Bellagio Meeting on
Posting and Transfer Practices in the Health Sector

Rockefeller Conference Centre, Bellagio Italy
3-7 February 2014

Meeting Report

Acknowledgements

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List of acronyms

AMDD	Averting Maternal Death and Disability
DALY	Disability-adjusted Life Years
DFID	Department for International Development (UK)
GAVI	Global Alliance for Vaccines and Immunisation
HPSR	Health Policy and Systems Research
HRH	Human Resources for Health
HRM	Human Resource Management
ILO	International Labour Organisation
MDGs	Millennium Development Goals
MI	Mission Inconsistent
MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health
MRC	Medical Research Council
P&T	Posting and Transfer
PEPFAR	US President's Emergency Plan for AIDS Relief
PHFI	Public Health Foundation of India
SAPs	Structural Adjustment Programmes
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organisation

Executive Summary

Since 2012, the Health Governance Hub, Public Health Foundation of India, and the Averting Maternal Death and Disability programme at the Columbia University Mailman School of Public Health, have been collaborating to explore the practices of posting and transfer (P&T) in the health sector. After a foundational literature review, a preliminary consultation in Delhi, and a case study in Tamil Nadu, India, a global meeting was held in Bellagio, Italy, 3-7 February 2014. Researchers and policy makers from India, the Middle East, West Africa, North America, and Latin America were invited to deliberate on the issues of P&T, and to consider the potential for a research and advocacy platform for P&T. The *a priori* objectives of the meeting were to a) advance a shared understanding of P&T, b) facilitate planning of future, multi-country research, and c) strategize on a roadmap for taking the issue forward.

The report is organised according to the objectives of each meeting day:

- Day 1 presented a series of in-country P&T experiences
- Day 2 probed possible 'frames' for positioning P&T research and intervention
- Day 3 proposed options for taking the P&T agenda forward

The discussions focused on the various perspectives in which the discussions on P&T could be embedded (as an issue of the health workforce, as an issue of health system performance, as an issue of human rights), and the implications of each. Given its complexity, the issues of P&T were considered to exist at the intersection of these perspectives. As such, the meeting recognised that methods for researching and advocating for action on P&T would necessarily require multiple methods grounded in various disciplines, and collaborating with different partners. The meeting achieved its objectives, though it unearthed a host of questions that will guide the future development of an innovative agenda for addressing P&T.

Background

Posting and transfer (P&T) refers to the manner in which the health workforce (frontline staff, managers, and high-level administrators) are deployed within health systems. P&T practice has major implications for government/public sector health service delivery, and the meeting focused on these factors. However, P&T also touches on, and is touched by, dynamics of human resource management (HRM) in the private and non-profit sectors (including faith-based service delivery), across both rural and urban settings. Though human resources for health (HRH) have become a major focus of health system strengthening, including pre-service and in-service capacity strengthening, and attempts to address the maldistribution of the health workforce, minimal attention has been given to the negotiation spaces in which deployment and transfer decision-making occurs. These negotiations necessarily take place in broader political, social, and economic contexts. P&T, as a neglected problem of health systems, is a profoundly entrenched issue characterised by organisational and social dynamics, and yawning gaps between official policies and actual practice.

What drives P&T processes? It is not clear that there is one single driver: P&T decisions can be punitive, granted as rewards, or even whimsical. While the issue of corruption is squarely acknowledged (both in terms of direct financial gain, and well as less overt forms of patronage and clientelism), it is also acknowledged that 'mission-inconsistent' (MI)[1] P&T is also linked to health system arrangements that obstruct effective and efficient P&T. Given the contextual variances of P&T practice, is there a 'gold standard'?

Some assumptions underpin the discussion on P&T: that non-transparent or unfair P&T erodes the trust, morale and satisfaction of the health workforce in the systems within which they work; that frequent transfers reduce the depth of local knowledge of the health workforce, and diminish trust and communication between communities and the health workforce; and that a higher number of transfers is linked to worse health outcomes, because of fragmented continuity of care. These inefficiencies exist at a cost to the system – there is great need to build the evidence base on how and why MI P&T occurs, its scale, its costs, who is most affected, and actionable solutions to improve P&T.

The Bellagio meeting on P&T was meant to address the 'open secret' of P&T, that is, the recognition that while the manner in which health workers and administrators are either posted or transferred in public sector health systems is crucial to the performance of those systems, P&T is rarely an issue of discussion, in either research or practice.

[1] Schaaf and Freedman (2013) refer to 'mission-inconsistent' P&T as *"not advancing population health goals and being incompatible with prevalent professional ethics regarding civil servant and health care worker rights and responsibilities".*

Day 1: Immersion (meeting objectives, country experiences)

Participants were warmly welcomed by the meeting organisers (Public Health Foundation of India, PHFI, and the Averting Maternal Death and Disability Programme, AMDD, of the Columbia University Mailman School of Public Health). Self-introductions followed.

Given the background, the meeting organisers noted the different perspectives with which they were approaching the issue of P&T:

1) *As an instrumental issue:* There is a need to staff the health system, particularly in the periphery, and where people live. P&T has ripple effects especially in maternal, newborn and child health (MNCH) services, due to their dependence on an equitably distributed health workforce.
2) *As a systems issue:* The health workforce, as a key sub-system of the health system (i.e. a 'building block') has implications for the functioning of other sub-systems. There is negotiation, contradiction and contestation involved in managing deployment. P&T becomes a window onto the 'software' of the systems it pervades – that is, its human and social dimensions. P&T is more than simply an issue of staff retention.
3) *As a human rights issue for health care workers, managers, and patients:* For a health system to be considered truly people-centred, it must consider the needs and preferences of its workforce, as well as organisational justice. There are power dynamics globally and locally, between patients and providers, between health workers and managers, and between politicians and health managers, which underlie the occurrences of P&T – the challenge is to make power legible, to read and understand how it works.

The issue of P&T is an intersection of the three perspectives, and can be viewed organisationally and societally. P&T raises several questions: what are the impacts of MI P&T on health system performance; on achieving the Millennium Development Goals (MDGs) and Universal Health Coverage (UHC); on the social mission of health systems, on the health of organisations themselves?

While the organisers noted the research and conceptual framing they had undertaken prior to the Bellagio meeting, they emphasised that for the meeting itself, there was no set approach to, or position on P&T; the meeting was open to diverse thoughts, generated together, from the global and on-the-ground experiences to be presented.

Objectives of the meeting

In addition to the *a priori* objectives stated by the organisers, the group identified additional objectives during the opening plenary. These were to:

- deliberate on how to *do* and *support* P&T research;
- move towards establishing a global research network that actively researches P&T in its various contexts; and

- identify next steps from this meeting to support a platform for doing P&T research.

Country experiences

Brief presentations were given from India, Morocco, Ghana, Niger, and Nigeria to highlight the specific contexts of P&T in different countries. In a wide-ranging discussion, several issues were raised.

Intrinsic motivation among the health workforce: Studies in Ghana illustrated that health staff posted to rural areas viewed the P&T process as largely unfair. Difficulties in serving in rural posts included lack of equipment and supplies, work overload, and minimal career advancement opportunities, among many others. Many staff feared 'being forgotten by the system' once posted to rural areas. Staff had little confidence and trust that the system works the way it is supposed to. For those who did stay in a rural posting, they did so because of intrinsic motivators (such as personal commitment, religious drive, or being an indigene of the area). Furthermore, those intrinsic factors were often overlaid, i.e. several motivators were at work simultaneously. The policy implication, then, is that frequently, staff stay in 'non-desirable' posts *in spite of the system*, and not because of it. Thus it is likely that an exclusive focus on external incentives may not improve the operation of P&T practice, and considerations of intrinsic motivation may require further attention. However, some evidence from India indicates that health workers perceived as fair and legitimate P&T processes which categorise postings by difficulty, according to criteria articulated by health care workers themselves, then creating rules for staffing such postings.

Health system performance: There was much debate about what precisely is the relationship between P&T and health system performance, especially at the outcomes level, and further, which outcomes matter i.e. health outcomes only, or the wider functioning of health systems as social institutions? It was strongly felt by participants that there is much need to explicitly link poor P&T practice to health outcomes, and to understand the written (where they exist) rules and policies which are meant to guide P&T, as well as the relevant unwritten norms.

Weak capacities for HRM information systems also affect the full spectrum of HRM from recruitment and hiring to P&T. The example was given of the low capacity for data use, analysis and integration in long-term planning and decision-making in Morocco, and how this influenced P&T over time. This example underscores a critical and complex point: there is a need to move beyond discussing only increasing the volume of postings (and focusing only on biomedical cadres), to more closely examining in-country governance (financial and delivery) arrangements, and exploring overall accountability mechanisms and institutional values and how they are expressed (e.g. performance appraisal systems, and other institutional incentives). This is to see where levers of change are located to change organisational cultures and reorient institutional accountabilities.

Concerns of equity, gender, and organisational justice were further raised in the vein of health system performance. This led to the question of what, then, is *'mission-consistent'* P&T practice? One possible meaning is: *having the right people in the right place at the right time, doing the right thing (and respecting their rights).*

The challenge of understanding scale: One clear need regarding P&T is to define its scale: what is the size of the P&T challenge? How prevalent and pervasive are MI P&T practices? How many staff are affected,

and which levels of the health system are most impacted? Furthermore, what are the consequences of taking action or no action? The example was given from global projections on numbers of midwives needed to adequately address MNCH. Numbers are already inadequate; this challenge is exacerbated when overlaid with poor P&T practice. There is need to review the literature to recognise not just what has been reported, but what has not been reported as well. What is feasible in terms of future forecasting vis-à-vis cost analyses of MI P&T, e.g. days lost to absenteeism or transaction costs of administrative management of P&T? One participant suggested using measures akin to DALYs. Indeed, qualitative evidence needs to be linked to quantitative perspectives.

The political nature of P&T: There is a strong political dynamic in some P&T decision-making. The example was given of a senior official in Pakistan with authority to delegate responsibilities for P&T to his subordinates, yet spending 80% of his time directly overseeing P&T because it makes him socially and politically relevant and influential as *"people are always in his office…"* The health sector in Niger, which is characterised by a typical command-and-control hierarchy, demonstrates that both direct and covert financial gain surround P&T*(see box)*. Elaborate sets of informal rules can contribute either constructively or destructively to the functioning of the system. Distinctions can be made between *practical norms*, which are implicit and de facto; *adaptive practical norms*, which don't break official norms but help to modify them to local contexts, and are thus largely tolerated; and *targetive norms*, which break local norms, but help to deliver services, and are deemed necessary in cases where the state is incapable of delivering services. This touches on the public administration perspective of P&T, and the fact that in many cases, street-level bureaucrats at different system levels are making decisions with divergent interests.

Clientelism and patronage in P&T processes

In Niger, many health care workers seek postings in urban areas because they can be lucrative due to opportunities for dual practice opportunities, and because of the higher concentration of donor funding (per diems, consulting, etc). Postings are often rewards disbursed through kin and social networks, operating amidst accountabilities to an appointer/protector. This reflects the 'winner takes all' orientation of the political system, but also underlines that when the rules of the system cannot be relied upon, power and entitlements get distributed in other ways, according to informal rules.

The policy implications of this is that superficial interventions for P&T won't work – we cannot expect a single lever to elicit major change. What is possible however, is creatively building on informal/practical norms that do exist.

Regulatory weaknesses: Often, P&T failures are due to weak regulation. There is a dearth of sanctions for poor P&T practice. A systematic review of workforce bonding effectiveness (i.e. contractual agreements that provide training/education financial support on the part of an employer for a prescribed period of service from the employee) was conducted by the Alliance for Health Policy and Systems Research (AHPSR). Though the study was largely descriptive, it noted that the efficacy of sanctions and regulations are deeply connected to a government's ability to enforce them.

The broader contexts: The point was made repeatedly that broader contextual issues, both within and external to the health sector impinge greatly on P&T practice. Particular contexts raised as important

were the increasing commercialisation of service delivery (in the case of India), public sector salary increases (in the case of Ghana), decentralisation reforms (in the case of India, Ghana and Nigeria), political and socio-economic divisions across geographic lines (in the case of Nigeria), and past public administration reforms (such as the influence of structural adjustment policies on public sector staffing).

In particular, the issue of decentralisation, and the mismatch between administrative, political and fiscal decentralisation policies was discussed in-depth in relation to the potential for decentralised district health systems to improve the fairness of P&T practice.

One crucial concern was the destabilising effects of development aid, particularly in terms of capacity-drain of health staff into donor projects and vertical programmes. In essence, access to aid-funded programmes functions as another resource that those with power over transfers can distribute as a reward. This is observed in several sub-Saharan African countries.

What are 'good' P&T practices? Given the wide range in contexts and practices, the question was posed: what would be the preferred practice of P&T? Is there such a thing as 'best practices' which would work across most country contexts, and which practices might guide the development of robust policies? Could lessons on P&T be learned from other civil service sectors which appear to have more stable or transparent processes? How can assessments of progressive/regressive P&T processes be made over time? For example, what is the classification of different types of 'desirable' and 'undesirable' postings (either urban or rural)? Are the 'right' people (in either skill or motivation) posted to the 'right' places at the 'right' time? The example was given from Thailand, where the problems of MI P&T are perceived to have largely been solved. The example was also given of Chile where doctors who stay in rural posts for three years are subsequently funded by the MOH for their residency training, in conjunction with accommodation, networking and mentoring opportunities. Further study on these positive examples, and how they were achieved is needed.

One area which participants deemed important, but which was little discussed is the role of civil society in the P&T debates. This was linked to comments on the need for the development of accountability frameworks to communities on P&T issues.

Reflections on emerging themes

Reflections from Day 1 addressed the perspectives being used to generate evidence, and the subsequent implications for those perspectives and evidence on what possible interventions can be considered for P&T.

In summary, four main themes of the day emerged:

1. There is a significant disconnect between P&T systems of formal rules and the way P&T actually functions.
2. The larger contexts in which P&T practices are embedded are critical.
3. The scale of the P&T challenge must be made explicit.

4. The connection of P&T to global policies on health, and to service delivery outcomes must be made.

Day 2: Interrogation (framing the issue through research)

Day 1 deliberations highlighted several definitional issues centred on investigating the problem of P&T – what precisely is the problem, is it perceived to be a problem, and what are the imperatives and functions behind P&T? It was also clear that there were several possibilities in setting the terms of P&T debate, each with its own implications. P&T could be positioned as:

- *an issue of the health workforce:* can build on HRH issues of mal-distribution and (in)equity.
- *an issue of health system governance:* how the health system is organised and administered in order to ensure equitable and appropriate workforce distribution, accountability and transparency of health services to communities, and responsiveness to community needs
- *an issue of system performance:* how does poor P&T affect health outcomes? Can be linked to the retention literature, where the links between retention and outcomes are already well-documented; can be linked to discussion of labour markets, and increasing commercialisation/commodification of service delivery; can also be linked to discussion of UHC debates by considering health systems as a development issue.
- *an issue of organisational justice:* are people's needs (both providers and communities) being met? How do providers experience P&T? What is the informal economy of P&T? What is its relationship with gender and other social inequities? What is its link to civil society?
- *a complex adaptive system issue:* need to consider the interconnectedness of P&T as part of a complex adaptive system, in relation to the health system's self-organising, emergent, non-linear and feedback characteristics.

Such positioning will be important for the P&T agenda both at global and national-levels, and in terms of both research and advocacy. Researching P&T is about understanding the relationship (or lack thereof) between policy and practice. It is also about understanding the experiences and relationships of diverse actors, and on relating these lived experiences to the written word of policy and the norms that guide behaviour. It is also about understanding multiple perspectives of multiple actors in the system and not limited to those in decision making roles.

Methods for researching P&T

Given the above, several possibilities for research approaches were presented, including:

Case study and mixed methods: can be used to explore policy implementation issues, informal practices, the impact of P&T practices on health worker and community trust, the career histories of different cadres of health workers, and the impact of P&T on facility, program, and/or health system functioning.

Participatory methods: can be used to seek meaning to allow for solutions that are grounded in reality, are actually implementable, and foster local ownership. Participatory methods also enable inclusiveness so that the right stakeholders can contribute data and sense-making. This means including health

workers, those in service, and those currently in pre-service training, and communities as well. The goal is to 'make things work better', and to send the message to policy-makers to act on emerging evidence, and not to wait for 'perfect research'. Ways of doing this (and potential sources of data) include exploring existing models and evaluating them to understand what is needed and where, exploring outcomes of decisions that have been made, aligning with service delivery needs, use of health workforce observatories, exploring support systems for health workers, and multi-country comparative case studies.

Implementation research, including realist approaches: can be used to assess interventions (such as emergency hiring, retention schemes, verticalisation, compulsory service, decentralisation of decision-making, local hiring schemes). These and other interventions are often implemented to short circuit P&T challenges, but they are rarely evaluated in terms of these goals. Realist approaches can elucidate how these schemes interact with existing context to trigger mechanisms which result in varying patterns of outcomes.

Policy analysis: can provide insight at multiple levels (policy-making, policy translation, negotiated outcomes within individual career trajectories). Moreover, given that P&T policies are poorly documented in the global literature, simple policy mapping in different sectors (such as health, education, and the police) may deepen the understanding of P&T in the health sector.

Historical analysis: can help us to understand how present P&T policies and practices came to be, to examine the impact of structural adjustment, colonial regulation and post-independence state building. Understanding the contexts and complex processes of institutional change from the past can strengthen our understanding of the present.

Economic analysis: given the relative scarcity of health workers and managers, an economic lens may help us to understand the official and unofficial labour market, including the market for posts and transfers themselves. This rational choice driven model risks being reductive, but it could illuminate the distribution of people, while other methods could shed lights on other aspects. In addition, discrete choice experiments can be used to understand the strength of the preferences of individual health workers and managers regarding P&T.

Less common approaches mentioned included ethnography, and discourse and legislative analyses. These could be used in the construction of a case study.

Overall, there was consensus to privilege methods which enable extensive probing of context, as contextual factors might be particularly salient. It was also agreed that perhaps an HRH approach to P&T was too narrow.

An editors' panel on how research on P&T might be positioned to gain more traction offered the following suggestions to examining P&T:

- through governance and leadership (macro level)
- through individual role and behaviour (micro level)
- as institutional factors influencing HRH policies and practices

- the role of power and politics
- as connection among health system actors (social network analysis)
- incentives for responsiveness and professional development
- through regulatory frameworks
- focusing on health systems actors themselves
- focusing on P&T as a public service function
- looking at P&T as a policy space that interrogates the values in a health system

The panel further underscored the importance of synergies between the research questions and the methodologies to address them, and a need for rigour and reflexivity in the research.

A broader discussion on research in the field of HPSR raised further points, namely the need to be participatory at the country level (e.g. consultation and priority-setting exercises); the need to consider the continuum between data generation and policy influence; the ethics of researching P&T (feasibility and political sensitivity of some data collection; understanding values – trust, respect, kindness/care, compassion – and how (or whether) institutions express them?; and being mindful of considering P&T as a window onto a larger set of questions without eliciting knee-jerk reactions from other policy-makers and researchers. On the issue of ethics, the discussion raised the issue of what precisely are values grounded in – whether values are grounded in the service delivery function, as health systems do not operate in isolation without communities. It is values which should drive health workers to serve the public good; yet the question was posed whether institutions intentionally attempt to express particular values, as at times there are differences between the values institutions admire versus those they maintain in practice (for example, do people operate under types of 'practical ethics' to enable their work?). It was understood that it is difficult to translate values into empirical words (e.g. what are the indicators?), and there is a problem of values being perceived as too esoteric. However, it was agreed that it is possible to distinguish values from sentimentality (for example, the Alma Ata declaration is full of values). New knowledge is to question, challenge and affirm old knowledge.

The day concluded with a call to be as 'cutting-edge' as possible, to consider innovative approaches to researching P&T, and to support policy-makers to refine their own questioning of P&T issues. While no one research question was stated, there was agreement that the 'spirit' of what was being broached was the issue of health systems as important social institutions, and whether they were meeting their social obligations. In terms of process, current P&T practice is often not fair. The fact that facilities are neither well-staffed, nor well-run in turn affects quality of care. This may cause communities to lose trust in services and seek care elsewhere.

Day 3: Intentions (roadmap and way forward)

A network for P&T advocacy and research

On the final day of the meeting, participants were tasked with considering ways of concretely moving the research and advocacy agenda for P&T forward. Naturally, there are differing views on what the challenge of P&T is, and how best to deal with it. Being complex in nature, P&T cannot be addressed by one single research discipline or methodology. It was agreed that different entry points can be pursued in different countries depending on what is feasible. Several participants presented briefly on preliminary ideas for taking P&T research forward in their settings.

There was consensus on viewing the purpose of the network as raising the profile of P&T, creating an inter-disciplinary body of knowledge, and supporting multi-country research. Advocacy efforts would highlight the urgency, scale, and need for more in-depth research the topic. One intention of the network would be to not only connect researchers with each other across settings, but also to support researchers to be connected with their own policy makers and programme managers to ground the agenda and better refine the focus of research.

Rather than a tightly regulated network with rigid structures, it was felt that the greatest value such a network could provide would be to enable multi-country teams to do work in relation to their own positionalities and disciplines, and provide linkages across different settings. Organisational and logistical support for continued P&T work over the next two years will be coordinated by a small secretariat at AMDD, funded by a MacArthur Foundation grant. AMDD and PHFI will take the lead on the listed next steps, with delegation to participants as needed.

A detailed discussion on attracting a consortium of potential funders ensued. Given the complexity of the topic, it was deemed important that the network itself should be simple and easy for any outsider to understand. The need to show potential funders the utility of such a network was highlighted. Several potential funders were identified: UN Women/ILO (rights/working conditions of frontline workers who are predominantly women), GAVI (impacts of P&T on immunisation), USAID (supporting selected sub-Saharan countries to move away from PEPFAR-paid salaries), Wellcome Trust/DfID/MRC (implementation research platform), Gates Foundation, the Global Health Workforce Alliance, AHPSR, and South-South collaborations, to name a few.

It was also mentioned that the network might gain most traction by being affiliated with existing network structures. One possibility might be establishing a technical working group under Health System Global (the membership organisation for promoting health systems research and knowledge translation internationally). A deadline for proposal submission is 1 June 2014. Momentum will also be sustained by a satellite session at the upcoming Third Global Symposium on Health Systems Research (October 2014), the theme of which is: *the science and practice of people-centred health systems.* Other existing networks include the Harmonisation for Health in Africa Communities of Practice, and the HRH Observatory in Latin America. To build on existing data, working with existing initiatives such as CapacityPlus would be beneficial.

One issue which was debated was the need (or not) for a theory-driven approach to P&T for the network. The theory does not need to be a unified field theory yet, and would necessarily have different aspects to it stemming from different contexts, disciplines and approaches to P&T. On the other hand, it was pointed out that while P&T research can be conceived at an empirical level, it may not lend itself to a relevant level of theorising. Possible theories might be rooted in conceptions of trust, gender, methodology, or leadership. No consensus was reached on this point.

Some identified challenges of networks included the at-times diffuse nature, and fragmented results, as well as the transaction costs of gathering and synthesising results. Secondly, issues of barriers to scaling-up network activities were mentioned. A further note of caution was the need to acknowledge the potential risks in engaging in P&T research given the political sensitivities, and the possible position of compromise researchers might find themselves in. As such, attention to couching the topic in a positive, non-threatening manner to better collaborate with government officials was emphasised – one area the network might add value would be in a 'safety-in-numbers' orientation, essentially building a critical mass of evidence globally. Attention should be paid to the type of language used in describing P&T.

Next steps

- define common principles for the network's operation;
- reach consensus on the broad areas of further enquiry;
- clarify types of research and advocacy gaps in P&T the network wishes to fill;
- draft concept note for P&T network for research/advocacy purposes;
- submit proposal for a P&T technical working group to Health Systems Global – one possibility is the theme: *strengthening government health services/public sector service delivery* (with sub-themes of P&T, quality of care etc.);
- organise satellite session at Third Global Symposium on Health Systems Research (October 2014, Cape Town), and possible next meeting of Bellagio participants at Cape Town;
- conduct global mapping (diagnostic) of P&T policies, processes, and actors: what do we already know?;
- trace evolution of P&T policies in-country over time;
- consider drafting a strategic paper which synthesises divergent perspectives on P&T to attract the interest of different audiences (e.g.: public administrators, sociologists, HRH specialists etc.);
- draft/submit brief commentary/perspective on P&T to peer-review journal;
- write blogs on P&T; and
- create P&T website.

The meeting drew to a close with mutual thanks between the participants and meeting organisers for an insightful meeting, and a commitment to further the work on P&T globally.

Appendices

Appendix A: List of participants

1.	Dr Kabir Sheikh	Health Governance Hub, Public Health Foundation of India
2.	Dr Surekha Garimella	Health Governance Hub, Public Health Foundation of India
3.	Mr Raman VR	Health Governance Hub, Public Health Foundation of India
4.	Professor Lynn Freedman	Mailman School of Public Health, Columbia University
5.	Ms Marta Schaaf	Mailman School of Public Health, Columbia University
6.	Professor John Porter	London School of Hygiene and Tropical Medicine
7.	Professor Mario del Poz	Social Medicine Institute, University of Rio de Janeiro, Brasil
8.	Dr Abdelhay Mechbal	Ministry of Health, Morocco; WHO EMRO *(retired)*
9.	Dr Abdul Ghaffar	Alliance for Health Policy and Systems Research, WHO
10.	Dr Jean-Pierre Olivier de Sardan	Laboratoire d'études et de recherches sur les dynamiques sociales et le développement local, Niger
11.	Dr Antony Kollannur	Former Director, State Health Resource Centre Chhattisgarh, India
12.	Dr Fadi El-Jardali	Faculty of Health Sciences, American University of Beirut
13.	Dr Dilip Singh	National Health Systems Resource Centre (New Delhi), India
14.	Dr Bruno Marchal	Institute of Tropical Medicine, Antwerp
15.	Dr Jim Campbell	Integrare Instituto de Cooperación Social, Spain
16.	Mr Jim McCaffery	CapacityPlus, Washington D.C.
17.	Dr Genevieve Aryeetey	University of Ghana School of Public Health
18.	Ms Aku Kwamie	University of Ghana School of Public Health
19.	Dr Seye Abimbola	National Primary Health Care Development Agency, Nigeria

Appendix B: Meeting agenda

Day 1: 03/02/2014 - Arrival		
Day 2: 04/02/2014: IMMERSIONS		
Time	*Activity/participants*	*Comments*
9.00-9.30	**Introductions**	
9.30-10.00	**Overview & expectations** K Sheikh, L Freedman	
10.00- 11.00	**"P&T Experiences" presentations:** (20 min + 10 min QA) G Aryeetey, A Kollannur (Chair: JP Olivier de Sardan)	Responding to questions: what do postings & transfers mean to you, from your experiences? How do you understand and interpret the issues arising therein?
11.00-11.30	Coffee break	
11.30-13.00	(20 min + 10 min QA) Raman VR, JP Olivier, J McCaffery (Chair: A Ghaffar)	
13.00-14.00	Lunch	
14.00-15.00	(20 min + 10 min QA) A Mechbal, Dilip S (Chair: M dal Poz)	
15.00-15.30	Coffee break	
15.30-16.30	(20 min + 10 min questions) A Kwamie, S Abimbola (Chair: B Marchal)	
16.30-17.00	**Take home from the day** L Freedman, K Sheikh (Chair: J Porter)	
Day 3: 05/02/2014 INTERROGATIONS		
9.30-11.00	**Research users panel** (15 min talks + open floor) A Ghaffar/J Campbell/J McCaffery/A Mechbal (Chair: F El-Jardali)	Responding to question: what kind of research on P&T do you want to see?
11.00-11.30	Coffee break	
11.30-13.00	**Methodologists panel** (10 min talks + open floor) B Marchal/JP Olivier de Sardan/Fadi El-J/M Schaaf/S Garimella (Chair: J McCaffery)	Responding to question: what methods / methodologies / frameworks can be applied to the issue?
13.00-14.00	Lunch	
14.00-15.00	**Journal editors panel** (10 min talks + open floor) M dal Poz/K Sheikh/J Porter (Chair: L Freedman)	Responding to question: what does the theme signify for broader research on health systems / health workers/public administration?
15.00 onwards	Groupwork on commentary (Kabir, Lynn, Marta, Surekha, Seye, Aku) *Others free for the rest of the day*	
Day 4: 06/02/2014 INTENTIONS		
9.00-11.00	**Roadmap roundtable 1** (10 min talks + open floor) L Freedman/ K Sheikh/ A Ghaffar/ M dal Poz/ J McCaffery/ B Marchal (Chair: A Mechbal)	Responding to questions: How can we build a global research network on the theme? What funding can we access and how best? How can we best

		advocate, disseminate and maximize the academic, policy value of work?
	Working Coffee break	
11.00 – 13.00	**Roadmaps roundtable 2** (10 min talks + open floor) Fadi El-J/G Aryeetey/S Garimella/JP Olivier /M Schaaf/A Kwamie/S Abimbola (Chair: J Porter)	Responding to question: How will you take the research forward in your context / setting?
13.00-14.00	Lunch	
14.00-15.00	**Wrap up and thanks** L Freedman, K Sheikh (Chair: A Ghaffar)	
15.00 onwards	Groupwork on roadmaps (Lynn/ Kabir/ Fadi/ Genevieve/ Surekha/JP Olivier/ Marta/ Aku/ Seye) *Others free for the rest of the day*	
Day 5: 07/02/2014- Depart from Bellagio		

Appendix C: Background documents

Public Health Foundation of India (2013). *Posting and transfer of government health workers: a qualitative case study at the primary care level in Tamil Nadu State (draft).*

Public Health Foundation of India; Averting Maternal Death and Disability (2013). *Global consultative meeting on posting and transfer practices in the health sector – meeting report.*

Schaaf M and Freedman LP (2013). Unmasking the open secret of posting and transfer practices in the health sector. *Health Policy and Planning, doi: 10.1093/heapol/czt091.*