 - **Compliance requirements for WHO Code implementation**
 - **Role and rationale for assignment of NDA**
 - **Data assembly for annual register update – in transition from manual to on-line web-based digital system**
 - **Analysis and collation of data for reporting**
 - **Completion of NRI for 2nd round reporting**
 - **Defining data set parameters for the General Practitioners case study**

STAKEHOLDER ENGAGEMENTS AND ADVOCACY & Policy Dialogue

JAR Meeting

- Active engagement and participation in the national Joint Annual Review (JAR) of Health Sector Performance – 1st year data presented to stakeholder and policy makers by a director in the MoH and a council registrar;

Advocacy & dissemination in multi-disciplinary fora:

- *Advocates for Professionalism and Quality in Health at Stakeholders' Workshop*

Engagement with development partners in destination countries:

- *Continue Engagement with EU-ACP parliamentary Committee for dialogue*

CHALLENGES

- 1. Challenge of effective buy-into the Code implantation tasks expected of countries**
 - ❑ Enhancing the voice of health system leadership to disseminate and use the Code provisions to manage country HWF stock and flows.
- 2. Gaining a common position on definitions of cadres for reporting in case studies as well as for NRI under the “others” category.**
- 3. Weak out-dated regulatory framework for health professionals and insufficient funding flows to regulators**

Thanks You

THE END