The International **Migration** of **Health Workers**:

A Human Rights Analysis

Judith Bueno de Mesquita and Matt Gordon

February 2005

challenging barriers to health

This paper was commissioned by health charity Medact as part of its programme of work on health, poverty and development. It was funded by the British Medical Association (through its Strategic Grant Agreement with the Department for International Development) and Save the Children UK, to whom Medact is grateful. The views expressed in the paper are those of the authors and not necessarily those of Medact or its funders. For further information, please contact info@medact.org.

Medact
The Grayston Centre
28 Charles Square
London N1 6HT
United Kingdom

T: +44 (0)20 7324 4739
F: +44 (0)20 7324 4734
W: www.medact.org

Medact is a UK charity for global health, working on issues related to conflict, poverty and the environment
Registered Charity 1081097
Company Reg. No. 2267125

The International Migration of Health Workers: A Human Rights Analysis

Judith Bueno de Mesquita[1] and Matt Gordon[2]

February 2005

Acknowledgements:

We are grateful for the financial support of this project, provided by the British Medical Association, Save the Children UK and Medact. Many thanks go to the following public health, medical and human rights experts who peer reviewed the draft: Kate Adams, Edwin Borman, Martin Carroll, Mac Darrow, Becky Dodd, Stefanie Grant, Paul Hunt, Sheldon Leader, Rene Loewenson, Maureen Mackintosh, Barbara McPake, Sallie Nicholas, Mike Rowson, Julian Sheather, Francoise Torchiana, Claire Walker and Alicia Yamin. We are also grateful to Muhammad Bawa, who prepared a background paper on relevant domestic law in Ghana, and to Maureen Mackintosh and Kwadwo Mensah, who prepared a sister paper on a framework for policy responses to skills drain. Further thanks go to Anne Slowgrove for logistical support.

[1] Senior Research Officer, Human Rights Centre, University of Essex

[2] Independent Policy Analyst, for Medact. Corresponding author: mattgordon@flconsulting.co.uk

Abstract

The international migration of health workers away from underserved areas in low-income countries is increasingly recognised as one of the most profound problems facing health systems, and the safeguarding of health, in these countries. The problem is particularly acute in sub-Saharan Africa where the burdens of poverty and under-resourcing, infectious disease and, worthy of distinct mention, HIV/AIDS which has infected up to a quarter of the population in some countries, are causing public health systems to break down. This breakdown is well-documented, and the human resource crisis in low-income country health systems is rising up the international policy agenda. In particular, questions are being asked about its impact on the achievement of the health-related Millennium Development Goals.

The language of human rights is commonly used when describing the motivations of health workers to migrate to seek a better life and to further their careers. But human rights are less commonly invoked to articulate the consequences of their migration, which may include most notably the impact on the right to health of health system users in the country of origin. A human rights framework provides a formal and explicit way to examine the different social, political and economic problems that both give rise to, and result from, international migration, in particular inequality. It also allows clear and explicit articulation of where the obligation to do something about these human rights impacts lies under international human rights law, together with suggestions for accountability mechanisms that may be used to hold duty bearers to account.

Most proposed policy responses aim to address some, but not all, of the human rights impacts of international health worker migration. Different policies have varying implications for the human rights of different groups. Analysing these human rights implications is relatively straightforward where policies work as intended. However, because it is often the success with which the policy is implemented that will determine the human rights implications, because the sets of conditions that determine human rights impacts vary from place to place, and because few of the policies examined have been put into practice, predicting human rights implications in practice is less straightforward. The most appropriate response to the problem of health worker migration is likely to be an integrated one: a combination of preventative and mitigating responses that address the human rights causes and consequences of the

migration of health workers; and ensures that any improvements in the right to health are achieved without any express limitation of any other rights, including freedom of movement and rights in work. This complex picture was given recognition in the Cairo Declaration and Programme of Action, adopted by States at the International Conference on Population and Development (1994):

> *"The long-term manageability of international migration hinges on making the option to remain in one's country a viable one for all people. Sustainable economic growth with equity and development strategies consistent with this aim are a necessary means to that end. In addition, more effective use can be made of the potential contribution that expatriate nationals can make to the economic development of their countries of origin.*
>
> *The objectives are: (a) To address the root causes of migration, especially those related to poverty; (b) To encourage more cooperation and dialogue between countries of origin and countries of destination in order to maximize the benefits of migration to those concerned and increase the likelihood that migration has positive consequences for the development of both sending and receiving countries; (c) To facilitate the reintegration process of returning migrants"*[3]

To be effective, developing strategies to address negative impacts of international health worker migration will require cooperation from source and destination countries, as well as from international financial institutions, donors and the private sector. Promoting and managing this cooperation could possibly be a role for international organisations. Applying a human rights approach to addressing international health worker migration can help ensure the maximum possible benefit in human rights terms.

Governments of countries of origin should improve rights in work for employees in their home country by strengthening their public health systems, including better human resource planning. They should allocate to health a share of the state budget commensurate with generally recognised international benchmarks and international agreements that they have signed up to. They should possibly adopt a range of other appropriate measures for meeting the right to health that are fast to implement in the short term, including auxiliary worker training, managed migration and a contract with health staff trained in the public system that invokes an obligation to the public health system for a period of time after training is completed. Destination country

[3] Chapter 10, paras 1 and 2.

governments should increase the resources available for countries of origin to strengthen health systems through positive and explicit financial acknowledgement of the human rights impacts of hiring of international staff – known as restitution, and should refrain from putting undue pressure on low-income countries to sign up the health sector to Mode 4 of the Generalised Agreement on Trade in Services (GATS). They should take steps to redress their domestic shortfalls in health staff, a main driver of international migration, through better human resource planning, and adopt a regulatory framework which exerts some influence on the recruitment policies of the private sector. Strong relationships between the health systems of source and recruiting countries should be developed so that managed migration can be combined with a rights-based approach to the recruitment of staff from abroad by high-income states. The private sector should adopt codes of conduct for their recruitment policies, and international financial institutions and donors should ensure that their policies are conducive to health system strengthening in countries of origin.

The act of international recruitment by high-income countries may not directly and exclusively contribute to the abuse of the right to health of poor communities. Many other factors also play a role. At the same time, however, the balance of power and wealth between source and destination countries, and their access to resources, must be acknowledged. Rich states have access to increasingly good information about the denial of the human right to health that international recruitment contributes to. That recruitment cannot be condoned if positive efforts to acknowledge and find solutions to the denial of rights are not being made. No solution is easy: it must safeguard the rights of migrants to their entitlement to leave their country, and not contribute further to the discrimination and negative opinion often meted out to migrants. However, it is the moral and legal obligation of *countries of origin* and *countries of destination* under human rights law to seek such solutions.

Introduction

Why conduct a human rights analysis of the international migration of health workers?

Freedom of movement is fundamental to the ability of individuals to seek a better life. Health workers, with transferable skills in demand across the world, exercise this freedom to a considerable extent, and they and their families derive significant benefit from it. However, in the absense of appropriate policy frameworks, some of the effects of this migration are negative. Most notably, the migration of health workers typically takes place away from already underserved areas of the world, or parts of health systems, towards relatively well-served areas. This creates an imbalance in the health workforce, with supply of health staff effectively inverse to need. Human resources are critical to the provision of health services, and the human resource crisis in certain parts of the developing world creates a corresponding crisis in the health system, with implications for the health of individuals served by that system.

The migration of health workers is rising fast up the health and development agenda due to the sheer scale of the problem. It has also been thrown into stark relief by the Millennium Development Goals. The Goals, which have been widely accepted as benchmarks for monitoring development progress, include important health commitments, including tackling HIV/AIDS, tuberculosis and malaria, reducing child mortality and improving child health. Health worker migration is a central component of a broader crisis of human resources in health which is considered as a major impediment to the attainment of the health-related Goals.[4]

The conception of this paper originated in the recognition by the commissioning organisation, and others, of three things. First, the international migration of health workers results in, and is also partly rooted in, human rights abuses. Most notable is inequality, which is a both a cause and consequence of migration. Also notable is the catastrophic impact of migration on the right to health in some countries of origin. Second, although the language of human rights is often invoked when considering the right of health workers to freedom of movement, it is less commonly invoked to explore the situation of communities losing access to healthcare services as a consequence of migration. Proposed policy responses to international health worker migration, which have not on the whole been explicitly guided by human rights, have mixed implications for the human rights of individuals in countries of origin, and health workers. Third, international human rights law gives rise to obligations on States. We explore how far countries of origin and destination are meeting their human rights obligations in relation to international health worker migration.

[4] Freedman, Wirth et al (2004)

These human rights issues have been given little explicit attention in the growing literature on the phenomenon of 'brain drain'.[5] This report introduces human rights implications of international health worker migration, and analyses speculative policy responses that seek to mitigate the negative effects of the process through the lens of human rights. The report acknowledges the wider determinants of health and the importance of addressing environmental and socioeconomic factors in any policy response that seeks to improve the right to health, but focuses on international health worker migration and its impact on health systems. The report also makes the case that the development and implementation of policy responses may benefit from certain aspects of a human rights approach.

It is a generally accepted principle that human rights should be promoted and protected, including through national and international policy processes. Human rights are concerned with the basic freedoms and entitlements necessary to secure human dignity. All states have recognised the moral and legal imperative of human rights, by their ratification of at least some international human rights treaties.

In addition to this moral imperative, human rights provides a comprehensive framework to analyse the causes and consequences of international health worker migration, and policy responses. The framework of human rights has much congruence with values associated with good development or public health practice: including redressing inequalities, ensuring civil society participation, the importance of good governance, appropriate private sector regulation, and ensuring that high-income countries give adequate assistance and pursue policies which support human development in low-income countries. Human rights also shares many objectives of other international frameworks for action in the field of health, development and migration, including the Millennium Development Goals, and the Cairo Declaration and Programme for Action.

However, the normative human rights framework has other distinct and powerful features. First, it encompasses a detailed and holistic set of norms. Second, it is widely endorsed by States, international organisations and non-governmental organisations – thereby providing a shared and mutually acceptable platform for action. Third, it provides a common and universal benchmark against which to measure progress of certain types. Fourth, it enhances accountability through its grounding in law, attribution of responsibilities in a precise manner, and the potential to use formal mechanisms concerned with the promotion and protection of human rights such as

5 Two notable exceptions are Friedman (2004) - which devotes a chapter to exploring the human rights implications of international health worker migration; and WHO (2003)

courts, tribunals and parliamentary processes to hold States and other duty bearers to account. Finally, it adds force to advocacy for social justice for the above reasons.

In recent years, increasing numbers of organisations working in the fields of public health and development have experimented with integrating a human rights approach into their work. Many have found that a human rights framework is a useful one to pursue. This report proposes that applying a human rights approach to policy-making vis-à-vis international health worker migration can be a worthwhile exercise, for the reasons described above. However, this approach does not provide answers to the full range of complex questions raised by the phenomenon. First, this is because some of those questions demand an explicit judgement about the tradeoffs between rights of different types, something that a human rights approach is unable to support. Second, whilst human rights discourse may prove useful to frame objectives and to be explicit about where accountability lies, it does not in isolation provide operational solutions that improve human rights – partnerships with other disciplines and sectors are needed. Third, the very accountability mechanisms that are described above as one of the main values of the human rights approach, are frequently weak in low-income countries where the consequences of the international migration of health workers are most profound. Fourth, the question of how many resources states should devote to meeting the right to health, and the definition of progress, are subject to debate and frequently subject to data limitations in low-income country settings.

Report structure

Chapter 1 of this report is intended as an introduction to human rights to those who do not have a background in this discipline. It introduces some basic concepts of human rights, defines which human rights are at stake in international health worker migration, specifies the duty bearers that have obligations to ensure the promotion and protection of human rights in this context, and identifies which accountability mechanisms may be utilised to hold these duty bearers to account.

Chapter 2 applies this framework of human rights and resulting obligations to an analysis of international health worker migration. Examining some of the causes and consequences of this phenomenon, it assesses how these are often rooted in and result in human rights abuses, and also applies the framework of responsibilities of international human rights law to States and other duty bearers.

Chapter 3 introduces a human rights approach to policy-making and uses it to examine policy responses to international health worker migration and their potential human rights implications. This human rights approach helps to ensure that policies assist, rather than jeopardise, the realisation of human rights.

1. Human rights in a global context

Human rights are civil, political, economic, social and cultural freedoms and entitlements, guaranteed by human rights law, and mainly concern the relationship between the State, on the one hand, and individuals and groups, on the other hand. They are defined in a series of international and regional treaties, other international instruments, and domestic law. Historically neglected, economic, social and cultural rights hold the same status under international law as civil and political rights. This report focuses on those rights affected by the international migration of health workers, including economic, social and cultural rights.

Predominantly, it is the rights of health workers, and the health system users they serve, that are most at stake when international migration takes place. The right to health, labour rights and right to freedom of movement are the most relevant rights at stake, but international health worker migration also has a significant impact on non-discrimination and equality in relation to the the enjoyment of these, and other, rights. The right to freedom of movement serves as a means for health workers to migrate in search of better working terms and conditions. A consequence of this migration is that the right to health of health system users in the health workers' countries of origin may be threatened. This can also have a knock-on impact on other human rights of health system users and their families, such as their rights to life, work, education, housing and food.

States hold the greatest responsibilities under international law towards safeguarding the human rights implicated in the international migration of health workers. States of origin have the primary obligation, which is binding under international human rights law, to safeguard the right to health of individuals and labour rights of health workers within their jurisdiction. States of destination must also meet their obligations to populations within their own jurisdictions, including migrant health workers, and also have obligations of international assistance and cooperation to respect, protect and fulfil the right to health and labour rights in source states. States of origin and destination must also undertake efforts to ensure that the private sector and other third parties do not limit the right to health. The private sector itself has certain responsibilities to respect the human rights implicated in international migration. As members of society, health workers themselves have responsibilities but these are not binding under international law.

Accountability is one of the defining features of human rights. Judicial accountability mechanisms in low-income states may be weak. However, other accountability mechanisms may also play an important and reinforcing role, including, at the domestic level, quasi-judicial, administrative and parliamentary mechanisms, and, at the international level, State party reporting to treaty bodies and the investigations of UN Special Rapporteurs.

Human rights are entitlements legally guaranteed by human rights law, protecting individuals and groups against actions which interfere with their dignity and fundamental freedoms. They predominantly concern the relationship of the State and other duty bearers with individuals and groups, such as women, children, ethnic and racial minorities, and migrant workers. Human rights are universal – they belong to all people everywhere.

Human rights encompass what are known as civil, political, economic, social and cultural rights. States and the international human rights community have tended to neglect economic, social and cultural rights (such as the rights to health, education and an adequate standard of living) compared to civil and political rights (such as freedom from torture, or freedom of expression). However, both 'sets' of human rights are enshrined in the Universal Declaration of Human Rights (1948) and in international human rights treaties. At the World Conference on Human Rights (1993), States recognised that 'the international community must treat human rights globally in a fair and equal manner, on the same footing and with the same emphasis.'[6] This report focuses on human rights that are particularly affected by the international migration of health workers and does not prioritise one category of rights over any other.

A note on sources - international, regional and domestic human rights protections

Human rights are enshrined in international and regional human rights law, and are additionally protected at the national level by many countries' Constitutions, or through domestic human rights law. The analysis in this report primarily focuses on international protections of human rights, notably by the following core international human rights treaties:

- International Covenant on Civil and Political Rights (ICCPR: 1966);
- International Covenant on Economic, Social and Cultural Rights (ICESCR: 1966);
- International Convention on the Elimination of All Forms of Racial Discrimination (ICERD: 1965);
- International Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW: 1979);
- Convention on the Rights of the Child (CRC: 1989); and
- International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (ICRMW: 1990).

6 Vienna Declaration and Programme of Action (World Conference on Human Rights 1993), para. 5

All States have ratified at least one of these treaties: most States have ratified the majority. Reference is also made to various treaties adopted under the auspices of the International Labour Organisation, which contain important labour rights standards, and some regional human rights treaties. Through ratifying international or regional treaties, States voluntarily assume obligations, which are binding in international law, to give effect to their provisions.

In addition to human rights treaties, reference is also made to a range of other important international human rights documents or norms. These include:

- *General Comments/General Recommendations* are texts, adopted by Committees of experts appointed to monitor the core international human rights treaties (ICCPR, ICESCR, etc), designed to clarify the rights and obligations enshrined in international human rights treaties. General Comments are non-binding in international law, but have been recognised to constitute authoritative interpretations of the human rights and corresponding obligations contained in international human rights treaties.[7]
- *Resolutions of the UN General Assembly and UN Commission on Human Rights* contain bodies of principles and human rights standards which help guide interpretation of human rights treaty provisions if these are unclear. These resolutions are on the whole non-binding, but some resolutions may contain norms and standards which are customary international law. *Customary international law* is a binding form of law that results from a general and consistent practice of states that they follow from a sense of legal obligation, and does not depend upon the ratification of any particular treaty.
- *Outcome documents of international conferences and the Millennium Development Goals* are political commitments, non-binding under international law, although some outcome documents, and the Millennium Development Goals, may include standards which are customary international law.[8] The texts of these documents contain commitments, and human rights standards, which can help to interpret human rights treaty provisions.

The full range of human rights, and human rights-related, documents referenced throughout this report is contained in Annex 1.

7 Craven (1995), Alston (1992)

8 See Alston (2004)

Which human rights, and which stakeholders, are affected in the context of international health worker migration?

There are three human rights commonly at stake in international health worker migration: the right to health (affecting individuals in countries of origin and destination), labour rights (affecting health workers), and the right to migrate (affecting health workers) – and, cutting across all of these, non-discrimination and equality. This chapter focuses on unpacking these rights. However, other human rights are also at stake, including the right to education; an adequate standard of living; non-discrimination; and the right to liberty and security of person.

Non-discrimination and equality

Non-discrimination is a fundamental principle of human rights. International and regional human rights treaties prohibit discrimination on a range of grounds, including race, ethnicity, gender, disability and health status.[9] The prohibition cuts across all other human rights – in other words, the right to health, or labour rights, must be given effect on the basis of non-discrimination. Coupled with this principle is equality, in other words the right to enjoy human rights on an equal basis. This often requires affirmative action to redress inequalities. These rights resonate with the ethical principle of equity, which is increasingly being integrated into public health and development discourse.

Right to the enjoyment of the highest attainable standard of physical and mental health

The central protection of the right to health in international human rights law is ICESCR article 12, which provides:

> *"1. The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*
>
> *2. The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:*
>
> *(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*
>
> *(b) The improvement of all aspects of environmental and industrial hygiene;*
>
> *(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;*
>
> *(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."*

[9] Eg see ICCPR article 2.1, ICESCR article 2.2

ICERD, CEDAW, CRC and ICRMW contain group-specific protections. Regional human rights treaties also enshrine the right to health (see Annex 1), as do 60 national constitutions[10], and other domestic legislation in some countries. In 2000, the Committee on Economic, Social and Cultural Rights adopted a General Comment (no 14) on the right to health which clarifies the norms and resulting obligations of the right to health.[11]

The General Comment clarifies that the right to health:

- is not a right to be healthy, it is a right to the *enjoyment of the highest attainable standard of physical and mental health* – the highest attainable standard will vary according to time and place, depending on, inter alia, the resources available to the State;[12]
- includes freedoms, such as non-discrimination, and entitlements – to health care and also underlying determinants of health, such as nutrition, safe drinking water and sanitation and healthy workplaces and environments. Other entitlements include child and maternal health; health education and information; particular health care services, including family planning services;[13] medication in the context of pandemics such as HIV/AIDS, tuberculosis and malaria;[14] and
- is a right to facilities, goods, services and conditions necessary to promote and protect health, including health care. Health care facilities, goods and services must be *available* in adequate numbers, *accessible* geographically, financially, and on the basis of non-discrimination, *acceptable* – or in other words respectful of medical ethics and culturally appropriate, and of *good quality*, including medically and scientifically appropriate.[15]

International health worker migration predominantly affects the right to health of individuals in countries of origin: where shortages of health workers arise, individuals may be denied their entitlement to health care goods, facilities and services.

[10] Hunt (2003)

[11] Also see CEDAW, General Recommendation 24 on women and health (1999), CRC, General Comment 3 on HIV/AIDS and the rights of the child (2003) and General Comment 4 on Aadolescent health and development in the context of the Convention on the Rights of the Child (2003)

[12] , General Comment 14, para. 9

[13] See CESCR, General Comment 14, paras. 8 and 9. See also CEDAW General Recommendation 24

[14] Commission on Human Rights Resolution 2004/26 on Access to Medication in the Context of Pandemics such as HIV/AIDS, Tuberculosis and Malaria (2004)

[15] CESCR, General Comment 14, para. 12

Freedom of movement

The right of everyone to leave any country, including his (her) own is recognised in article 12 of ICCPR, as well as article 13 of the UDHR and article 12 of the African Charter on Human and Peoples' Rights (article 12(2)). ICCPR article 12 states:

> *"1. Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence.*
>
> *2. Everyone shall be free to leave any country, including his own.*
>
> *3. The above-mentioned rights shall not be subject to any restrictions except those which are provided by law, are necessary to protect national security, public order (ordre public), public health or morals or the rights and freedoms of others, and are consistent with the other rights recognized in the present Covenant.*
>
> *4. No one shall be arbitrarily deprived of the right to enter his own country."*

The right to freedom of movement may be legitimately limited in a range of precisely defined circumstances, including where this is necessary to protect public health. To be permissible, restrictions must be provided by law, and must be necessary for the protection of these purposes. They must be the least intrusive instrument amongst those which might achieve the desired result; and they must be proportionate to the interest to be protected.[16]

The limitation of movement is a legitimate restriction on grounds of a serious threat to 'public health', for example where it is strictly necessary to contain an outbreak of certain highly infectious diseases. However, the conditions that must be satisfied in order to do so are highly stringent[17] and it is highly unlikely that a policy of restricting freedom of movement of health workers as a response to international health worker migration would meet these threshold requirements. Restriction of freedom of movement is unlikely to be the least intrusive policy that can be adopted to improve the right to health in the context of tackling health worker migration.

Rights to and in work (labour rights)

Poor terms and conditions of work are a primary cause of health workers seeking to migrate. ICESCR, article 6 recognises the right to work, whilst article 7 recognises a range of rights in work including adequate remuneration, safe and healthy working

[16] General Comment 27 on Freedom of Movement by the Human Rights Committee (1999); Siracusa Principles on the Limitation and Derogation Principles in the International Covenant on Civil and Political Rights, UN doc. E/CN.4/1985/4, Annex

[17] Siracusa Principles (ibid)

conditions, equal opportunities to promotion, rest, leisure and reasonable limitation of working hours:

"The States Parties to the present Covenant recognise the right of everyone to the enjoyment of just and favourable conditions of work which ensure, in particular:

(a) remuneration which provides all workers, at a minimum, with:

(i) fair wages and equal remuneration for work of equal value and without distinction of any kind, in particular women being guaranteed conditions of work not inferior to those enjoyed by men, with equal pay for equal work

(ii) a decent living for themselves and their families in accordance with provisions of the present Covenant

(b) safe and healthy working conditions

(c) equal opportunity for everyone to be promoted in his employment to an appropriate higher level, subject to no considerations other than those of seniority and competence

(d) rest, leisure and reasonable limitation of working hours and periodic holiday with pay, as well as remuneration for public holidays."

These and other workplace related rights are also firmly entrenched in International Labour Organisation conventions, as well as the other main international human rights treaties (see Annex 1). The Migrant Workers Convention provides detailed protections for the labour rights of this group.

Other rights

Other rights are briefly mentioned here because they may also be implicated in the motivation of a health worker to migrate. Health workers may migrate to safeguard the right to education of their children. They may do so to seek an adequate standard of living; and they may seek the right to liberty and security of person. Conversely, the negative impact on the right to health of health system users in source states can be an obstacle to the enjoyment of a range of other human rights, including the rights to life, work, education, adequate shelter and adequate nutrition.

Which actors have duties to take action to ensure the promotion and protection of human rights? What is the nature of these obligations?

States of origin and destination

International human rights law gives rise to obligations on States: through voluntarily ratifying international human rights treaties, States accept to be bound by the terms of these treaties. International human rights law gives rise to obligations on countries of

origin and destination. The nature of these obligations varies between civil and political rights, and economic, social and cultural rights.

Civil and political rights obligations: Under ICCPR, States have an obligation to respect and ensure these rights. This includes an obligation to ensure that individuals and groups are protected from violations by State agents, and third parties.[18] State obligations relating to civil and political rights primarily concern duties on States to ensure these rights to all individuals within their territory and subject to their jurisdiction, although States parties should also give attention to violations of civil and political rights in other States parties.[19]

Economic, social and cultural rights: Under ICESCR, States have three levels of obligations: to respect, protect and fulfil these human rights:[20]

- the obligation to *respect* requires States to refrain from interfering directly or indirectly with the enjoyment of economic, social and cultural rights;
- the obligation to *protect* requires them to take measures that prevent third parties (eg private sector actors) from interfering with these rights; and
- the obligation to *fulfil* requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of these rights: this includes the provision of health services.

Whereas ICCPR primarily involves an obligation on States to give effect to the provisions at the domestic level, ICESCR article 2.1 recognises that in addition to an obligation on States to give effect to economic, social and cultural rights at the national level, they also have obligations of *'international assistance and cooperation.'*[21] This includes a duty to: respect economic, social and cultural rights in other countries; prevent third parties from violating these rights in other countries, if a State is able to influence them through political or legal measures; and, depending on available resources, facilitate access to these rights, in particular *minimum essential levels* (see below) of each right. States must also take account of their human rights obligations when negotiating international treaties and in the context of their membership of international organisations, including international financial institutions.[22] This

[18] ICCPR, article 2.1; Human Rights Committee, General Comment 31 on the Nature of the General Legal Obligation Imposed on States Parties to the Covenant (2004), para. 8

[19] Eg.Human Rights Committee, General Comment 31, paras. 1-3

[20] Eg. CESCR, General Comment 14, paras. 33-37

[21] ICESCR, article 2.1; CRC, article 4

[22] Eg. CESCR, General Comment 14, paras. 38-42

transboundary dimension of responsibility articulated in ICESCR (and also in CRC) resonates with provisions in other international treaties, including the Charter of the United Nations[23] – and also Goal 8 of the Millennium Development Goals which enshrines a commitment to create a global partnership for development.[24] The next chapter explores the implications of this international dimension of responsibility on countries of destination, as well as domestic obligations of countries of origin.

ICESCR recognises that it is unrealistic to expect States to instantaneously give effect to all the rights in the Covenant immediately, given the widely-faced constraint of resource limitations. Article 2(1) places an obligation on States to take steps towards the *progressive realisation* of the rights, making use of maximum available resources. Despite this progressive nature of obligations, States have some obligations of immediate effect, for example to undertake to guarantee the enjoyment of the relevant rights on the basis of non-discrimination, and the obligation to take deliberate, concrete and targeted steps towards the realisation of these rights. States also have a core *obligation* to give effect to *minimum essential levels* of each of the rights in the Covenant, including essential primary health care.[25]

Private sector recruitment companies

International human rights law predominantly concerns the relationship of the State with individuals and groups – as such, some commentators have questioned its relevance in a globalising world where private sector actors have accrued functions more traditionally the preserve of the State – in no field is this more true than health care, where the private sector is increasingly involved in, among others, provision of services, medical education and training, and recruitment.

However, private sector accountability is increasingly being engaged through both an *indirect*, and a *direct*, route in international human rights law.[26] As already highlighted, States have an obligation to protect against harm by third parties, such as private sector companies (*indirect* route). This indirect route is already quite firmly rooted in the jurisprudence of international treaty bodies and regional monitoring and accountability bodies.[27] For example, the Human Rights Committee (the committee that monitors the ICCPR) has emphasised that States must take appropriate measures, and exercise due diligence to prevent, punish, investigate or redress the harm caused by

[23] Charter of the United Nations, articles 1, 55 and 56

[24] http://www.developmentgoals.org/Partnership.htm accessed 18th Jan 05

[25] CESCR, General Comment 3, para. 10

[26] See International Council on Human Rights Policy (2002)

[27] Eg. See Osman v UK, 28 October 1998; Center for Economic and Social Rights and Social and Economic Rights Action Committee v Nigeria, 27 May 2002; Velasquez Rodriguez Case, 29 July 1988

such acts by private persons or entities.[28] The Committee on Economic, Social and Cultural Rights (which monitors ICESCR) has emphasised that the duty to protect has an international dimension vis-à-vis social economic and cultural rights – States must take legislative and appropriate measures to ensure, as far as possible, that private actors within their jurisdiction do not interfere with these human rights in other countries.[29] This has implications for States of destination – where the activities of private sector recruitment companies inhibit the enjoyment of economic, social and cultural rights in another country, they are under a legal obligation to take measures to redress this situation.

International human rights law recognises that the private sector does have some responsibilities towards human rights (*direct* route), including the right to health.[30] These responsibilities were first framed in the preamble of the Universal Declaration on Human Rights which states:

> *"every individual and every organ of society, keeping this Declaration constantly in mind, shall strive….by progressive measures, national and international, to secure their universal and effective recognition and observance."*

Private sector actors are increasingly encouraged to commit to respecting international human rights standards. Very recently, there has been a move to develop specific human rights standards tailored towards the activities of private sector actors. The Norms on the Responsibilities of Transnational Corporations and Other Business Enterprises with Regard to Human Rights adopted in 2003 by the UN Sub-Commission on the Promotion and Protection of Human Rights, establish specific standards for private sector actors. Among others, the Norms state:

> *"within their respective spheres of activity and influence, transnational corporations and other business enterprises have the obligation to promote, secure the fulfilment of, respect, ensure respect of and protect human rights recognised in international as well as national law, including the rights and interests of indigenous peoples and other vulnerable groups."*[31]

[28] Human Rights Committee, General Comment 31, para. 8

[29] CESCR, General Comment 14, para. 39

[30] See CESCR, General Comment 14, para. 42; Committee on the Rights of the Child, The Private Sector as Service Provider and Its Role in Implementing Child Rights, contained in CRC/C/121, Report on the 31st Session of the Committee on the Rights of the Child, 20 September 2002

[31] Para. 1

Whilst these are non-binding, the Norms, adopted by an international body of human rights experts, can be legitimately used as a benchmark to monitor the performance of private sector actors, such as private sector recruitment companies.

International financial institutions (IFIs)

In the context of international health worker migration, the right to health and rights in work are the human rights primarily affected by the policies and lending of the IFIs. This paper adopts the positions taken by the Committee on Economic, Social and Cultural Rights, and the UN Special Rapporteur on the right to health, respectively that IFIs should pay greater attention to the protection of human rights in their lending policies, credit agreements and structural adjustment programmes;[32] and that it is incumbent on these institutions to respect the human rights obligations of States when negotiating and providing loans, including in the context of approving poverty reduction strategy papers.[33]

Health workers

As members of society, health workers have responsibilities towards the community, including in relation to the right to health.[34] These duties derive from the recognition in the Universal Declaration on Human Rights that 'everyone has duties towards the community'. However, the same document also states that 'in the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others…'[35] Criticisms have been levied at human rights for their focus on rights and freedoms without duties, but it is important to remember the fundamental ethos of human rights – to protect individuals against harm by the State.

Where health workers are employees of the State (state agents) they are partly responsible for meeting that State's obligations to respect human rights. In this capacity, health workers have a duty to respect human rights in their work – eg. they must not be complicit in human rights violations such as torture.[36] However, this does not necessarily place a personal responsibility on individual doctors, nurses, technical assistants or other workers to *fulfil* human rights such as the right to health. The health

[32] CESCR, General Comment 14, para. 64

[33] Hunt (2005). For a more detailed study of IFI responsibility, see Darrow (2003).

[34] CESCR, General Comment 14, para. 42; Universal Declaration on Human Rights, article. 29; African Charter on Human and Peoples' Rights, article 27

[35] Article 29.2.

[36] See: Principles of Medical Ethics… etc (1982)

worker has a contractual obligation to the State, and if the health worker chooses to terminate that contract then the State has an obligation to ensure that an appropriate replacement is found, if necessary. Codes of professional ethics may also set out some useful principles relating to the patient-carer relationship, such as beneficence, non-maleficence, justice, continuity of care, non-discrimination and obligation to treat which may also be relevant in the context of international health worker migration.

Which mechanisms can be used to help enhance accountability in the context of the skills drain?

Accountability is a fundamental principle of human rights law. Accompanying the array of international, regional and national law is a range of mechanisms designed to enhance accountability of duty bearers – in particular, States. Selected international human rights mechanisms are described below:

- *Treaty Bodies:* States that have ratified international human rights treaties are required to submit and present regular reports on their progress towards meeting their obligations to the UN treaty bodies, committees of independent experts appointed to monitor treaty implementation. The treaty bodies engage in a dialogue with the State and then issue a set of recommendations called "Concluding Observations". These are non-binding, but can be useful tools to help guide the government in its policies, and for civil society advocacy.[37] Civil society organisations can submit information to the treaty bodies in relation to State reports, and the information they submit often influences Concluding Observations. Treaty bodies should be encouraged to issue Concluding Observations in relation to international health worker migration.
- *Commission on Human Rights:* The Commission has appointed a Special Rapporteur on the right to health. The mandate of this independent expert is to report on the status of the right to health throughout the world, and to make recommendations for its realisation.[38] He may be asked to hold particular Governments to account on this issue in several ways. He may send communications to the Government of a particular country expressing his concern at information he has received alleging particular right to health problems relating to an act or omission by that State, requesting clarification and action where necessary. He also undertakes two country missions per year to investigate the status of the right to health in a particular country – he may be encouraged to go to a particular country of origin or destination to investigate international

[37] For more information, see www.ohchr.org

[38] Commission on Human Rights resolution 2002/31 on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2002)

health worker migration and its bearing on the right to health. Following the mission, the Special Rapporteur writes a detailed report, including concerns and recommendations, on his findings, which is submitted to the Commission on Human Rights. He also writes annual reports to the Commission on Human Rights and the General Assembly, which may include reference to concerns about international obligations – and has on more than one occasion commented on his concern about the impact on the right to health of international health worker migration.[39]

Each regional body, including the Organisation of American States, the Council of Europe and the African Union, has its own human rights accountability procedures. All regions have complaint procedures, whereby individual victims of a violation of a human right recognised in one of the relevant treaties may submit a complaint to the relevant monitoring mechanism – in some cases, the judgements of the relevant body are binding (eg Inter-American Court of Human Rights, European Court of Human Rights). There have been cases concerning the right to health decided by mechanisms in each region, mainly concerning access to antiretrovirals, although in a recent case, the African Commission on Human Rights also ruled on access to health care facilities and services.[40] Each regional mechanism encompasses a State party reporting process, which is similar to the UN treaty monitoring process.

Domestic mechanisms vary considerably from one state to another. Where human rights are enshrined in domestic law, the courts, or tribunals, can often play an important role in enforcing the law. In some countries there are independent National Human Rights Institutions, or Ombuds, which can receive complaints or undertake investigations. Elsewhere, parliamentary processes play an important accountability role, as does the press, and civil society activity.

[39] See Hunt (2003), Hunt (2004.b)

[40] Purohit and Moore v Gambia, African Commission on Human and Peoples Rights, Communication 241/2001

2. Whose rights first? The migration of health workers

Human rights abuses may be a cause and a consequence of international health worker migration. Many of the consequences are negative, predominantly the impact on the right to health. But many are positive, including the ability for the health worker to seek improvement of his or her enjoyment of human rights.

Understanding the scale and nature of international health worker migration is difficult, due to poor quality and scarcity of data. However, a broad picture is emerging. The breakdown of health systems in some parts of sub-Saharan Africa means that health worker migration has an especially large impact there. Absence of health workers threatens the quality and availability of health services and contributes to a wider resource problem that seriously threatens the progressive realisation of the right to health and the Millennium Development Goals.

The motivation of health workers to migrate is complex and varied but often includes the inability for health workers to ensure the enjoyment of their rights in work, demand for their skills in high-income countries and facilitating factors such as agencies acting as intermediaries and increasingly well-established patterns of migration. Policies that try and redress negative human rights effects of international health worker migration seek a difficult balancing act if they are not to damage the positive human rights effects of migration.

Models of medical and nursing training around the world are, for the most part, remarkably consistent. For example, a general practitioner trained in the United Kingdom and with a professional interest in tropical diseases may need little additional training aside from language skills to work effectively as a general practitioner in many parts of the Zambian health system. Likewise, a nurse trained in Zambia, where nurse training takes place in English, may find it easy to overcome the hurdles to registration in order to work in the UK, and indeed many do, albeit sometimes not to their full skill level.[41] This portability of skills facilitates an increasing phenomenon: the migration of health workers from one country to another. There are a variety of

[41] Browne (2001); Allan and Aggergaard Larsen (2003)

factors motivating health workers to migrate – some of them relating to human rights[42]– and many different and changing patterns of migration, discussed much more fully in the sister paper to this one.[43]

There are, of course, many positive aspects to migration,[44] including some positive human rights dimensions. Whilst giving some attention to these positive dimensions, this paper primarily examines an aspect of the migration of health workers that is increasingly argued to have a particularly negative impact on human rights; that of migration away from areas that are underserved by health services in low-income countries. There are several dimensions to this process: domestic migration from underserved, to less underserved, areas; transfer of workers from public to private systems of healthcare; and temporary or permanent migration from low-income to more high-income countries. This paper uses the term 'health worker migration' to describe the process. The analysis focuses primarily on international migration from low-income to OECD countries, although health worker migration from rural to urban areas in low-income countries, between low-income countries, or from low- to middle-income countries, can cause similar inequities and lead to shortages in regions or countries of origin, and all need to be addressed.

The scale of the problem and countries affected

There are two separate considerations in understanding the scale of migration of health workers from a country: first, the quantity of migrants, and second, the staffing ratios in the health sector of the countries they leave.

Sub-Saharan Africa is widely regarded to be suffering the greatest crisis in human resources for health. Overall, 36 countries in Africa do not meet the 'Health For All' target of one doctor per 5000 people.[45] Doctor-to-patient ratios in peaceful countries such as Zambia (approx. one doctor to every 14,500 population) and Ghana (approx. 1:11,000) compare with ratios of around 1:600 in the United Kingdom and 1:350 in the United States. Had the UK recruited from Africa to meet its estimated shortage of 35,000 nurses and midwives identified in the 2002 NHS Plan[46], it could have hired all the nurses and midwives in Tanzania, Botswana, Ghana and Malawi and only just met the gap. Put another way, the UK's nursing shortage was the same as the *entire nursing*

[42] Padarath, Chamberlain et al. (2003); Friedman (2004)

[43] Mensah, Mackintosh and Henry (2005)

[44] Lowell and Findlay (2001)

[45] Figures at http://www.who.int/GlobalAtlas/DataQuery/browse.asp?catID=180000000000&lev=2 last accessed 22nd January 2005

[46] http://society.guardian.co.uk/NHSstaff/story/0,7991,460023,00.html

workforce of three countries from which it is known to have attracted staff, with a combined population greater than that of the UK.[47] African workers are also much less likely to return than workers originating from many other countries.[48] Other countries – eg the Philippines and India – contribute more nursing and medical staff but in the context of better domestic staffing ratios.

Comprehensive information about the exact scale and impact of health worker migration does not exist. It is difficult to measure emigration by skill level, and assess whether measured migration is permanent or temporary; but various facts, pieced together, provide a picture. For instance, it is estimated that more than 80% of doctors, nurses and therapists who graduated from the University of Zimbabwe medical school since independence in 1980 have gone to work abroad.[49] 30%–50% of health graduates leave South Africa for the USA and UK each year; two thirds of Jamaica's nurses left permanently in the 1990s; in 1999, Ghana lost more nurses than it trained; and so on.[50] In the context of the already deeply severe staffing crisis in some of the developing world's health systems and the rising death toll of health workers due to HIV/AIDS, these losses can be devastating for many countries.

All OECD countries (as well as middle-income countries and some low-income countries) are potential destinations for health workers from low-income countries. However, some attract more than others. Factors that affect the choice of destination countries by migrating workers include the extent of shortages of health workers in the destination country, historical patterns of migration, language considerations and the relative difficulty or expense of migrating to a particular country for employment. Notable destinations for Asian, African and Latin American health workers include the United Kingdom, Australia, the United States, Canada, and the Gulf states.

Why health workers matter: negative consequences of migration on the right to health

ICESCR places an obligation on States parties to create conditions that would assure to all medical services and medical attention in the event of sickness; and to prevent, treat and control diseases.[51] Health services must be available in adequate numbers, accessible, and of decent quality. Health workers play a key role in all respects. The efficient delivery of quality health services or disease control programmes, whether via

47 ibid http://www.who.int/GlobalAtlas...

48 Wickramasekara (2002)

49 Lowell and Findlay (2001); Meldrum (2003)

50 Lowell and Findlay (2001); Huddart and Picazo (2003)

51 ICESCR, article 12.2

state health systems, the for-profit private sector or the non-profit private sector, depends largely on human resources: skilled health workers guide health system users in medication strategies, administer operations and medicines, and care for health system users or advise them and their families how to do so. Health leaders from low-income countries have identified the availability and quality of human resources as one of the main determinants of health system performance.[52] The ebb of human resources away from the health system of a low-income country severely jeopardises the likelihood of that country meeting its obligations towards the right to health of its population as well as other health-related commitments such as the MDGs.[53]

The right to health includes a responsibility on the part of States to ensure *good quality* health care services, which is to be achieved through, among others, the employment of skilled medical and nursing personnel. Health system quality, including sufficient numbers of qualified staff, is not the only determinant of health in a country's population, but it is important. Studies that seek a positive relationship between human resources in health systems and positive health benefits[54] have historically shown mixed results, but more recent work using improved data reveals a significant negative correlation between health worker density and mortality rates in low-income countries,[55] and that higher nurse staffing levels improve health outcomes.[56]

Aside from their inability to continue to provide health services in the area, and the loss to the health system of considerable investment in training, there may be several, more strategic, negative and reinforcing quality-related consequences when a health worker migrates away from a health service in an underserved region. The most talented and experienced workers may be the most attractive to overseas employers; if they leave, a disproportionate amount of human capital may leave with them, including the skill to educate other, more junior health workers.[57] The increased workload on remaining workers may demotivate them, increasing the pressure on them to leave. Considerable state resources are often put into training of health staff: if they leave for good, this is, to varying degrees, lost. And if entire specialist teams, or many health workers from the same area, leave, the small number of migrants may belie a disproportionately high impact on particular health services in a particular area.[58]

[52] Marchal and Kegels (2003)

[53] Hunt (2004.b)

[54] Controlling for socio-economic and environmental factors

[55] Anand and Baernighausen (2003)

[56] See Mercer and Dal Poz (2003)

[57] Bundred and Levitt (2000)

[58] Martineau, Decker et al. (2004)

The Millennium Development Goals and the right to health: norms and responsibilities

International organisations, including the WHO, the World Bank and the ILO, are increasingly identifying international migration of trained health workers away from low-income countries as a brake on progress towards the Millennium Development Goals (MDGs).[59] A recent estimate suggests that sub-Saharan Africa is approximately 700,000 doctors and 700,000 nurses short of the staffing requirements necessary to meet the MDGs.[60] The targets identified for the health-related MDGs, and indicators identified to monitor progress, correspond relatively precisely with specific entitlements of the right to health (see Table 1).

In other words, if health worker migration hinders the achievement of the MDGs, it is also almost certainly an obstacle to the enjoyment of these specific corresponding right to health entitlements.

Despite the relatively precise correlations between the MDGs and these right to health norms, and other related human rights, there are differences between the MDGs and human rights. For example, whilst MDGs are framed in terms of societal averages, human rights must be achieved on the basis of equality and non-discrimination. Health worker migration, at all levels, tends to exacerbate inequalities in the enjoyment of the right to health, since women, poor and rural groups are more vulnerable in the context of health worker shortages.

Obligations on States

States parties to international human rights treaties recognising the right to health, including ICESCR, CEDAW and CRC, are under an obligation to take appropriate measures to ensure that international health worker migration does not constitute a threat to the availability, accessibility or quality of health care services. This obligation falls on States of origin. But States of destination must also comply with their obligations of international assistance and cooperation, as well as the MDG commitment to create a partnership for development (Goal 8), and ensure that they respect the right to health in other countries. Actively recruiting, or permitting private recruitment agencies to recruit, from countries, professional specialisations, or localities where there are shortages, would be highly questionable. Some specific policies and measure which States may take to fulfil their obligations are outlined in chapter 3.

[59] Findlay (2002); WHO and World Bank (2002); Friedman (2004)

[60] Kurowski, Wyss et al. (2004)

Table 1: Health-focused MDGs, targets and indicators, and corresponding right to health norms and obligations

Millennium Development Goal/Target	Corresponding MDG Indicators	Principal relevant human right norms/obligations
Goal 4: reduce child mortality by two thirds between 1990 and 2015	Under-five mortality rate Infant mortality rate; Proportion of under 1 year olds vaccinated against measles.	Right to health obligation on States under ICESCR to take steps to reduce the stillbirth rate, infant mortality and for the healthy development of the child.[61]
Goal 5: improve maternal health; and reduce the maternal mortality rate by – between 1990 and 2015	Maternal mortality ratio; Number of births attended by skilled health personnel.	Right to health obligation on States parties to ICESCR, CEDAW and CRC to ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period; ensure their equality of access to health services, including family planning services.[62]
Goal 6: combat HIV/AIDS, malaria and tuberculosis; to have halted and begun to reverse the spread of HIV/AIDS, malaria and other major diseases by 2015	HIV prevalence among pregnant women aged 15-24; Condom awareness and use; Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years; prevalence and death rates from malaria; proportion of affected populations using malaria prevention; TB prevalence; DOTS cure rate	Right to health obligation on States to provide medication in the context of pandemics such as HIV/AIDS, tuberculosis and malaria; carry out prevention efforts;63 the right of adolescents to access adequate information essential for their health, including on sexual and reproductive health and contraceptives and how to prevent sexually transmitted disease, as well as their entitlement to access preventative measures such as condoms.[64] (also relevant in this context are other human rights including the rights to privacy;[65] and to be protected from violence)

61 ICESCR, article 12.2.a; CRC, article 24

62 ICESCR, article 12; CESCR, General Comment 14, para. 21; CEDAW, article 12; CRC, article 24.2.d

63 Commission on Human Rights resolution 2004/26 on Access to Medication in the Context of Pandemics such as HIV/AIDS, tuberculosis and malaria; CESCR, General Comment 14, para. 16

64 CRC, General Comment 4, paras. 26-33

65 Eg see ICCPR article 9

Motivating factors for the migration of health workers

The migration of health workers from low-income countries to richer ones is increasing, in line with the explosive net increase in migration of all skilled personnel in the last quarter-century, both quantity of migrants and speed of migration.[66] 'Highly qualified' (ie educated to tertiary level) emigrants from post-independence sub-Saharan Africa numbered around 1,500 per year on average between 1960 and 1975, around 8,000 per year in the mid-80s and by the 1990s the most conservative of all estimates were around 20,000 per year.[67]

Reasons for the rise in migration of health workers from low-income to high-income countries are highly complex and varied, including huge salary differentials (up to a factor of 30x), enhanced career prospects, continuing professional education in the destination country, better working conditions in general, political and economic stability, the existence of social networks created by former migrants which may reduce the psychosocial costs of migration, and the rise of private sector agencies specialising in skilled migration which may reduce search costs. Economic growth has created a middle class that is more skilled and better connected, and hence more able to migrate, and enhanced access to information using improved telecommunications has raised awareness of career and salary prospects abroad.

While not all motivations for migration are connected to human rights, nevertheless, human rights shortcomings also play a critical role, particularly for migrants from certain countries. This section examines human rights in four important contexts for migration: poor respect for human rights in countries of origin; the facilitating factors of private sector recruitment and the General Agreement on Trade in Services (GATS); and the sometimes inadequate support for labour rights in countries of destination.

Human rights abuses and the balance of power in countries of origin

Migration is also often connected to the failure, or inability, of States to give effect to their human rights obligations. Whilst reference is made above to improving economic indicators playing a role in fuelling migration, conversely, deteriorating economic, social and political stability in many low-income countries causes migrants to leave to seek a better life.

Poor working conditions, even in politically stable countries, including poor levels of pay or inequitable salary structure,[68] long hours of work, a lack of opportunities for professional development, and unsafe working conditions often motivate health

66 Nyberg-Sorensen (2004)

67 Marchal and Kegels (2003)

68 Friedman, (2004)

workers to leave. These problems arise in the context of consistent under-resourcing of health systems, and have been exacerbated by public sector retrenchment in some countries, often promoted as loan conditions by IFIs,[69] the increased workload generated by past emigration, and the burden of the HIV/AIDS pandemic.[70] They may amount to abuses of rights in work, including: rest, leisure and reasonable limitation of working hours; safe and healthy working conditions; fair and equal wages; and occupational safety.[71] In some countries, health workers are also vulnerable to violations of other human rights including in the workplace, and sometimes on account of their profession, including torture, liberty and security of person and freedom of expression.[72] This can encourage them to migrate (either as migrant workers or as refugees).

All States have ratified international human rights treaties protecting labour rights and civil and political rights, and are therefore under an obligation to take measures to protect and promote these human rights of health workers. Given the significant impact that these abuses have on the right to health, it also becomes a right to health imperative to redress these problems – this is partly recognised in General Comment 14, which states that part of making health care available is ensuring the existence of medical and professional personnel receiving domestically competitive salaries.[73] However, given that a health worker from a low-income country may achieve a salary boost of between 1000% and 3000% by taking a job in some high-income countries, this dimension of availability appears increasingly out of step for certain parts of the world. National health strategies should give attention to ensuring sound human resource policies, as detailed below. This may aid retention to a certain extent, but competing with international salary levels is a problem that will almost certainly require international assistance or policies that raise the costs of migration.

In some cases, States may be unwilling to devote adequate expenditure to human resources (often the most significant use of the health system budget). Few African states have met their pledge, made at the African Summit on HIV/AIDS, TB and Other Related Infection Diseases in Abuja in 2001 to spend 15% of budgets on health.[74] In other cases, States may face significant resource constraints which hinder

69 See for example, Rowden (2004)

70 Huddart and Picazo (2003); Friedman (2004)

71 See, among others, ICESCR, article 7, ILO Occupational Health and Safety Convention, article 4; ILO Nursing Personnel Convention, article 7; ILO Resource Development Convention, article 1; UNESCO Convention on Technical and Vocational Education, article 3

72 Amnesty International (2000)

73 General Comment 14, para. 12.a

74 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, adopted by the African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001)

their capacity to improve salaries, working conditions and so on. Resource constraints can arise on account of domestic obstacles, such as corruption or inadequate revenue collection. Alternatively, States may simply choose not to allocate maximum available resources to health, seen in budgetary allocations skewed away from the health sector or from spending on social services in general. States have a right to health obligation to maximise available resources to fulfil the right to health.[75] Other resource-constraining problems facing some countries, in particular low-income countries, have an international dimension, including the burden of debt servicing, and the loan terms of international financial institutions, which have carried conditions of limits on public sector expenditure as part of structural adjustment programmes.[76] Moreover, donors have historically been keen to support capital investments, but less happy to support recurrent expenditure, such as human resources.[77] If a country is to meet its obligations towards the right to health, and if donors are to fulfil their obligations of international assistance and cooperation in meeting economic, social and cultural rights, then they must give much greater attention to creating conditions that will help ensure health workers are available in adequate numbers for services to be delivered.

It is not just the difficulties of retaining staff in the public health system that States must face when seeking to realise the right to health. A range of other problems at the national level, including the actions of third parties and the protection of vested interests, may hinder the actions of States in attempting to reduce the right to health implications of human resource constraints. For example, professional associations may resist the training of 'appropriately' skilled staff (eg, clinical officers and other mid-level cadres) who find less demand for their services abroad.[78] Resource constraints may make it difficult for States to observe and regulate the actions of the private sector. Addressing the causes of ill health may be a more efficient way to use limited resources to meet obligations towards individuals' rights to health.

Private sector recruitment agencies

An important facilitator of international health worker migration is the rise of private sector agencies specialising in international recruitment, which may reduce search costs

75 Norton and Elson (2001)

76 Medact and Wemos (2004)

77 Levels of public sector expenditure, and reliance on donor support raise important macroeconomic and political debates. This debate falls outside the scope of this paper, but we note that it was addressed in the recent Medact and Wemos report, Pushing the Boundaries: Health and the Next Round of PRSPs (June 2004), which argued that if poverty targets are to be met, delivering more resources to health is vital, and some countries may need to rely on donor support in the longer term

78 Hongoro and McPake (2004)

for those seeking work abroad.[79] Under international human rights law, States have an obligation to protect the right to health against harm by third parties, both individually and through international assistance and cooperation.[80] Countries of origin where private recruitment agencies are operating, and States where private recruitment companies are headquartered, have obligations to take legal or other political measure to regulate their activities.

The influence of private sector agencies calls for regulatory frameworks to ensure that their activities are conducted in a manner that does not jeopardise the right to health – eg they do not proactively recruit from countries, localities or specialisations where to do so would result in depriving individuals and groups of the right to health entitlement to *available*, *accessible*, *acceptable* and *quality* health care services. Private recruitment companies should also consider mainstreaming a human rights approach to their activities, for example through adopting and abiding by human rights-based codes of conduct. They may use the UN Norms on the Responsibilities of Transnational Corporations and Other Business Enterprises with Regard to Human Rights as a framework for their responsibilities, coupling this with the more detailed normative framework of the right to health to provide specific guidance in the context of their work.

General Agreement on Trade in Services (GATS)

Trade in health services has only been opened up to a limited degree compared to other sectors. When negotiating trade agreements, including GATS, States should carry out an impact assessment to anticipate the impact of that agreement on the right to health and other human rights and should, if necessary, adjust their policies to ensure promotion and protection of human rights.[81]

Countries of destination and the inadequate protection of labour rights and the right to health

In richer destination countries, these same factors of poor terms and conditions contribute to the under-valuing of health professions there, and the consequent difficulty in attracting sufficient quantities of people from the recipient country into training, or retaining health workers. This creates the demand for health workers from abroad – a pull factor. Increasing demands for health and care services in high-income countries, resulting from the ageing of the population, increasing wealth, new medical

[79] Bach (2003)

[80] See pp 15-17

[81] Hunt (2004)

technologies and the reduced role of the family in caring for the elderly, compounds the need of higher-income countries for more health workers. Destination countries should ensure that they take steps to progressively realise the right to health, but this should be done in a manner that respects the right to health in other countries. Whilst recruiting States may argue that hiring from abroad is in fact simply making use of maximum available resources in the most efficient manner, making use of maximum available resources to strengthen domestic training and recruitment will preclude the need for the quick-fix option of recruiting from abroad. In Chapter 3, we consider the different policy options which these States may pursue (eg improved human resource planning, restitution, and managed migration) and how far these may be considered as appropriate steps towards these States fulfilment of their human rights obligations.

The rights of migrating health workers

Whilst migration can be a means for health workers to improve their enjoyment of human rights, health worker migration can also have negative human rights implications for migrants.

There is evidence of systematic discrimination against migrant health workers in terms of career opportunities, for instance in the United Kingdom.[82] Under ICESCR and ICERD, States have an obligation to ensure that human rights, including equal opportunity for everyone to be promoted in his or her employment to an appropriate higher level, are exercised on the basis of non-discrimination. States may not differentiate between citizens and non-citizens except in relation to a small number of rights, notably the right to participate in elections, to vote and to stand for election.[83]

Migrant health workers are vulnerable to a range of other difficulties. Various groups – including recruitment agencies, may exploit and reinforce, or fail to dispel, unrealistic expectations amongst migrant health workers about the nature of opportunity abroad.[84] Under the ILO Migration for Employment Convention, each member must undertake to ensure that there is 'an adequate and free service to assist migrants for employment, and in particular to provide them with accurate information' and take all appropriate permissible steps so far as its regulations permit 'against misleading propaganda relating to emigration and immigration.'[85] Migrants can also be vulnerable to the withholding or confiscation of their passports or other identity documents by unscrupulous employers. Under CERD and MWC, States must take measures to

[82] Decker (2001); Singh (2003)

[83] E.g. See CERD General Comment 30 on Discrimination Against Non-Citizens (2004), para. 3

[84] Browne (2001); and http://news.bbc.co.uk/1/hi/programmes/newsnight/3637890.stm accessed 17th January 2005

[85] ILO Migration for Employment Convention , articles 2 and 3

prevent and redress the retention of passports of migrant workers.[86] On account of their status, or because of the posts that migrant health workers tend to occupy, they may also be vulnerable to other human rights abuses in the workplace, including violence.

Many migrant health workers are women. Women migrant workers may face the burden of discrimination on grounds of gender, which compounds the discrimination they may face on grounds of national origin, race or ethnicity.[87] This renders women migrant workers particularly vulnerable to the human rights abuses suffered by migrants. Under CEDAW, States parties are under an obligation to eliminate all forms of discrimination against women, including refraining from discrimination and taking measures to protect women against discrimination by other persons, organisations or enterprises, and to take measures to guarantee the enjoyment of human rights of women on a basis of equality with men.[88]

Positive consequences of migration: a conflict of rights?

The positive effects of the migration of health workers are significant for certain groups, and cannot be ignored.

Those from richer nations are often lucky enough to be able to take for granted their right, and ability, to migrate. Migration from low-income countries may enable individuals to flee from human rights abuses, for instance breaches of labour rights, an inadequate standard of living, or violence - where the State has not lived up to its human rights obligations to redress these abuses. Even if they are not subject to specific human rights abuses, health workers from low-income countries may migrate simply to seek better salaries, and "use their qualifications as a passport to freedom, intellectual and emotional fulfilment, and professional satisfaction."[89]

Monetary remittances are of significant benefit to the families of migrants, used not only for consumption but also for investment in human capital including health.[90] Monetary remittances may facilitate the realisation of a range of human rights for migrating health workers, in particular the right to remuneration that enables an adequate standard of living, and educational opportunities, for themselves and their families.[91]

86 MWC, article 21; CERD, General Comment 30, para. 34

87 IoM (2002)

88 CEDAW articles 2 and 3; also see CEDAW General Recommendation 19 on violence against women (1992).

89 Loefler (2001)

90 Nyberg-Sorensen (2004)

91 ICESCR, in particular article 7

The positive effects of migration do not simply accrue to the migrants themselves, and their families. Health systems users in destination countries benefit insofar as migrant health workers fill vacancies in these countries caused by shortfalls in training opportunities, the poor terms and conditions of some posts, and low retention of staff.

These positive effects of international health worker migration may give rise to questions in the minds of some policy makers about conflicts of rights. For example, is it moral and compatible with human rights to stem the flow of international health worker migration, even if it improves the right to health in low-income countries, if another outcome is to exacerbate shortages in staffing in high-income countries and if it conflicts with the right of health workers to freedom of movement, including the right to leave their country?

The complexity of international health worker migration probably means that no one response that seeks to mitigate the negative effects of migration (in essence, to promote the right to health) is likely to score perfectly in an analysis of its overall human rights implications. An integrated set of responses, which engenders an optimal balance between the rights of different groups, is more likely to approach this ideal. The question at the heart of the matter is: what is the optimal balance between the rights of different groups? Clearly, at present policies relating to international health worker migration do not balance the human rights of different stakeholders very fairly.

Human rights provide some guidance as to how to balance competing claims. For example, in the context of international health worker migration:

- Human rights must be considered of equal value – in other words, no right is intrinsically superior to any other right, and no one right necessarily trumps another.[92] So the freedom of movement of health workers does not ordinarily trump the right to health of individuals, or *vice versa*; however
- Poverty and discrimination are central concerns of human rights. Where policies benefit the wealthy or enfranchised at the expense of the poor or disenfranchised, as international recruitment of health workers typically does, they become subject to legitimate human rights criticisms. Policies, programmes and legislation should be driven by the human rights concern of equality – this means that policies must support the realisation of human rights of impoverished or other marginalised groups in low-income countries, likely to be more subject to abuses of their human rights than the rich;
- Balancing rights must be guided by the core obligation on States to ensure the enjoyment of the *essential minimum levels* of economic, social and cultural rights,

[92] Vienna Declaration and Programme of Action, para. 5

including ensuring the availability of essential primary health care, and health care facilities, goods and services that are equitably distributed and accessible on the basis of non-discrimination and equality – these minimum entitlements cannot be bargained away;[93]

- Non-retrogression is an established principle of human rights. In other words, if a State policy leads to a deteriorating situation for a human right or group of human rights (eg worsening access to health services in low-income countries), then it is incompatible with human rights. Retrogression may only be justified by reference to the totality of the rights in a given situation, and in the context of the full use of the maximum available resources;[94] and
- Some human rights, including the right to freedom of movement, can be limited in specific circumstances. Whether it is ever justifiable to limit the international migration of health workers is briefly examined in section 1.

Some policies can pre-empt human rights balancing acts, for example through removing negative effects that motivate migration including improving terms and conditions in countries of origin, and reducing excessive demand factors, including through ensuring better terms and conditions and training more health workers in countries of destination so that less international recruitment is needed. Other policies explicitly require the balancing of one right, or right-holder, against another. For instance, 'ethical' recruitment policies may have the outcome of improving the right to health in states of origin but worsening the human rights situation of health workers. Policy responses are explored in more detail in chapter 3.

[93] CESCR, General Comment 14, para. 43

[94] CESCR, General Comment 3, para. 9

3. Fixing the problem: can human rights guide policies

Any policy that seeks to mitigate the negative effects of the international migration of health workers seeks to redress vast systematic inequality in the balance of power and wealth between rich and poor countries, and may be contrary to the interests that motivate powerful and wealthy stakeholders. For this reason, the policies outlined here may face significant obstacles.

This chapter only analyses policy measures that are credibly part of the international debate about how best to address the negative causes and outcomes of health worker migration. The fact that no policy analysed here necessarily incurs severe human rights violations is promising. However, the human rights implications of policy responses can be uncertain, given that outcomes, positive and negative, are a function of the success with which the policy is implemented.

The most appropriate response to the problem of health worker migration is likely to be an integrated one: the combination of preventative and mitigating responses that address the human rights causes and consequences of the migration of health workers. An integrated approach that ensures that improvements in the right to health are achieved without any express limitation of any other rights, including freedom of movement and rights in work, should combine positive steps by source country governments to improve rights in work for employees in their home country (health systems strengthening); increase resources for doing so through positive and explicit financial acknowledgement by destination countries of the human rights breaches exacerbated through their hiring of international staff (restitution); and include steps by the destination country to redress the shortfall in health staff that drives international migration (better human resource planning in destination countries). A range of other appropriate measures for meeting the right to health in the source country that are fast to implement in the short term (auxiliary worker training, managed migration and a contract with health staff trained in the public system that invokes an obligation to the public health system for a period of time after training is completed) may also have an important role to play in some countries. Strong relationships

between the health systems of source and recruiting countries must be developed such that managed migration can be combined with an ethical approach to the recruitment of staff from abroad by high-income states.

Adopting a human rights approach is a way that States, and other actors, can build human rights considerations into the development, design and implementation of policies.

Policies, including those that currently apply, often contain implicit human rights judgements, including tradeoffs between different human rights, and/or the human rights of different groups. For example, in 2002/03, approximately 1,500 South African nurses and midwives found employment in the UK.[95] The scale of this migration was arguably a conseqence of a range of UK policies, including former encouragement of international recruitment, and poor human resource policies in the NHS leading to nursing shortages. The nurse and midwife ratios[96] in South Africa are 30% lower than in the UK[97] on average, and much lower even than that in some parts of South Africa. Meanwhile, the need for nurses and midwives in South Africa is particularly acute given the country's burden of disease, notably on account of the HIV/AIDS pandemic. Because policymakers and recruiters in the UK may not have considered the human rights implications of their actions, and may not have been aware of the full extent of the problems faced in South Africa, their recruitment of these health workers reveals a predominant concern with the provision of health care in the UK, and perhaps with the rights of migrating health workers, but comparative disregard for (or ignorance of) the right to health of South Africans. The human rights causes and consequences of health worker migration must be addressed in all potential responses (or lack of responses). This is a moral imperative and a legal obligation on States.

A human rights approach to public health and migration policies

Under international human rights law, responses should be developed in a way that is informed by, and respects, the human rights of *all* stakeholders. This means the objectives and outcomes of a policy should be to achieve an optimal and equitable balance between the human rights of different stakeholders. Policies should be grounded in the human rights of non-discrimination and equality, and should seek the views of affected stakeholders, including health system users in countries of origin, as far as possible, maybe through representative bodies including appropriate civil society,

95 NMC (2003)

96 Quantity of qualified staff per head of population

97 Figures at http://www.who.int/GlobalAtlas/DataQuery/browse.asp?catID=180000000000&lev=2 last accessed 22nd January 2005

the ministry of health and local health authorities in the country concerned. This approach is often referred to as a 'human rights approach.' and should be made an integral part of the design, implementation, monitoring and evaluation of health related policies and programmes in all spheres, including political, economic and social.[98]

Within public health, human rights approaches have been tailored to specific contexts, such as HIV/AIDS and maternal mortality.[99] International agencies, donors and NGOs are increasingly adopting this approach, whilst some private companies, including some pharmaceuticals, are also trying to give more attention to human rights dimensions of their work. Adopting a human rights approach to policy responses to international health worker migration is a way to ensure that the policies adopted benefit, rather than harm, human rights.

This paper does not include a step-by-step guide to making a human rights approach operational. However, it sketches out some of the key objectives and features of a human rights approach, applied in the context of health worker migration. It then uses a human rights framework to analyse proposed responses to the negative consequences of health worker migration.

Does a human rights approach change public health programming?

A human rights approach may alter what public health practitioners do (eg adopt policies with objectives consistent with human rights), how they do it (eg ensure that human rights are given effect in policy-making processes) and why they do it (eg ensure that inequality and discrimination are addressed as a priority in public health programming). However, a human rights approach does not necessarily represent a dramatic departure from public health programming. There are many examples of public health policies which already contribute to the realisation of human rights, for example by improving health outcomes in a manner consistent with the right to health and other human rights; empowering vulnerable groups; promoting equality; seeking meaningful participation of affected rights-holders; and engaging monitoring and accountability mechanisms. A human rights approach helps reinforce and legitimise good practice where it exists. There are also examples of public health policies that do not contribute to the realisation of human rights. In these cases, a human rights approach has a more substantive contribution to make: in particular, to encourage the policy-maker to recognise the rights of stakeholders not normally within the frame of reference of public health programming – notably, in the case of the migration of health workers, health system users and their families and communities in countries of origin (and, in some cases, health workers).

[98] WHO (2002)

[99] UNAIDS/OHCHR (1996); WHO (2001)

What are the main features of a human rights approach to health development?

The main features of a human rights approach include:

- *Accountability:* Accountability is central to a human rights approach since without accountability, human rights are no more than window dressing. In the context of health worker migration, there is a range of accountability mechanisms that may be used to hold States and other actors to account for human rights, and ensure redress where violations occur (see pp 18).
- *Explicitly recognising the national and international human rights normative framework:* A human rights approach requires that policies are guided by internationally and nationally recognised human rights, with particular reference to a State's treaty and Constitutional obligations (simply throwing in references to human rights in a policy document does not in itself constitute a human rights approach). Policies or programmes should explicitly reference these frameworks and indicate how they intend to give effect to them.
- *Non-discrimination and equality:* Any policy relating to the migration of health workers should have the objective of securing equality and freedom from discrimination, advertent or inadvertent, in its design and implementation. In order to monitor equality and non-discrimination, data should be disaggregated (eg gender of health workers migrating from a source country and into a destination country; numbers of different categories of health workers working in different areas in source countries; etc). Longitudinal collection of such data is an important way to monitor progress (or otherwise) over time.
- *Empowering poor and marginalised groups:* human rights approaches aim to empower these groups by recognising, and making them aware of, their human rights entitlements (and the resulting obligations that fall on other actors) and enabling them to play a role in designing and implementing policies or programmes. In the context of the migration of health workers, a human rights approach to mitigation strategies should empower stakeholders, including poor and marginalised communities in countries of origin and health workers, and, so far as possible, seek their active and informed *participation*.
- *Participation:* a human rights approach requires identification of those whose rights might be affected by a policy, and encourages their participation in shaping that policy, its implementation and monitoring. This process will involve identifying and reducing constraints to equal participation by all stakeholders. In the context of responses to health worker migration, a human rights approach engages the

participation of health workers (including those that may migrate, have migrated, and those left behind) and as far as feasible, that of health system users and their families and communities in source countries or organisations that represent them.[100]

Other key features of a human rights approach include safeguarding human dignity and ensuring transparency. WHO has identified four further key features to mainstreaming a human rights approach to health: make the attainment of the right to the enjoyment of the highest attainable standard of health the explicit ultimate aim of activities which have as their objective the enhancement of health; ensure health systems are made accessible to all, especially to the most vulnerable sections of the population; only limit the exercise or enjoyment of a human right for public health reasons as a last resort and only consider this legitimate if each of the provisions reflected in the Siracusa Principles[101] is met; and ensure optimal balance between good public health outcomes and the promotion and protection of human rights including the freedom of movement.[102]

Why use a human rights approach, and what are its limits?

Through involving a self-conscious assessment of the relationship between policy processes and outcomes, on the one hand, and human rights on the other hand, a human rights approach enhances potential to strengthen human rights promotion and protection through public health policy. As has already been discussed, a human rights approach may also empower individuals and enhance accountability. Additionally, a human rights approach provides a shared and authoritative platform for advocacy and cooperation between different actors.

It is important to also recognise that human rights approaches are limited in some ways:

- The literature on human rights approaches provides more guidance on frameworks, values and objectives than practical information on how to make such an approach operational.
- Human rights frameworks do not in themselves always resolve complex policy choices, especially where there are equally valid competing claims on limited resources, or where other trade-offs are unavoidable.
- Although progress is being made, there is a lack of clarity surrounding, in particular, several economic, social and cultural rights including the right to health.

[100] UNDP (2000); Hunt, Nowak et al. (2002); WHO (2002); Jonsson (2003)

[101] Siracusa Principles

[102] WHO (2002)

For example, it is unclear how 'maximum available resources' can be defined with precision in any given context, and which indicators and benchmarks would be acceptable to measure compliance with the obligation to devote maximum available resources.

- In resource-poor settings, the absence of workable accountability mechanisms may mean that the State is not held accountable for its failure to realise human rights in the event that it should have been capable of doing so; conversely, an over-emphasis on certain accountability mechanisms, especially the law, may mean that access to certain rights is privileged to those with access to justice, which poor rural communities typically do not have.

The remainder of this chapter focuses on analysing the human rights implications of policies to mitigate the negative effects of international health worker migration. Many of these policies may not have been formulated or implemented with reference to human rights. This paper argues, however, that all responses should be guided by a human rights approach, as we have defined it. Human rights should be taken into consideration during policy development, implementation and monitoring.

An analysis of the human rights implications of mitigation measures

Since the problems that can be associated with health worker migration became subject to scrutiny, academics, international organisations, civil society and governments have proposed a range of initiatives to redress the inequalities that cause and result from migration. Responses can broadly speaking be categorised into two groups:

- Preventative responses, which seek, through coercive action or incentives, to prevent the flow of health workers from South to North (or from rural to urban areas, or the public to the private sector); or
- Mitigating responses, which do not aim to prevent or interfere with the flow of health workers, but which encompass proposed mechanisms to mitigate the negative impact on source countries.[103]

A more detailed characterisation is the 'six Rs' – Return (of migrants to home country), Restriction (of migrants from leaving home country), Recruitment (a reduction of recruitment of international migrants by destination countries), Reparation (by hiring countries to sending countries), Resourcing (formalisation of remittances), and Retention (through improvement in planning and working conditions in source countries).

[103] Lowell and Findlay (2002)

There is a general, albeit ill-defined, recognition by policy-makers in countries seeking to recruit from low-income countries that inhibiting talented and skilled health workers from moving to the place where they are most able to fulfil their potential is illiberal, and may amount to a violation of human rights[104]. The right to health of health system users left behind in underserved areas is less commonly considered, and is rarely framed in human rights terms. A human rights approach seeks a more holistic analytical and practical response to mitigate the problems created by migration of health workers, and to make explicit the human rights effects of each policy. What is the exact bearing of each policy on the human rights of all stakeholders? What human rights breaches take place in the absence of a policy solution? What is the optimal balance between the human rights of different stakeholders where tradeoffs are inevitable? Does the status quo strike this balance? How far does each mechanism integrate the key features of a human rights approach, namely empowerment, participation, reference to human rights, accountability, and equality and non-discrimination?

The following assessment of seven policy responses takes account of the obligation of progressive realisation on States to realise the right to health: with a problem as complex as the migration of health workers, and the functioning of health systems in resource limited settings, it is unrealistic to expect that any policy will address simultaneously the many human rights causes and consequences involved in migration. The policies are judged in part on their potential to contribute to the progressive realisation of the right to health, but also their consistency with other human rights, such as the right of health workers to freedom of movement.

We consider a fundamental human rights consideration is whether a human rights approach is mainstreamed in each policy. In other words, if a policy is considered or implemented, are participation, accountability, equality- and non-discrimination, and grounding in internationally recognised human rights built in?

The analysis is an introductory overview. First, it does not provide a full treatment of the practicality of each solution in the context of different countries or regions. Practicality, however, is a fundamental concern. Given the weakness of legal institutions and health systems in many countries losing health staff, policies may simply not work as designed; or they may have unforeseen circumstances. The treatment below touches on possible negative human rights side-effects of each policy, but not all. Policies have to be designed pragmatically in order to achieve the desired effects and minimise perverse incentives. Second, although the policy responses are expressed as discrete responses, in reality a more successful approach is likely to combine more than one

[104] ibid

response – possibly combining mitigation and prevention; and possibly addressing both cause and consequence of the migration of health workers. For example, bonding may work best if its sanction is set within a wider process of managed migration.[105] The importance of multi-pronged approaches to addressing migration was acknowledged by States at the International Conference on Population and Development, where they commited to address the root causes of migration, especially poverty, encourage more dialogue between source and destination countries to maximise positive benefits for both countries and facilitate the reintegration process of returning migrants.[106] Third, whilst the sections below make some reference to international human rights and obligations, they do not reference the relevant provisions comprehensively. This is done in Annexes 1 and 2.

Health systems strengthening in countries of origin

Health systems strengthening in countries of origin may be defined as a policy that seeks to improve the overall efficiency, effectiveness, governance and equity of the health system. Human resources are the most important input in health services – the performance of health systems depends on the motivation and skills of their staff.[107] As a response to attrition of staff from the health system, human resource aspects of health system strengthening address those deficiencies within the health system that motivate health professionals to leave, for example poor pay, unsafe working conditions, or inadequate staffing levels which place an often intolerable burden on staff. Of course there are many other aspects to health system strengthening, including building infrastructure and communications.

However, considerable complications exist. The Commission on Macroeconomics and Health recommended a minimum per capita expenditure on healthcare of between US$30 and US$40: but this may represent as much as 10% of the GDP of some sub-Saharan African countries, and in the case of Zambia, for instance, is around 55% of government tax revenues. In the Abuja Declaration, African states committed to devoting 15% of their annual budgets to health, a level that falls far short of the minimum targets proposed by the CMH.[108] The levels of expenditure in many low-income countries, in particular many sub-Saharan countries, fall far short of the Abuja targets. Human resources are the most significant cost in a health system, and

[105] Wibulpolprasert and Pengpaibon (2003)

[106] ICPD, chapter 10.

[107] WHO (2000)

[108] Commission on Macroeconomics and Health (2001); Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, adopted by the African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001)

improving human resource policies, whether terms and conditions or levels of staff, may demand devotion of additional resources to the health sector. However, how much, in the context of such large salary differentials between rich and poor states? In other words, if states allocated more resources, how far would they progress in solving the problem of health worker attrition? Finding technical expertise to ensure adequate planning, training and motivation of human resources can be an additional challenge.[109]

A human rights analysis of health systems strengthening

Health systems strengthening as a response to international health worker migration can be seen to address the realisation of the right to health care;[110] and the rights of health workers, such as adequate remuneration, freedom from discrimination, and reasonable working hours.[111] These represent respectively consequences and causes of international health worker migration. Health system strengthening also corresponds with commitments made at the International Conference on Population and Development for 'Governments of countries of origin and of countries of destination [to] seek to make the option of remaining in one's country viable for all people.'[112]

Short of excessive budgetary allocations to the health system creating a shortfall in other areas of public spending with corresponding human rights implications, no distinct negative human rights effects of health systems strengthening can be identified.

Recommendations for duty-bearers

Countries of origin should apply a human rights approach, as defined earlier, to the design of health systems' strengthening policies, examining how they will promote equity in access to health care, the right to health and the rights of health workers, and should recognise the significant resource requirements of a health system that intends to retain its staff in the face of competition from high-income destination countries. In accordance with international human rights treaty provisions relating to the right to health, they should devote maximum available resources to health system strengthening, and improving the terms and conditions of health workers,[113] and African states should spend at least the amounts committed in the Abuja Declaration.

[109] Hongoro and McPake (2004)

[110] eg ICESCR, article 12

[111] eg ICESCR, articles 2.2, 6, 7, 11

[112] Cairo Declaration, para. 10.3.

[113] Eg ICESCR articles 2.1 and 12.

Consistent with their obligations of international assistance and cooperation[114], *recruiting states* should continue to promote efforts in low-income countries to strengthen health systems in order to promote the right to health, and should significantly increase funds for such efforts, for example in conjunction with a policy of restitution as defined below. Monitoring and evaluation of the use of funds should give attention to whether policies improve the right to health and other human rights. Attrition of health workers, and human resource policies in general, must be recognised as a fundamental area of focus for efforts to strengthen source country health systems. Domestic policies should explicitly 'do no harm' to the health systems of low-income countries, whilst aid policies improve those systems.

International institutions such as the WHO should continue to disseminate technical support on best practice in human resource planning.

In accordance with their responsibilities to respect the human rights obligations of States (see page 17) the international financial institutions should relax spending caps in the health sector to allow sufficient funding to finance a response to the exodus of health workers, without any negative implications for the funding of infrastructure or supplies.

Restitution

Restitution, also commonly called *reparation* or *compensation*, seeks to determine where the costs of international migration fall, and to allocate compensation accordingly – allowing countries to use the resources to address some of the inequalities that give rise to, and result from, migration. Costs fall on the governments and citizens of countries that train, at their own expense, health workers, only to lose them to richer countries. Wider costs include the increased morbidity and mortality in low-income countries that occur when health workers are not available in adequate numbers, and the associated social and economic costs.

Determining how much compensation is necessary rests upon understanding the full costs incurred by the source country, including training costs and wider social and economic costs, or alternatively the value to the hiring country, which at the very least saves the cost of training a health worker at home. There are challenges in doing so – not insurmountable – which are properly addressed in the sister paper to this one.[115] Other challenges, also addressed, include the poor quality of information available about migration of health workers; and incentives opposing the payment of restitution by hiring countries that may limit recruitment (a 'tax on migration') and make restitution unpopular with health workers. Hiring countries may argue that they

[114] ICESCR, article 2.1

[115] Mensah, Mackintosh and Henry (2005)

contribute considerable finance towards the health system of the countries they hire from and that restitution is therefore already happening. Others suggest that a significant increase in funding of salaries within the health sector of a poor country will lead to macroeconomic instability. Nevertheless, the practical obstacles associated with restitution are surmountable with sufficient motivation to do so by recruiting states and a properly designed method for restitution.[116]

A human rights analysis of restitution

Restitution, as a response to the negative implications of the migration of health workers, corresponds closely with two human rights and corresponding obligations:

- The obligation of destination countries to respect, protect and fulfil the right to health in other countries,[117] as well as with MDG8, both through contributing funds that enable strengthening of health systems, and by acting as a disincentive to proactive recruitment of health workers from countries where there are shortages; and
- Redistribution of funding may enable source countries to address human rights *causes* of health worker migration, in accordance with their obligations under international human rights law, including facilitating the realisation of the right to favourable working conditions[118] and the right to health, on the basis of equality.[119]

In the absence of integration with other policy responses to health worker migration, restitution is unlikely to have significant negative effects on human rights, at least in relation to the right to health and the rights of health workers to, and in, work.

In order to have the maximum possible benefit for these rights, the redistribution of funding should be allocated to the health sector and contribute to *health systems' strengthening* (see above) by countries of origin, including the improvement of pay and conditions for health workers in underserved areas, in an equitable and sustainable manner.

Its overall implications for the right of health workers to freedom of movement are hard to predict. Depending upon the size of the restitution sum, it may have negative implications for the health of health system users in destination countries if it disincentivises international recruitment so much that it leads to staff shortages: it

[116] Mensah et al (ibid)

[117] eg under ICESCR, articles 2.1 and 12, and CRC articles 4 and 24

[118] eg under ICESCR, article 7

[119] eg ICESCR, article 12

therefore needs to be accompanied by improved workforce planning in countries of destination.

If improperly implemented, restitution may have a range of effects which inhibit the realisation of human rights. Poorly governed, restitution funds may not be used to correct the negative human rights causes or consequences of the migration of health workers, notably inequality. This is an important risk, especially in the context of poorly governed low-income states, and social spending thresholds imposed for macroeconomic stability. Misuse of funds might not worsen human rights in countries of origin: however, given the increase in 'available resources,' a misuse of funds would amount to a greater failure on the part of the obliged state to meet human rights obligations to devote maximum available resources towards the realisation of the right to health, and rights in work.[120] In this context, transparency and monitoring of restituted funds is important. If restitution also incentivised states in countries of origin to encourage emigration, then it could have negative human rights implications if the amount restituted did not compensate for expertise lost, exacerbating an already serious problem defined earlier in this paper. A human rights approach to the management of restitution is recommended, including participation by affected stakeholders (for example in designing policies and monitoring them), and transparent and accountable use of funds.

Recommendations for duty-bearers

States of destination and origin that work together to implement a policy of restitution that recognises the costs of health worker migration on states of origin must:

- Ensure that restitution payments are properly governed, and take steps to ensure that decisions about their use are taken using information about the *causes and consequences* of migration, with explicit recognition of human rights. This requires coordinating the use of restitution funds with other mitigation policies, and establishing accountability mechanisms that will address misuse of funds;
- Ensure that restitution is used for implementation of policies that meet the right to health;
- Ensure that the sums restituted fully compensate for the costs borne by the low-income country in the loss of a health worker, including the cost of training, social costs and wider losses of capacity to the health system;[121] and
- Ensure that the costs of restitution are borne by the beneficiary – ie, the hiring institution in the destination country.

[120] eg ICESCR, articles 2(1), 7, 12

[121] Mensah et al (ibid)

International institutions such as the WHO can:

- Promote restitution, and mediate between source and destination countries to ensure that restitution policies are applied fairly and efficiently; and
- Provide technical assistance to ensure that a rights-based approach and appropriate technical expertise is applied to the use of restitution funds.

The private sector must:

- Meet its share of the costs of restitution and participate with hiring-country governments to ensure accurate and timely information about flows of staff.

International Financial Institutions must:

- Refrain from imposing ceilings on recurrent expenditure in the health sector which would inhibit the ability for a restitution fund to contribute to, amongst other things, the retention of staff.

Better human resource planning in destination countries

Better human resource planning in destination countries promotes more attractive terms and conditions and more training places for health workers in these countries, recognising that until the problem of excess demand for health workers in destination countries, coupled with undersupply, is redressed, policies that try and limit international recruitment will not address this major root cause of the problem. If better human resource planning was applied in conjunction with a policy of restitution, which would oblige destination countries to correctly compensate low-income countries for the costs that those countries incur when losing health staff, international recruitment would become comparatively more costly. Compared to the costs of hiring from abroad and paying restitution, the cost differential of training more staff domestically would be lower, and it would seem more viable to do so.

Complications include the fact that while international recruitment is a relatively low cost solution to excess demand for health workers, countries have little incentive to train more staff and remunerate them more, at considerable expense. Even so, the human right to health, the obligation of international assistance and cooperation, and evidence of the harmful impact on the right to health of international recruitment, suggest that improving their own human resource planning is a human rights obligation on high-income governments.

A human rights analysis of better human resource planning in destination countries

Better human resource planning in destination countries improves the supply of health workers and their terms and conditions. The improvement of human resource supply in destination countries is driven by the same human rights objective as the international recruitment of health workers – the need for high-income States parties to meet their obligations towards the right to health. But better human resource planning in destination countries achieves this impact without the negative side-effect of damaging source countries' efforts to meet their obligations towards the right to health.

A policy implemented by a high-income country that seeks to improve the internal supply of health workers and distribute them more equitably, addresses the following rights:

- Through the allocation of maximum available resources to the right to health, resonance with improving the right to health in countries of destination;[122]
- Through improving terms and conditions of health workers, it resonates with the right to just and favourable conditions of work[123], and may redress a cause of migration out of destination countries ('the chain'), thereby also helping to ensure the right to health by preventing staff shortages;[124] and
- Through a reduction in the number of international health staff actively recruited to migrate, a reduction in one of the main *consequences* of the migration of health staff – namely understaffing of health services in the source country – contributing towards the respect of the obligation of international assistance and cooperation towards the right to health.[125]

Institutions in the health sector may still retain good reasons to hire international staff, not least the possibility that those staff may be the best for the job, especially where certain specialist experience is required. For example, UK immigration policy grants the right to employers to employ overseas staff where a suitably-qualified internal candidate cannot be found. Therefore, hiring from low-income countries will still take place and because the staff hired are often those most highly qualified, the impact of their departure is especially high. Second, a policy that reduces the employment options in high-income countries of health workers in low-income countries may have negative implications for those individuals' chances of using emigration as an

[122] eg ICESCR article 12

[123] eg ICESCR article 7

[124] eg ICESCR article 12

[125] eg ICESCR articles 2.1, 12

informal means to improve their enjoyment of human rights,[126] such as working conditions and pay. Third, whilst the policy may help stem the net outflow of health workers from certain countries, leading to an improvement in those states' ability to progressively realise their obligations towards the right to health, given that no single country is the only recruiter of health workers, it might simply divert migration elsewhere. This underlines the need for a coordinated international solution to the negative aspects of migration of health professionals.

Recommendations for duty-bearers

For recruiting states, better human resource planning, such that internal supply of health workers meets demand, is essential, for the reasons described above. Due to the sheer scale of the demand, it is an essential complement to policies that seek to more directly address the negative effects of the migration of health workers, such as health system strengthening in, and restitution to, countries of origin (see pages 44-49).

Managed migration

Managed migration, also known as *brain exchange* and *circulation*,[127] is a term usually used to denote positive encouragement of migration by the source country but also encouragement of the health worker to return. Managed migration often occurs as part of a bilateral or multilateral agreement with destination countries. Policies often promote links between diaspora communities and the home country in a way that may promote North-South learning – ie, social remittances.

The term 'managed migration' is relatively loose. However, this paper makes the assumption that most sensible managed migration policies will seek to build on a process of migration that already occurs, and formalise it, and could consist of three main principles:

- Constant communication with the migrant: this will allow states to encourage return, promote certain training that will be beneficial to the source country and possibly generate revenue from the diaspora through voluntary contributions; it may also help to improve pay and conditions for workers in destination countries; and finally there is an emphasis on rapid reintegration into work for the returning health professional;
- Possible two-way flows of staff such that health workers from the recipient country provide a period of service in the source country; and

[126] Note that for certain, serious, civil and political rights abuses, individuals' ability to seek refuge in the United Kingdom would remain unaffected

[127] Wickramasekara (2002)

- Partnership with a recipient country or recipient country institution, possibly to generate appropriate training opportunities and also revenue for the source country that is applied to strengthen the health system in the source country.

The Cairo Declaration and Programme of Action places significant emphasis on managed migration as a strategy to temper negative consequences of, and foster positive consequences of, international migration, stating: 'Governments of countries of destination are invited to consider the use of certain forms of temporary migration, such as short-term and project-related migration, as a means of improving the skills of nationals of countries of origin, especially developing countries and countries with economies in transition.'[128]

There is little evidence that managed migration has been successfully applied to ameliorate the problem of health worker emigration in any country suffering a real shortage. The Philippines operates a policy of managed migration, but in the unique context of state assertions of an excess of health workers. This situation is not typical of most low-income countries. Some countries and organisations, including the Institute of Migration, have experimented with return policies, eg RQAN?. However, these are often extremely expensive – and there is little evidence that they motivate any more return than would otherwise take place[129]. Managed migration has been proposed, in the context of GATS, as a way for low-income countries to formalise revenues from the 'brain drain'.[130] In this respect it possibly overlaps with restitution mechanisms.

A human rights analysis of managed migration

A managed migration policy corresponds with the following human rights objectives:

- By limiting the permanence and duration of migrants' period of work abroad, to improve staffing levels in the source country's health system and hence the *right to health* in the source country;[131]
- By remaining in contact with the individual member of staff and by forming partnerships with respectable institutions abroad, to improve the chances that the migrant will enjoy non-discrimination and equality in the workplace, as well as favourable working conditions and opportunities for career advancement and training;[132] and

[128] Para. 10.5

[129] See, for instance, UNESCO International Association of Universities Newsletter Jan 2004 at http://www.unesco.org/iau/newsletters/iaunew10-1-2-en.pdf

[130] Hilary (2001)

[131] eg ICESCR article 12

[132] eg ICESCR articles 2.1, 6, 7, 12

- By reducing any stigma or sanction associated with migration, encourage the right to migrate of health workers.[133]

The range of positive human rights consequences of a policy of managed migration *that is successfully applied* is defined above. It is difficult to assess the likelihood that a policy of managed migration will be successfully applied, given the range of possible settings under which its application is possible. The following considerations are important:

- The capacity of the implementing State may be insufficient to successfully manage a policy with a large number of migrants;
- The likelihood of return may be diminished by application of a managed migration policy. If the quality of the migrant's experience overseas is enhanced by the application of a policy of managed migration, they may be less likely to return. In addition, the training that they achieve in a recipient country may make them even more in demand in that country. If this happens, it may diminish the efforts of the State to pursue the *right to health* in the source country;
- If the existence of a managed migration scheme reduces the financial and social costs of migration for a health worker and as a consequence, increases the number of migrants, without increasing the rate of return by a similar amount, this will have a negative impact on the *right to health in source countries*;
- There is a risk that a managed migration scheme may not be sufficiently transparent and a risk of inequity in the selection process for those able to benefit from the scheme meaning a failure of the health professional's right to non-*discrimination and equality*; and
- Efforts of a coercive nature to stimulate return by workers overseas must be avoided, to preserve the *right to migrate.*

Recommendations for duty-bearers

Managed migration should not be a primary response to the negative impact of health worker migration, unless there is strong evidence that the policy will have the effect of significantly improving the right to health of health system users in the source country. From the point of view of the right to health, training received by participants in the process contributes to the right to health if it is appropriate to the burden of disease and needs of the country that they are from. Recruiting states must participate fully in positive source country efforts to encourage diaspora return. In addition, they must encourage two-way benefit – ie ensure, either through the provision of funding or

[133] UDHR, article 13; ICCPR, article 12 and General Comment 27; ACHPR, article 12

support in kind, that the source country benefits from the process as much as the migrant and the recipient country. Any restitution paid under such a scheme should be subject to the same concerns about governance and magnitude as defined in the restitution section of this paper. Managed migration is, however, a positive experience for many health professionals, promoting their opportunities for professional development.

Source States parties that implement a policy of managed migration must ensure that it:

- Is transparent and fair;
- Is non-coercive and respects the dignity and human rights of the health worker;
- Is developed, implemented and monitored using a participatory approach, engaging health workers and communities in countries of origin and destination;
- Is supported by accountability mechanisms and closely monitored over time;
- Is based on evidence that it improves the overall stock and/or quality of health workers in the source country who are able to contribute to improving the right to health;
- Considers the rights of all stakeholders including health system users in the country of origin;
- Pays close attention to the rights of health workers when overseas; and
- Uses funds generated from a managed migration scheme in a transparent way to contribute to the alleviation of negative impacts within the health system created by the emigration of health workers.

International institutions such as the WHO may have a role to play in providing technical and administrative support to managed migration policies; by monitoring success and applying a rights-based approach to the analysis of managed migration schemes; and possibly by promoting multilateral managed migration policies.

Ethical recruitment by destination countries

Ethical codes of practice typically promote 'best practice' in the recruitment and treatment of international health workers as well as considerations by employers of the ethical implications of hiring from certain countries. So far as the authors are aware, despite promotion of ethical codes of practice by several international organisations,[134] only the UK National Health Service (NHS) has tried to implement such a code. This chapter uses the NHS Code as a case study.

[134] WONCA (2002); Commonwealth Secretariat (2003); Commonwealth Secretariat (2003)

The NHS Code has the following features.[135] First, NHS employers may not target low-income countries for health staff, nor utilise agencies that do, unless there is a direct government-to-government agreement that allows targeted recruitment in that country to take place. Second, principles of non-discrimination apply to the employment of health workers from abroad: migrant workers with sufficient training and proficiency in English may be considered for posts if they have applied proactively and must be treated fairly whilst in employment. Third, the Code relates to both permanent and temporary staff. Fourth, it does not bind private sector employers.

A human rights analysis of the NHS Code

The NHS Code generally seeks two main human rights objectives:

- The enjoyment of the right to health in countries of origin;[136] and
- Protection of the rights of migrant health workers, ensuring non-discrimination and equality in rights at work.[137]

A fundamental problem with the NHS Code is that it mis-specifies the problem as being international health worker migration, rather than the real problem of inequality between source and destination countries (of which international health worker migration is often merely a symptom).

There is little evidence of any sustained impact of this Code on the rate of recruitment of health workers from countries suffering shortages – in fact, the registration rates in the UK of health workers from proscribed countries have risen, year on year, since the Code was introduced.[138] In other words, it fails to protect the right to health in source countries. In part, this is because it does not bind the private sector: private agencies have continued to actively recruit in developing countries. Under international human rights law, States have an obligation to protect against harm by third party actors, including their actions in other countries.[139] The Code seemingly fails in this respect. This is also a particular concern for another reason - since the Code may divert migrating workers into employment by less reputable institutions that fail to respect their human rights in the process of migration or in employment in destination countries.[140] In other words, while seeking to protect the rights of migrant health

[135] DoH (2001); DoH (2004)

[136] eg ICESCR articles 2.1 and 12

[137] eg ICESCR articles 2.2 and 7

[138] NMC (2002); NMC (2003); Mensah et al (2005).

[139] See page 18.

[140] Browne (2001); Allan and Aggergaard Larsen (2003)

workers, the Code may sometimes inadvertently have precisely the reverse effect.

The UK Code prohibits active recruitment by the NHS in a list of developing countries which are assessed to have shortages of health workers. Health workers have raised concerns that this amounts to discrimination on grounds of nationality, or race.[141] Whilst non-discrimination and equality are central concerns of human rights, it is not clear that human rights law provides a conclusive answer on this question. On the one hand, discrimination on these grounds is prohibited under international human rights law.[142] On the other hand, if criteria for differentiation are reasonable and objective and if the aim is to achieve a purpose which is legitimate under human rights treaties,[143] including for example, the reduction of inequalities in access to health workers between nations which may arise as a result of indiscriminate recruitment, then the policy may be legitimate. It should also be pointed out that while the Code prohibits active recruitment, it does permit health workers of any national origin to seek recruitment in the UK. Finally, it is questionable whether the governments of poor countries[144] that enter into agreements with the UK to allow active recruitment are really promoting the right to health in their countries.

Recommendations for duty-bearers

The Code of Conduct is welcome from the point of view that it is an active acknowledgement by the Department of Health and the NHS of the problems arising from indiscriminate recruitment of workers in some developing countries. While we believe the Code has significant shortcomings and should not be strengthened to become an outright ban on the right to work in the UK for health workers from proscribed countries, which would be a breach of human rights, we also do not advocate that the Code is abandoned. However, it should not be used as a fig leaf to mask the significant and wider rôle played by the UK health sector in attracting health workers away from places where they may otherwise help safeguard the right to health of the poor. States of destination should therefore build more effective and appropriate responses:

- In line with their obligations of international assistance and cooperation towards the right to health in other countries, and MDG 8, develop other solutions, such as restitution or partnerships, that are more likely to redress inequalities in terms

[141] Mensah et al (2005).

[142] See Human Rights Committee, General Comment 18 on non-discrimination (1999).

[143] UN Human Rights Committee (1989)

[144] For instance, India, where according to the WHO the ratio of nurses and midwives to every member of the population is only one ninth of that in the UK (www.who.int/globalatlas).

and conditions of health workers, and the enjoyment of the right to health, between source and destination - at the same time as promoting opportunities for health workers from developing countries;

- Ensure regulation of private sector international recruitment, and the protection of human rights of migrant health workers in the private sector.

The private health sector, including umbrella organisations and associations, and organisations that do not directly deliver health services (such as personnel agencies and laboratories), should voluntarily adopt the measures set out in the State party's Code of practice on international recruitment, and participate openly with efforts by the State party to monitor the success of the Code.

Bonding

Bonding can take two forms: monetary and in-kind. Monetary bonding is a contractual obligation by the recipient of training towards the country or institution where their training is provided; if the recipient wishes to leave the service of the State/institution within a specified period of time then they must pay a fee in order to do so. In Ghana, for instance, health workers trained at government expense are expected to commit to a minimum period of service, or pay a fee to compensate for the costs of their training.[145] In-kind obligation means that the recipient of training must serve a minimum period of time working in the public health system before they may seek other opportunities. In Ghana, nurses must serve for a minimum period of time before obtaining proof of their qualification.[146] Both types of scheme are relatively common in middle-income or high-income countries; South African doctors are obliged to serve for at least one year in a rural community[147]; university undergraduates in the UK who have their living costs financed by the military must serve a minimum term, or buy themselves out of the obligation.

There is no consistent evidence that bonding schemes that have been applied in health systems in low-income countries have been successful. Contracts often need strong institutions if they are to be successfully enforced, but these do not exist in many low-income countries. This increases the chance that a bonded individual may be able to break the contract and a policy of bonding will fail to promote the right to health. Bonding schemes in Ghana are poorly enforced.[148] Bonding by a State cannot be justified for staff who fund themselves through training in the private sector, as

[145] Buchan and Dovlo (2004)

[146] ibid

[147] Reid (2002)

[148] Buchan and Dovlo (2004)

happens for instance in Colombia, as the State does not make the investment in their training and cannot argue the case for a return on an investment.

Inflation has been very high in many low-income countries since the 1970s, thereby quickly reducing the deterrent of the bond; and for many of the countries suffering the most serious shortages of health workers, the difference between pay rates in the country and those available overseas are so substantial that the effects of bonding may be negligible. Having debt to repay as a consequence of buying themselves out of a bond may delay a health worker from returning to their country; a worker who has broken their bond may be discouraged from returning; these effects may exacerbate the negative effects of migration.

A human rights analysis of bonding

Bonding seeks to make explicit recognition of the investment made by a State in the individual in question, and to seek to guarantee a return on that investment. By achieving a 'return on investment' – namely ensuring service within the public health system as a return on investment for supporting training – a policy of bonding seeks to improve the supply of health workers able to meet human resource staffing needs within the public health service and in underserved areas, and, by doing so, assist States in their obligations towards the right to health in source countries.[149]

The human rights implications of the bonding contract will depend on the terms of that contract. However, the application of a policy of bonding can have negative human rights implications: it can render the health worker more vulnerable to human rights violations, not least through limiting, in practice, their freedom of movement (since bonding may significantly disincentivise health workers to migrate because of the price of breaking a contractual obligation)[150] which can serve as an important means to escape other abuses if redress is not forthcoming. Any bonding provision would need to be purely contractual and mutually acceptable to the employee and employer, the terms and conditions and agreement made explicitly at the beginning of a process of training for a health worker, and involve the opportunity for frequent review and redress in the event of human rights violations. Methods of limiting mobility that are non-voluntary and non-contractual, ie coercive, are very unlikely to be acceptable under human rights law (see page 15 - Freedom of movement).

Recommendations for duty-bearers

Source States should consider carefully whether the policy of bonding is likely to work (can it be enforced, could there be negative human rights effects?), and consider

[149] eg under ICESCR, article 12

[150] eg ICCPR, article 12

applying more positive policies to the problem of emigration of health staff, such as improving pay and working conditions to reduce workers' desire to leave.

If the decision to use bonding is made, it should be accompanied by full participation of health workers in the design of the scheme, and its implementation and monitoring; it should be framed in terms of international human rights, eg explicitly recognise the rights of health workers; be applied in a non-discriminatory manner, for example, not bonding only particular groups, and be accompanied by accessible and effective redress mechanisms.

Auxiliary worker training

Auxiliary worker training refers to a policy of increasing the stock of 'auxiliary workers' in the health system. Auxiliary workers, or 'mid-level cadres' are typically health workers trained in a range of clinical skills appropriate to the setting, but not for as long as doctors or nurses nor, typically, with such stringent entrance requirements. The policy might be characterised as a context-sensitive approach to human resources in health for low-income states, and is a proposal that recognises that realistically, given the vast differences in GDP that exist between low-income countries and OECD countries, there will always be demand for qualified doctors and nurses from low-income countries able to successfully operate in OECD health systems. There is evidence of success with the use of auxiliary health worker grades in low-income country health systems, for instance, clinical officers in southern Africa.[151] Recognition that their qualifications may not be recognised in Northern health systems means that auxiliary staff are incentivised to remain practising in their home country. Auxiliary workers are cheaper and quicker to train than professionals with a wider range of skills. The increase of auxiliary worker use is complicated by resistance from professional organisations in source countries against the increase in use of auxiliaries, and by the accusation that it represents a neo-colonial 'dumbing-down' of Southern qualifications.[152]

A human rights analysis of auxiliary worker training

Auxiliary worker training seeks to increase the stock of health staff able to provide health services but who are less in demand in international health systems and therefore less likely to leave, thereby addressing one *consequence* of the migration of health workers and improving the conditions for the realisation of the right to health in countries of origin.[153]

[151] Dovlo (2004)

[152] Marchal and Kegels (2003)

[153] eg ICESCR, article 12

A policy that trained auxiliary workers and deployed them to areas of greatest health need would promote the right to health substantially and tackle inequality between different parts of the health system, addressing a consequence of health worker migration. However, the following considerations are necessary:

- Auxiliaries may not emigrate so easily, but in the absence of sufficiently attractive working conditions in the public sector or incentives to work in underserved rural araeas, they may still migrate within the country towards urban areas, private sector and internationally-funded health programmes outside the public health system. Although this is less negative than international migration in terms of its impact on health for the country, it still works against the organisation of an equitable and efficient health system that is able to meet need in underserved areas, thereby undermining the *right to health* and equality;
- Auxiliary workers are trained to a lower standard than doctors, nurses and pharmacists, whom they often replace. Although many of the interventions in which they engage are simple procedures, this may have implications for quality of care, a fundamental element of the right to health. One review of evidence suggests that no loss of quality is seen when auxiliary health workers substitute for doctors in health systems in low-income countries,[154] but there are concerns, such as the need for doctors to supervise and coach auxiliaries. Not addressing quality in the expansion of an auxiliary cadre will have negative implications for the *right to health*;
- Training a cadre of workers to fill the gaps left by differently-qualified health workers within a health system doesn't address the *causes* of migration: namely the abuse of workers' *rights in work* and *right to a decent standard of working conditions*. Increasing the training of auxiliary workers should be conducted in conjunction with a policy to positively address these causes; and
- In some countries, for example Ghana,[155] auxiliaries must first qualify as nurses. Their incentive to migrate is therefore just as great as for nurses.

Recommendations for duty-bearers

Recruiting States parties should finance and provide training resources in kind for the training of auxiliary workers in health systems in source countries, but not in the absence of support for policies that limit the causes of medical migration, namely those that address the negative motivations for migrating and alleviate excess demand in destination countries.

[154] Dovlo (2004)

[155] ibid

Source States parties that propose a policy of increasing the number of auxiliary workers in their health system must ensure that the employment of these staff is in conjunction with evidence on the location of health need, and equitable. A policy of auxiliary training must be applied alongside policies that address the rights-based *causes* of emigration, so would need to improve pay and conditions and continuing professional education for all workers, not just auxiliaries. They must ensure adequate participation of all stakeholders, in particular health system users from poor and marginalised communities, and in particular in monitoring the success (or otherwise) of this policy.

International institutions can support the training and continuing professional education of auxiliary health workers and disseminate information about auxiliary health workers between countries implementing such policies.

Professional associations of health workers in countries of origin have been known to argue against the formation of training programmes for auxiliary health workers, despite the profound constraints obvious in health systems there and the extremely constrained training capacity for doctors who may often be trained to high, internationally recognised, standards.[156] States that support such claims can be argued to be violating their obligations towards the (realistic) and progressive realisation of the *right to health*.

[156] Hongoro and McPake (2004)

Conclusions and recommendations

By ratifying international human rights treaties, States voluntarily assume legally binding obligations to give effect to human rights. Where the migration of health workers is a result of, or causes, inequality or other human rights problems, States parties to international human rights treaties have legally binding obligations to redress this situation. These obligations are reinforced by relevant political commitments made by States at the International Conference on Population and Development, World Conference Against Racism, and the Millennium Summit towards ensuring equitable and managed migration, combating racism faced by migrant workers, and tackling major health problems including HIV/AIDS, malaria, tuberculosis and child and maternal mortality.

High-income countries that hire health workers from low-income countries, or allow the independent sector to do so, are clearly contributing to a process in which certain rights of certain groups, rights which they hold under international law, are being denied. Most clear and obvious of these rights is the right to health of health system users in low-income countries, which is being sacrificed in order to protect and fulfil the rights of more powerful stakeholders in the process, namely health system users in high-income countries and, to a lesser extent, health workers themselves. No solution is easy: it must redress inequalities between health system users and health workers in the north and the south; safeguard the rights of migrants to freedom of movement, and not contribute further to the discrimination and stigmatisation of migrants. However, it is the legal obligation of countries of origin and countries of destination under human rights law to seek such solutions.

Recommendations

Responses to the negative causes and consequences of migration of health workers can be positively guided and informed by a human rights approach. Responses should be grounded in international human rights law. They should also involve the active consideration of the rights of all affected stakeholders at all stages of the development, implementation and monitoring of responses to migration, including the right of these stakeholders to participate at each of these stages. This includes the rights of groups in other States that may be affected by migration, especially health system users and their families as well as health workers left behind. A human rights approach also promotes non-discrimination and equality – ie does not consider it acceptable to pursue the rights of one group over another, for instance healthcare users in Europe over those in Africa. And it argues that all policies, including those that explicitly or implicitly address health worker migration, must be supported by accountability mechanisms.

The following recommendations are directed at different actors that play a role in health worker migration. However, finding solutions to this problem is likely to be most successful through active engagement of all stakeholders, and the most successful response is likely to be one that is international and multilateral.

World Health Organisation/World Health Assembly

The WHO/WHA should provide a forum to develop a multilateral, and multi-stakeholder, legal or policy response that sets out a framework for action for a range of actors. This legal or policy response should be explicitly grounded in international human rights law.

States

Countries of Origin should ensure they meet their obligations towards equality, the right to health, labour rights and the right of health workers to freedom of movement. They should:

- Increase investment in strengthening health systems;
- Train and recruit adequate numbers of health workers;
- Incentivise health workers to continue employment in underserved areas, especially through ensuring respect of their human rights rather than through applying coercive measures;
- Engage with countries of destination, and private sector recruiters, to develop coordinated policy responses that respect the human rights of all stakeholders; and
- Ensure good quality health care goods, facilities and services are accessible to individuals and groups.

Recruiting countries should ensure that they meet their international legal obligations towards the right to health in their jurisdiction, and countries of origin, and towards the human rights of migrants. They should:

- Refrain from proactively recruiting health workers, and protect against the active recruitment of private sector agencies, in countries, localities or professions where this is likely to post an obstacle to the realisation of the right to health, including its minimum essential levels; but not extend the ban on recruiting health workers to those who seek proactively to work within their jurisdictions;
- Engage more positively with private sector recruiters and employers to ensure consistent national responses, and with other countries of destination to ensure more coordinated international responses;

- Ensure adequate numbers of health workers with necessary and appropriate skills are being trained and recruited domestically;
- Take active measures to redress any harm caused by international health worker migration to the right to health in countries of origin, including through development assistance, restitution, and managed migration schemes;
- Adopt legislative and other measures to ensure that migrant health workers are not subject to abuses of their human rights by the independent sector, including withholding their work and identity documents; restrictions on freedom of association; and discrimination in the workplace; and
- Ensure that migrant health workers receive information about their human rights, and have access to redress.

Private sector recruitment agencies and employers should respect the right to health in countries of origin, and the human rights of migrant health workers. They should:

- Refrain from the proactive recruitment of health workers in countries or localities where to do so would seriously jeopardise the right to health and public health interests;
- Engage with the governments of countries of origin to ascertain when this might be the case;
- Ensure that migrant health workers in their employment receive information about their human rights; and
- Ensure that they respect the human rights of migrant health workers.

International financial institutions and donors should give greater attention to the role of human resources in strengthening health systems. They should:

- Ensure that their policies support improving terms and conditions of health workers, and recruiting more health workers where required; and
- Respect the human rights obligations of countries of origin towards the right to health, and not set ceilings on social sector expenditure which inhibit the ability of States to meet this obligation.

Human rights treaty bodies should give greater attention to the human rights dimension of health worker migration in their examination of the periodic reports of States parties of origin and destination, and should address concluding observations to States parties on these issues. They should also give attention to clarifying unclear norms and obligations recognised in the treaties they monitor and which are relevant in the

context of international health worker migration. In particular, the Committee on Economic, Social and Cultural Rights should clarify the meaning of the obligations of "international assistance and cooperation" and the obligation to devote "maximum available resources" towards the realisation of economic, social and cultural rights. In addition, the notion of "domestically competitive salaries" in General Comment 14 fails to recognise that in an increasingly integrated world, the salaries available to health workers abroad are a significant motivator of health worker migration.

The UN Special Rapporteur on the Right to Health should devote greater attention to the problems that health worker migration causes for the right to health in countries of origin and destination, both in his annual reports to the Commission on Human Rights, and in his country missions.

National human rights institutions and human rights non-government organisations should give greater attention to the human rights problems of health worker migration in-country, increase monitoring at the national level, and raise awareness about the human rights dimensions of the problem.

ANNEX 1: Key international and regional human rights references and other key documents

Treaties

International human rights treaties

- International Covenant on Civil and Political Rights (ICCPR: 1966; 152 States parties)
- International Covenant on Economic, Social and Cultural Rights (ICESCR: 1966; 149 States parties)
- International Convention on the Elimination of All Forms of Racial Discrimination (ICERD: 1965; 169 States parties)
- International Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW: 1979; 177 States parties)
- Convention on the Rights of the Child (CRC: 1989; 192 States parties)
- International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (MWC: 1990; 25 States parties)

ILO treaties

- ILO Convention No 97 – Migration for Employment Convention (1949; 42 States parties)
- ILO Convention No 142 – Human Resources Development Convention (1975; 62 States parties)
- ILO Convention No 143 – Migrant Workers (Supplementary Provisions) Convention (1975; 18 States parties)
- ILO Convention No 149 – Nursing Personnel Convention (1977; 37 States parties)
- ILO Convention No 155 – Occupational Safety and Health Convention (1983; 42 States parties)

African regional treaties

- African Charter on Human and Peoples' Rights (1981), and the Protocol to the African Charter on Human and Peoples' Rights on the Human Rights of Women in Africa (2003)

European regional treaties

- European Convention for Protection of Human Rights and Fundamental Freedoms (1950)
- European Social Charter (1961), and the revised European Social Charter (1995)

Americas regional treaties

- The American Convention on Human Rights (1969) and the Additional Protocol to the American Convention in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador") (1988)

General Comments adopted by UN Treaty Bodies

Committee on Economic, Social and Cultural Rights

- General Comment No. 3 on the Nature of States parties obligation (1990)
- General Comment No.14 on the Right to the Highest Attainable Standard of Health (2000)

Human Rights Committee

- General Comment No.15 on the Position of Aliens under the Covenant (1986)
- General Comment No. 18 on Non-Discrimination (1989)
- General Comment No.27 on Freedom of Movement (1999)
- General Comment No. 31 on the Nature of the General Legal Obligation Imposed on States Parties to the Covenant (2004)

Committee on the Elimination of Racial Discrimination

- General Recommendation No. 30 on Discrimination Against Non-Citizens (2004)

Committee on the Elimination of Discrimination Against Women

- General Recommendation No. 19 on Violence Against Women (1992)
- General Recommendation No. 24 on Women and Health (1999)

Committee on the Rights of the Child

- General Comment No. 3 on HIV/AIDS and the Rights of the Child (2003)
- General Comment No. 4 on Adolescent Health and Development in the Context of the Convention on the Rights of the Child (2004)

Declarations/Principles adopted by resolutions of the General Assembly

- Universal Declaration of Human Rights (1948)
- Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhumane and Degrading Treatment or Punishment (1982)
- Declaration on the Human Rights of Individuals Who are not Nationals of the Country in which They Live (1985)
- Declaration on the Right to Development (1986)
- Declaration on the Elimination of Violence Against Women (1993)
- Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms (1998)

Resolutions and documents adopted by the Commission on Human Rights

- The right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Resolutions 2004/27, 2003/28, 2002/31)
- Human rights of migrants (Resolutions 2004/53, 2003/46, 2002/62. 2001/52, 2000/48, 1999/44)
- Access to medications in the context of pandemics such as HIV/AIDS, tuberculosis and malaria (2004/26, 2003/29)
- The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) (2003/47. 2001/51)
- Siracusa Principles on the Limitation and Derogation Principles in the International Covenant on Civil and Political Rights, UN doc. E/CN.4/1985/4, Annex

Reports of the UN Special Rapporteur on the right to health submitted to the Commission on Human Rights and the General Assembly

- Hunt, P. (2003). Preliminary Report to the Commission on Human Rights of the UN Special Rapporteur on the right to health. UN doc. E/CN.4/2003/58
- Hunt, P. (2003.b). Report to the General Assembly of the UN Special Rapporteur on the right to health. UN doc. A/58/427.
- Hunt, P. (2004). Report of the Special Rapporteur on the Right to Health to the Commission on Human Rights: Addendum: Mission to the World Trade Organization UN doc. E/CN.4/2004/49/Add.1.
- Hunt, P. (2004.b), Report of the Special Rapporteur on the right t o health to the General Assembly. UN doc. A/59/422.
- Hunt, P. (2005). Report of the Special Rapporteur on the Right to Health to the Commission on Human Rights: Addendum: Mission to Mozambique. UN doc. E/CN.4/2005/51/Add.2

Principles adopted by the Sub-Commission on the Promotion and Protection of Human Rights

- The Norms on the Responsibilities of Transnational Corporations and Other Business Enterprises with Regard to Human Rights (2003)

International Conference Outcome Documents

- World Conference on Human Rights, Vienna (1993): Vienna Declaration and Programme of Action;
- International Conference on Population and Development, Cairo (1994): Cairo Declaration and Programme of Action;
- Fourth World Conference on Women (1995): Beijing Declaration and Platform for Action
- United Nations General Assembly Special Session (UNGASS) on AIDS (2001): Declaration of Commitment on HIV/AIDS "Global Crisis–Global Action";
- World Conference Against Racism, Racial Discrimination Xenophobia and Related Intolerance, Durban (2001): Durban Declaration and Programme of Action

Cases

- *Osman v UK*, European Court of Human Rights application 23452/94, judgement of 28 October 1998
- Center for Economic and Social Rights and Social and Economic Rights Action Committee v Nigeria, African Commission on Human and Peoples' Rights Communication No. 155/96, 27 May 2002
- Purohit and Moore v Gambia, African Commission on Human and Peoples' Rights, Communication 241/2001, judgement of October 2002.
- *Velasquez Rodriguez Case*, Inter-American Court of Human Rights, judgement of 29 July 1988.

ANNEX 2: Documentation matrix relating selected international and regional (African and European) instruments to rights and stakeholders in the context of international health worker migration from Africa to Europe

Rights holders	Selected human rights under international and regional law (listed according to main stakeholder relevance)						
	Health	**Work**		**Standard of Living**	**Education**	**Non-discrimination**	**Freedom of movement**
	The right to health	The right to work	The right to just and favourable conditions of work	The right to an adequate standard of living including housing and food	The right to education	The right to non-discrimination and equality	The right to freedom of movement and leave any country including one's own
Health system users in African Countries of Origin	ICESCR article 12 CEDAW articles 12, 14 CRC article 24 UDHR article 25 ACHPR article 16, PRW article 14 ACRWC article 14	An underlying determinant of health: see below	An underlying determinant of health: see below	An underlying determinant of health: see below	ICESCR article 13 CRC article 28 CEDAW article 10 UDHR article 26 ACHPR articles 9, 17 PRW article 12 ACRWC article 11	ICESCR article 2(2) CERD CEDAW CRC article 2 UDHR article 2 ACHPR article 2 PRW article 2 ACRWC, article 3	
Health Workers/ their families in Africa or Europe	As above	ICESCR, article 6 CEDAW article 11 UDHR article 23 ACHPR article 15, PRW article 13 ESC part II, article 1	ICESCR, article 7 CEDAW article 11 ICRMW, articles 25, 37, 40 UDHR article 23 ILO No. 97 article 6 ILO No. 143 article 10 ILO No 149 ILO No. 155 ACHPR article 15 ESC part II, articles 2, 3, 4, 8, etc	ICESCR article 11 CRC article 27 CEDAW articles 13, 14 UDHR article 25 ACHPR article 24, PRW articles 15, 16	As above, and additionally ICRMW article 30	As above, and additionally ICPPR article 2 ICRMW articles 7, 43 ILO No. 97 article 6 ILO No. 111 ILO No. 143 article 10 ECHR article 14 ESC article 19	ICCPR article 12 UDHR article 13 ACHPR article 12
Health system users in European Destination Countries	As above (international instruments), and additionally ESC, article 11	As above (international instruments)	As above (international instruments)	As above (international instruments)	As above, and additionally ECHR, protocol 1, article 2	As above (international instruments)	As above (international instruments)

ANNEX 2: continued

Duty bearers	Further selected human rights standards specifying obligations where not mentioned above						
	Health	**Work**		**Standard of Living**	**Education**	**Non-discrimination**	**Freedom of movement**
	The right to health	The right to work	The right to just and favourable conditions of work	The right to an adequate standard of living including housing and food	The right to education	The right to non-discrimination and equality	The right to freedom of movement and leave any country including one's own
State of Origin (towards persons in their jurisdiction)	ICESCR article 2(1) CEDAW articles 2, 3, 4 CRC article 4 ACHPR article 1 PRW article 25 ACRWC article 1	ICESCR article 2(1) CEDAW articles 2, 3, 4 CRC article 4 ACHPR article 1	ICESCR article 2(1) CEDAW articles 2, 3, 4 CRC 4 ACHPR article 1	ICESCR article 2(1) CEDAW articles 2, 3, 4 CRC article 4 ACHPR article 1, PRW article 25	ICESCR article 2(1) CEDAW articles 2, 3 4 CRC article 4 ACHPR article 1 ACRWC article 1	ICCPR article 2 ACHPR article 1	
Main responsible ministry	Health	Labour	Labour	Ministries responsible for food and housing	Education	Cross-cutting (all ministries)	
State of Destination (towards persons in their jurisdiction)	ICESCR article 2(1) CEDAW articles 2, 3, 4 CRC article 4	ICESCR article 2(1) CEDAW articles 2, 3, 4 CRC article 4	ICESCR article 2(1) CEDAW articles 2, 3, 4 CRC 4	ICESCR article 2(1) CEDAW articles 2, 3, 4 CRC article 4	ICESCR article 2(1) CEDAW articles 2, 3, 4 CRC article 4 ECHR article 1	ICESCR article 2(1) ECHR article 1	(towards migrants) ICESCR article 2(1) ICCPR article 2
States of Destination (and other donor States) torwards persons in source countries	ICESCR articles 2(1), 15(4), 22, 23 CRC article 4	ICESCR articles 2(1), 22, 23 CRC, article 4	ICESCR articles 2(1), 22, 23 CRC article 4	ICESCR articles 2(1), 11(1) 15(4), 22, 23 CRC article 4	ICESCR articles 2(1), 22, 23 CRC article 4	ICESCR articles 2(1), 22, 23	CRC article 4

ANNEX 2: continued

Duty bearers	Further selected human rights standards specifying responsibilities where not mentioned above						
	Health	**Work**		**Standard of Living**	**Education**	**Non-discrimination**	**Freedom of movement**
	The right to health	The right to work	The right to just and favourable conditions of work and freedom from exploitation through work	The right to an adequate standard of living including housing and food	The right to education	The right to non-discrimination and equality	The right to freedom of movement and leave any country including one's own
Other actors							
The Private Sector (not country-specific)	TNC Norms, para 12 (also note legal obligation on States to protect against harm by the private sector)		TNC Norms, paras and 8 (also note legal obligation on States to protect against harm by the private sector)	TNC Norms, para 12 (also note legal obligation on States to protect against harm by the private sector)	TNC Norms, para 12 (also note legal obligation on States to protect against harm by the private sector)	TNC Norms, para 2 (also note legal obligation on States to protect against harm by the private sector)	
International Financial Institutions	Respect human rights obligations of States						
Health Workers	UDHR article 29 ACHPR article 27						

Key: International Covenant on Economic, Social and Cultural Rights (ICESCR); Convention on the Elimination of All Forms of Racial Discrimination (ICERD); International Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); Convention on the Rights of the Child (CRC); International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (ICRMW); Universal Declaration on Human Rights (UDHR); Norms on the Responsibilities of Transnational Corporations and Other Business Enterprises with Regard to Human Rights (TNC Norms); ILO Migration for Employment Convention (ILO 97); ILO Discrimination (Employment and Occupation) Convention (ILO 111); ILO Human Resources Development Convention (ILO 142); ILO Migrant Workers (Supplementary Provisions) Convention (ILO 143); ILO Nursing Personnel Convention (ILO 149); Occupational Safety and Health Convention (ILO 155); African Charter on Human and Peoples' Rights (ACHRP); Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (PRW); African Charter on the Rights and Welfare of the Child (ACRWC); European Social Charter (ESC); European Convention on Human Rights (ECHR).

ANNEX 3: Other references

Adams, O. and B. Stilwell (2004). "Health professionals and migration." *Bull World Health Organ* **82(**8): 560.

Allan, H. and J. Aggergaard Larsen (2003). "We need respect": experiences of internationally recruited nurses in the UK. London, European Institute of Health and Medical Sciences, University of Surrey, for Royal College of Nursing, UK.

Alston, P. (1992) "The Committee on Economic, Social and Cultural Rights" in Alston, P. (ed) *The United Nations and Human Rights: A Critical Appraisal*. Oxford, Clarendon.

Alston, P. (2004) A Human Rights Perspective on the Millennium Development Goals: Paper Prepared as a Contribution to the Work of the Millennium Project Task Force on Poverty and Economic Development. New York, Millennium Project.

Amnesty International (2000). Harming the Healers: Violations of the Human Rights of Health Professionals. London, Amnesty International.

Anand, S. and T. Baernighausen (2003). Human Resources and Health Outcomes. Cambridge, MA, Global Equity Initiative.

Bach, S. (2003). International Migration of Health Workers: Labour and Social Issues. Geneva, International Labour Office.

Browne, A. (2001). Abused, threatened and trapped - Britain's foreign 'slave nurses'. *The Guardian*. London.

Bundred, P. E. and C. Levitt (2000). "Medical migration: who are the real losers?" *The Lancet* **356(**9225): 245-246.

Commission on Macroeconomics and Health (2001). Macroeconomics and Health: Investing in Health for Economic Development. Geneva, World Health Organization.

Committee on the Rights of the Child (2002). Report on the 31st Session of the Committee on the Rights of the Child. Geneva, UN Office of the High Commissioner for Human Rights.

Commonwealth Secretariat (2003). Code of Practice for the International Recruitment of Health Workers.

Commonwealth Secretariat (2003). *Companion Document to the Code of Practice for the International Recruitment of Health Workers.*

Craven, M. (1995). The International Covenant on Economic, Social and Cultural Rights: A Perspective on Its Development. London, Clarendon.

Darrow, M. (2003). Between Light and Shadow: The World Bank, the International Monetary Fund and International Human Rights Law. Portland, Oregon, Hart.

Decker, K. (2001). Overseas doctors: Past and present. *Racism in medicine: An agenda for change.* N. Coker. London, Kings Fund.

DFID (2004). Statistics on International Development 99/00 - 03/04.

DoH (2000). The NHS Plan. London, Department of Health.

DoH (2001). Code of Practice for NHS employers involved in the international recruitment of healthcare professionals. London, Department of Health.

DoH (2004). Draft Code of Practice for the international recruitment of healthcare professionals. London, Department of Health.

Dovlo, D. (2004). "Using mid-level cadres as substitutes for internationally mobile health professionals in Africa. A desk review." *Hum Resour Health* **2**(1): 7.

Duckworth, L. (2001). Nurses expect NHS to charge within a decade. *The Independent*. London.

Findlay, A. (2002). From Brain Exchange To Brain Gain: Policy Implications For The Uk Of Recent Trends In Skilled Migration From Developing Countries. Geneva, International Labour Office.

Freedman, L., M. Wirth, et al. (2004). "Millennium Taskforce 4 Child and Maternal Health: Interim Report."

Friedman, E. A. (2004). An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa. Boston, Physicians for Human Rights.

Hilary, J. (2001). The Wrong Model: GATS, trade liberalisation and childrens' right to health. London, Save the Children.

HM Treasury (2004). Spending Review 2004 Press Release: Further boost to UK aid budget. http://www.hm-treasury.gov.uk/spending_review/spend_sr04/press/spend_sr04_press09.cfm accessed 25 October 2004.

HM Treasury (2004). Spending Review 2004 Press Release: Record health funding means shorter waits, more choice and better care and advice. http://www.hm-treasury.gov.uk/spending_review/spend_sr04/press/spend_sr04_press13.cfm accessed 25 October 2004.

Hongoro, C. and B. McPake (2004). "How to bridge the gap in human resources for health." *Lancet* **364**(9443): 1451-56.

Huddart, J. and O. Picazo (2003). The Health Sector Human Resource Crisis in Africa: An Issues Paper. Washington, USAID.

Hunt, P., M. Nowak, et al. (2002). Human Rights and Poverty Reduction: A Conceptual Framework. Geneva, Office of the United Nations High Commissioner for Human Rights.

International Council on Human Rights Policy (2002). Beyond Voluntarism: Human Rights and the Developing Legal Obligations of Companies. Geneva, International Council on Human Rights Policy.

IoM (2002). Gender and Migration. Geneva, Institute of Migration.

Jonsson, U. (2003). Human Rights Approach to Development Programming. New York, United Nations Childrens' Fund.

Kurowski, C., K. Wyss, et al. (2004). Human resources for health: requirements and availability in the context of scaling up priority interventions in low-income countries. Case studies from Tanzania and Chad, HEFP working paper 01/04. London, London School of Hygiene and Tropical Medicine.

Loefler, I. J. (2001). "Medical migration." *Croat Med J* **42**(5): 504-5.

Lowell, B. and A. Findlay (2001). Migration Of Highly Skilled Persons From Developing Countries: Impact And Policy Responses. Geneva, International Labour Organisation.

Lowell, B. and A. Findlay (2002). Migration Of Highly Skilled Persons From Developing Countries: Impact And Policy Responses. Geneva, International Labour Organisation.

Maastricht Conference (1997). *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights*, Maastricht, International Commission of Jurists

Marchal, B. and G. Kegels (2003). "Health workforce imbalances in times of globalization: brain drain or professional mobility?" *Int J Health Plann Manage* **18 Suppl 1**: S89-101.

Martin, L. (2004). Fears for health service as nurses flock to America. *The Observer.* London.

Martineau, T., K. Decker, et al. (2004). ""Brain drain" of health professionals: from rhetoric to responsible action." *Health Policy* **70**(1): 1-10.

Medact and Wemos (2004). Pushing the Boundaries: Health and the Next Round of PRSPs. Medact and Wemos. June 2004.

Meldrum, A. (2003). 'Mugabe says we are being stolen. All we want is better pay'. *The Observer.* London.

Mensah, K. Mackintosh, M. and Henry, L. (2005). The Skills Drain of Health Professionals from the Developing World: a Framework for Policy Formulation. London, Medact.

Mercer, H. and M. Dal Poz (2003). Human Resources for Health: Developing Policy Options for Change. *Towards a Global Health Workforce Strategy*. P. Ferrinho and M. Dal Poz. Antwerp, ITGPress. **21**.

NMC (2002). Statistical analysis of the register. London, Nursing and Midwifery Council.

Norton, A,, D. Elson (2001). What's Behind the Budget? London, Overseas Development Institute.

Nursing and Midwifery Council (2003). Record number of nurses from India coming to work in the UK. London, Nursing and Midwifery Council.

Nyberg-Sorensen, N. (2004). The Development Dimension of Migrant Remittances. Geneva, Institute of Migration.

Nyberg-Sorensen, N., N. Van Hear, et al. (2004). The Migration-Development Nexus: Evidence and Policy Options. Geneva, Institute of Migration.

Padarath, A., C. Chamberlain, et al. (2003). Health Personnel in Southern Africa: Confronting maldistribution and brain drain. Rondebosch, Health Systems Trust.

Pang, T., M. A. Lansang, et al. (2002). "Brain drain and health professionals." *BMJ* **324**(7336): 499-500.

Pecoud, A. and P. de Guchteneire (2004). Migration, Human Rights and the United Nations: An Investigation into the Low Ratification Record of the UN Migrant Workers Convention. Global Migration Perspectives No 3. Geneva, Global Commission on International Migration.

Rowden, R. (2004). Blocking Progress: How the fight against HIV/AIDS is being undermined by the World Bank and International Monetary Fund, Washington, Action Aid USA

Singh, D. (2003). "Racism rife in the medical profession, BMA report says." *BMJ* **326**(7404): 1418-.

UN Economic and Social Council, Conference on Brain Drain and Capacity Building in Africa (2000)

WHO (2000), World Health Report 2000, Health Systems: Improving Performance. Geneva, World Health Organization.

WHO (2001). Advancing Safe Motherhood through Human Rights (WHO/RHR/01.5). Geneva, World Health Organization.

WHO (2002). 25 Questions and Answers on Health and Human Rights. Geneva, World Health Organization.

WHO and World Bank (2002). Building Strategic Partnerships In Education And Health In Africa: Consultative Meeting On Improving Collaboration Between Health Professionals, Governments And Other Stakeholders In Human Resources For Health Development.

WHO (2003) International Migration, Health and Human Rights. Geneva, World Health Organization.

WHO (2004). WHO Global Atlas of Infectious Diseases: Human Resources for Health, World Health Organization at http://www.who.int/GlobalAtlas/DataQuery/browse.asp?catID=180000000000&lev=2

Wibulpolprasert, S. and P. Pengpaibon (2003). "Integrated strategies to tackle the inequitable distribution of doctors in Thailand: four decades of experience." *Hum Resour Health* **1(**1): 12.

Wickramasekara, P. (2002). *Policy responses to skilled migration : Retention, return and circulation*. Meeting on skilled migrations, Neuchatel, International Labour Office.

Willets, A. and T. Martineau (2004). *Ethical international recruitment of health professionals: Will codes of practice protect developing country health systems?*, Liverpool School of Hygiene and Tropical Medicine.

WONCA (2002). *The Melbourne Manifesto: A Code of Practice for the International Recruitment of Health Care Professionals.* 5th Wonca World Rural Health Conference: Working Party on Rural Practice, Melbourne.

Zurn, P., M. R. Dal Poz, et al. (2004). "Imbalance in the health workforce." *Hum Resour Health* **2**(1): 13.

ANNEX 4: Glossary

AU	African Union
CEDAW	International Convention on the Elimination of All Forms of Discrimination Against Women
CERD	Committee on the Elimination of all forms of Racial Discrimination
CESCR	Committee on Economic Social and Cultural Rights
CRC	Convention on the Rights of the Child
DFID	Department for International Development
DoH	Department of Health
GATS	General Agreement on Trade in Services
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of all Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICN	International Council of Nurses
IFI	International Financial Institutions
IHA	International Healthcare Association
ILO	International Labour Organization
IoM	Institute of Migration
MDG	Millennium Development Goal
MWC	International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families
NGO	Non-Governmental Organisation
NHS	National Health Service
NMC	Nursing and Midwifery Council
OAS	Organisation of American States
OAU	Organisation of African Unity
OECD	Organisation of Economic Cooperation and Development
RCN	Royal College of Nursing
RQAN	Return of Qualified African Nationals: IoM programme
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting – now NMC
UN	United Nations
UNDAW	UN Division for the Advancement of Women
UNHCHR	UN: Office of the High Commissioner for Human Rights
UNCTAD	United Nations Conference on Trade and Development
WHA	World Health Assembly
WHO	World Health Organization
WONCA	World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians