Taking the WHO Global code of Practice on the International Recruitment of health Personnel from bottom drawer to negotiating table and action in Africa

ESA countries face many challenges in the absolute shortages, maldistribution, low production and poor utilisation of their health workforces. The World Health Organisation (WHO) Global Code of Practice on the International Recruitment of Health Personnel (the "Code") was unanimously adopted by the World Health Assembly in May 2010 to address recruitment and migration of health workers. However, its implementation has shown limited progress in east and southern Africa, according to a study in the EQUINET Research programme on global health diplomacy. Health worker migration is not seen to be the scale of problem it was a decade ago in the region. While concerns from the region were mostly included in the Code, the demand for "mutuality of benefit" and "compensation" were not. This was interpreted by some stakeholders to mean that the Code did not fully accommodate African interests. Implementation of the Code is reported to be impeded by lack of champions; of resources for implementation; by weak functional data (systems) on mobility of health personnel, and by limited domestication and dissemination of the Code in ESA countries. This brief presents opportunities to use the Code in negotiating bilateral agreements and suggests ways of strengthening its implementation.

What is in the WHO Global code of Practice on the International Recruitment of health Personnel?

The Code is a comprehensive but non-binding instrument that guides member states to address matters of the international recruitment of health workers in an ethical manner. It aims to

* establish and promote voluntary principles and practices for the ethical international recruitment of health personnel

* serve as a reference for member states in establishing or improving the legal and institutional framework required for the international recruitment of health personnel;

* provide guidance that may be used where appropriate in the formulation and implementation of bilateral agreements and other international legal instruments;

* facilitate and promote international discussion and advance co-operation on matters related to the ethical international recruitment of health personnel as part of strengthening health systems.

It suggests partnerships between source and destination countries for the benefit of both. The focus on health worker migration and ethical international recruitment in the discourse on the Code has tended to obscure its other provisions on health workforce development, health systems sustainability, technical collaboration and financial support.

What role did African countries play in its negotiation?

Countries in the ESA region motivated and contributed to the development of the Code. In the late 1990 and early 2000s most countries in the region wanted to arrest the health worker "brain drain" and obtain some form of compensation for

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the loss of skilled health professionals. There then ensued a long diplomatic process, across a range of regional and international institutions that included consultations by African Health Ministers with the WHO, World Bank and UNESCO in 2002 at which it was agreed to set up a task force on development of health workers in Africa. This was followed by the negotiation of the Commonwealth Code of Practice for the International Recruitment of Health Workers ("Commonwealth Code of Practice") in 2003, and by the World Health Assembly (WHA) 2004 Resolution 57.19 mandating the organisation to develop a non-binding code of practice on the international recruitment of health workers in consultation with Member States and relevant partners.

Notwithstanding the fact that many of the proposals made by African countries were included in the final wording of the Code, as the negotiations progressed, African countries yielded ground on some issues. One of these was the issue of "compensation" and "mutuality of benefits", that is on getting a return on the investments they had made on training and developing health workers that had migrated, often seen to be due from higher income countries. The fact that those two concepts were not explicitly included seems to have been interpreted as a watering down of the Code. Another concern often expressed by African stakeholders is the "voluntary nature" of the Code, although this was the mandate in the 2004 WHA Resolution.

African countries were among the strongest advocates for the Code at all stages. As the negotiations progressed over many years, however, the processes were not always well communicated to stakeholders within African countries, weakening their awareness and support for positions and their later implementation of the Code. The study on the Code found that the weakness in subseqent implementation related in part to lack of dissemination and awareness of code amongst national stakeholders.

The process was also long, and some of the key champions in the early stages were no longer at the table in later stages.

What learning can we draw from the negotiation?

One lesson learned from the processes of developing and negotiating the Code is that these negotiations take time and need to be widely communicated at all stages *within* ESA countries and not left to the negotiators alone. Another lesson learned was the importance of a collective voice from African countries, and thus communication *across* countries. Through WHO-AFRO, through the African group of countries in the Commonwealth, and through the Africa Group at the WHA, African countries were able to develop combined negotiating positions that helped to strengthen their voice and influence in the process. The downside to this may be that country-specific interests yielded to broader regional interests, in a spirit of compromise. Any gains at global level must thus be supported by more specific bilateral, within region and country engagement to ensure that national interests are also protected.

These actions at country or regional level can inform or support the global negotiations, including by demonstrating the possible. For example a national coalition in Malawi was able to lever bilateral funding for health workers under an Emergency HR Plan, breaking the idea that international resources cannot be used to support recurrent expenditures on health workers. The regional initiatives of health ministers at the East, Central and Southern Africa Health Community (ECSA HC), Southern African Development Cooperation (SADC) and WHO AFRO, and global initiatives through the Commonwealth and WHO also opened health worker training and retention issues for global negotiation. They did so by incorporating them in treaties at regional or international level, as in the Commonwealth Code of Practice, the UK undertaking to not recruit health workers from countries facing massive HR shortfalls and the signing of a SADC protocol that barred recruitment of health professionals from within the region, unless supported by a government to government agreement. Indeed even while the Code was being negotiated, these other arrangements progressed to deal with the challenges being faced.

Providing for implementation in the treaties

During the negotiation of the Code, there was little discussion on the inclusion of implementation capacities and processes. This was perhaps a missed opportunity. As a result after the Code was adopted many countries found themselves poorly prepared to implement the instrument. Those who framed and negotiated the Code failed perhaps to anticipate the complexity of the processes, resources and capacities required to implement it. So too did civil society. There is a lesson that future international negotiations of this nature should factor in the mechanisms, capacities and where relevant the resources for its implementation. Where the instrument is global its implementation should also be seen to be a shared responsibility in this respect.

Where was civil society?

The negotiation of the Code was supported by many civil society actors, such as the Health Worker Migration Council, Health Workforce Advocacy Initiative (HWAI), EQUINET, Wemos and professional organisations such as World Medical Association, International Council of Nurses and International Council of Midwives. Since its adoption, there has been little heard on it from civil society, except for the civil society in the European region of WHO that has taken an active role in tracking its implementation and bringing matters before the EU parliament. Coincidentally, in the 2013 report by the WHO Secretariat on the implementation of the Code, it was European countries that had made significant steps in implementation of the Code.

It does appear that civil society is a critical force in negotiations and in implementation. Civil society plays a key role in raising awareness and explaining its contents in simpler terms and in holding governments domestically and internationally to account on implementing the commitments in the Code. It is thus important that civil society invite the other role players to tackle the Code in the spirit of "eating an elephant piece by piece" – to make clear its contents and support its implementation, in each and all its clauses. However civil society and states also need resources for this. Since 2010 there have been limited resources assigned either nationally or internationally for tracking, monitoring of or disseminating information on the Code, with the exception of multi-country initiatives in the European region. It would seem timely for African actors and partners to step up support for these civil society activities to galvanising action on the Code.

Where to now?

As the major international instrument in global health diplomacy for addressing health workforce issues, the Code provides for international, regional and bilateral cooperation on many aspects of health workforce development. Its potential impact is huge, but as yet unrealised.

The code in Article 6 calls for 'comparable and reliable' data collection for ongoing monitoring of health worker recruitment and migration and reporting to the WHO secretariat as a means to promote implementation and accountability, Member states are due to report to the WHO Secretariat on the code every three years and its contents are considered as dynamic, subject to review. The wider implementation of the Code depends on how it is perceived and acted on by member states. Nevertheless in many areas the Code does not demand policy or action beyond what is already within the measures and processes set out in strategic plans and policies in member states. The task is thus to domesticate the Code, and to ensure that countries then apply the contents in ways that are relevant and applicable to their contexts, and to the human resource challenges they face.

Some of the key areas for tracking implementation include
i.   Are there national HRH coordination mechanisms for all relevant stakeholders and partners to facilitate policy dialogue for the HRH agenda and oversight of implementation (such as the Country Coordination Forum - CCF)?

ii. Are there national health workforce sustainability plans in place?

iii. Is there policy and practice encouraging migration within countries in east and southern Africa and return migration from destination countries?

iv. Is there data collected on health worker migration to destination countries?

v. Is there policy or law requiring recruiters to follow ethical recruitment practices that covers state and private and non state actors?

vi. Is there collaboration of source countries and destination agencies or countries to sustain and resource development and training of health workers?

vii. Are there any bilateral, regional, multilateral arrangements on health workers between source and destination countries?

viii. Are there any new development assistance efforts to support coordination and collaboration on health worker migration between destination and source countries?

To move the Code from its current position of weak implementation to more active use, and review we propose that:

1. Countries in the region appoint designated national authorities to drive the implementation and reporting processes on the Code, as for their HR strategies generally. This should be accompanied by efforts to strengthen the HR Departments within ministries of health, and their HR information systems.

2. Regional organisations such as ECSA HC, SADC, Economic Community of West African States (ECOWAS), West African Health Organization (WAHO) and the African Union (AU) play a more active role in bringing countries together to plan implementation of the Code and negotiate and provide technical support for this, in collaboration with WHO, to ensure a regional voice and momentum in implementing and monitoring the Code.

3. WHO take leadership and support member states in implementing and monitoring the Code, through activities such as Code-specific dissemination meetings and technical support to countries.

4. Civil society in Africa play a greater role in advocacy for implementation and accountability on the commitments made in the Code, supported by evidence and in collaboration with other national stakeholders.

5. Academic and research institutions generate evidence and data on the extent and impact of HRH migration to inform decision making in the region. For example the perception that external migration is no longer an issue needs to be tested.

6. A commitment be made by member states, supported by WHO and regional organisations, that all report on their implementation of and issues faced with the Code in the next cycle (2014-2015).

Further information and resources

i. WHO (2010) The WHO Global CODE of Practice on the International Recruitment of Health Personnel: Implementation by the Secretariat, available at: http://www.who.int/hrh/resources/Code_implementation_strategy.pdf

ii. Dambisya YM, N Malema, C Dulo, S Matinhure, P Kadama (2014) 'The engagement of east and southern African countries on the WHO Code of Practice on the International Recruitment of Health Personnel and its implementation', EQUINET Discussion paper 103, EQUINET, Harare.

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