Literature review on codes of practice on international recruitment of health professionals in global health diplomacy

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Executive summary

The World Health Organisation (WHO) Global Code of Practice on the International Recruitment of Health Personnel (hereinafter called the "Code") adopted by the World Health Assembly (WHA) in May 2010 was the culmination of efforts by many different actors to address the maldistribution and shortages of health workers globally. African stakeholders influenced the development of the Code, but two years after its adoption only four African countries had designated national authorities, and only one had submitted a report to the WHO Secretariat.

This review is part of the Regional Network for Equity in Health (EQUINET) programme of work on *Contributions of global health diplomacy to health systems in sub-Saharan Africa: Evidence and information to support capabilities for health diplomacy in east and southern Africa*. The programme aims to identify factors that support the effectiveness of global health diplomacy (GHD) in addressing selected key challenges to health strengthening systems in eastern and southern Africa (ESA). It seeks to disseminate and use the learning to strengthen the capacity of key African policy actors and stakeholders within processes of health diplomacy. This includes work on the Code that seeks to address:

- The extent to which the policy interests of African countries were carried (or not carried) into the Code in the negotiations around the code and the perceived factors affecting this;
- The extent to which countries in east and southern Africa view the Code and how they implement it as an instrument for negotiating foreign policy interests concerning health workers; and
- The motivations, capabilities and preparations for monitoring the code to engage in the diplomatic environment on African policy interests concerning health workers.

The authors conducted a review of published and grey literature on codes of practice, and on bilateral and multilateral agreements at the end of 2012, with a focus on implications for the health workforce. The search strategy for relevant documents applied specific terms in Internet search engines such as Google, Google Scholar, Pubmed/Medline, EQUINET database and websites for organisations such as WHO and International Organisation for Migration (IOM). The search was expanded through a snowballing technique, resulting in 137 documents to be analysed in depth. The information was analysed using the policy analysis triangle to capture the changing context, processes, content and major actors in the development of the Code, and documentation on its progress and implementation since its adoption.

The context of health worker migration has changed over the years, from original concerns of migration of skilled workers from the United Kingdom to North America, to a focus on loss of health professionals from developing countries. What seems to have remained constant is the reliance of some English-speaking countries – UK, USA, Canada, Australia and New Zealand – on foreign-trained health professionals whereas the outflows from the ESA region have been difficult to quantify. Several studies addressing the costs of such losses show that the source countries are net losers in the health worker migration equation. Mass emigration of health professionals from less-developed countries results in even greater pressure on those who remain in these countries, weakening health systems.

The focus on the losses from the developing world led to calls for ethical recruitment, recognising the rights of health workers to move, while also addressing the needs of the health systems of the source countries. Work through agencies such as the Joint Learning Initiative led to the conclusion that managing international health worker migration would require global political consensus. The development of the Code included ministries of

health from the developing countries who initiated calls for action on the human resources for health (HRH) crisis. African institutions, such as the African Union, Southern African Development Community (SADC) and East, Central and Southern African Health Community (ECSA HC), contributed to earlier initiatives such as the Commonwealth Code of Practice for international recruitment of health personnel, and the 2004 WHA Resolution that called for development of a code on ethical recruitment. The global community – including researchers and experts (e.g. through the Joint Learning Initiative (JLI) and the Health Workforce Advocacy Initiative [HWAI]), and professional organisations such as International Council of Nurses (ICN) and World Organisation of Family Doctors (WONCA) – contributed to the global momentum in addressing the issue of brain drain from developing countries. It was not possible to track whether there were changes in specific actors and roles.

The WHO Global Code of Practice on the International Recruitment of Health Personnel was negotiated at various levels. Common positions by African health ministers provided the momentum for the Commonwealth Code of Practice for International Recruitment of Health Personnel, a precursor to the 2004 WHA resolution. In the negotiations some of the wishes of the developing countries, such as compensation and mutuality of benefits, were dropped from the final wording of the Code to keep the support of powerful nations and the Code was made non-binding and voluntary. Earlier positions from African stakeholders (SADC and ECSA HC) explicitly called for compensation to source countries, which was unacceptable to countries in the North. This raises the question of whether the WHO Code as adopted represents the original wishes of African countries. We did not find any documents explicitly addressing this particular issue, but we explored the various iterations of the case to see what was kept and lost and will explore it further through fieldwork.

While soft law instruments (such as the Code) are not legally binding, they may have moral force in ensuring better global co-operation on health workforce issues. The literature indicates that bilateral agreements, especially between developing countries, tend to be more successful than codes of a more international nature. That may have influenced the inclusion in the WHO Code of bilateral agreements for its operationalisation.

The relative lull in efforts on the issue of health worker migration following adoption of the Code could in part be due to a perception that its contribution to the health worker crisis was less significant than originally aspired to. In addition, positive impacts from initiatives have helped alleviate the crisis in the most hard-hit countries, such as Malawi, in this case through the emergency HRH Plan. It is also possible that those seeking compensation were disillusioned by the final content of the Code and its voluntary and non-binding nature.

Codes have played some role in raising global awareness of the ethical considerations in the recruitment of health workers, raising the issue to a mainstream discussion. They have also been weak instruments, reliant more on moral than legal force. The WHO Global Code of Practice has been characterised by Taylor and Dhillon (2011) as including ethical norms and institutional and legal arrangements to guide international co-operation on the issue of health worker migration. It serves as a platform for continuing dialogue. Its non-binding nature may be a weakness, although many high-income countries showed no political will to support a legally binding instrument, given the complexity of the issue.

The main question is what impact the Code as an international instrument will have. The challenges associated with international mobility of health workers are too complex to be solved by one instrument, the Code, and it is insufficient to solve the shortages and inequitable distribution of health workers present in low-income countries. To the extent that the Code does impose an ethical standard for the global community, it has the potential for success. That success, however, will have to be reclaimed through vigilant efforts, especially by civil society organisations, in watching which country is doing what, and how that has changed with the adoption of the Code.

1. Introduction

The adoption of the World Health Organisation (WHO) Global Code of Practice on the International Recruitment of Health Personnel (hereinafter referred to as the Code) by the World Health Assembly in May 2010 was the culmination of efforts by many role players to address health worker shortages. Whereas the African voice was instrumental in the development and lobbying for the adoption of the Code, it is not clear to what extent east and southern African countries were prepared for and had capacity to implement the Code and navigate the global diplomatic environment to see its fruition. After adoption of the Code there was a lull in activities on the issue among African countries, which begs the following questions:

- To what extent were the policy interests of African countries carried (or not carried) into the code in the diplomacy around it and what affected this?
- To what extent do countries in east and southern Africa see the code as an instrument for negotiating foreign policy interests for health workers, and how are they using it?
- What motivations and capacities are there to monitor and use the Code, including for diplomacy on African policy interests for health workers?

We sought to better understand the foreign policy negotiations on the Code in relation to:

- agenda setting and policy development;
- using and monitoring the Code for diplomacy on health workers.

We are exploring these issues as part of the Regional Network for Equity in Health in East and Southern Africa (EQUINET) programme of work on *Contributions of global health diplomacy to health systems in sub-Saharan Africa: Evidence and information to support capabilities for health diplomacy in east and southern Africa*. This programme identifies factors that support the effectiveness of global health diplomacy in addressing selected key challenges to health strengthening systems in eastern and southern Africa, to disseminate the learning and to strengthen the capacity of key African policy actors and stakeholders within processes of health diplomacy. One of the areas of work under the EQUINET programme is on diplomacy around the Code.

This explored from existing literature (policies, official documents, published materials including peer review publications) the extent to which the policy interests of African countries were or were not carried into the code and the factors affecting this. It sought to identify the use of the Code at national and regional levels and to reflect on the role and limitations of the Code as a soft law instrument in addressing health worker issues.

1.1 The health worker crisis

Countries in the sub-Saharan African region (SSA) have been affected by a human resources for health (HRH) crisis characterised by an absolute shortage of skilled health workers, poor investment in production and retention of health professionals (especially in rural and remote areas), disparities between private and public sectors, inappropriate skills mix, and low morale and low productivity of the existing workforce (Padarath et al, 2003; JLI, 2004). Thirty-seven of the SSA countries have critical shortages of skilled health personnel below the threshold of 2.3 doctors, nurses and midwives needed for the most effective health interventions (JLI, 2004; WHO, 2006). The health worker crisis is one major reason for the poor progress made in the region towards achievement of selected Millennium Development Goals (MDGs) (Anand and Bärnighausen, 2004, 2012; Travis et al, 2004; Hongoro and McPake, 2004; Sheikh, 2011).

The genesis of the health worker crisis in African countries is complex and context specific. Nevertheless, common factors are applicable across the region (Dussault and Franceschini, 2006). An underinvestment in the social sector, which accelerated in the 1980s and 1990s as part of the Brenton Woods institutions (IMF/World Bank) structural adjustment programmes, undermined the health sector (JLI, 2004; Chen et al, 2004; Mullan, 2005; Windisch et al, 2009). Health workers experienced significant falls in their earnings, to the point where it became imperative for them to seek alternative sources of income. The quality of services offered deteriorated in many countries, and the appeal to seek green pastures became more alluring for health workers from the region (Kuehn, 2007). In addition to the problems prevaling in African countries, pull factors in the global north attracted health personnel from the countries already facing shortages (Cheng, 2009; Labonte et al, 2007; Eastwood et al, 2005; Oberoi and Lin, 2006).

The migration of health professionals from low-income countries with high disease burdens and low densities of health personnel attracted international attention, and became the subject of research and discourse in global diplomacy, such as at the WHO, UN General Assembly and other high level forums (Hagopian et al, 2004; Kirigia et al, 2006; Scheffler et al, 2008; Muula et al, 2007; Mills et al, 2011). EQUINET and the East, Central and Southern Africa Health Community (ECSA HC) led work that identified the push and pull factors responsible for the outflows of health personnel from the region (Padarath et al, 2003) and on strategies used to retain health personnel (e.g. Gilson and Erasmus, 2005; Pagett and Padarath, 2007; Dambisya, 2007; Mwaniki and Dulo, 2008).

Health worker migration is neither new nor unique to African countries (Mackay, 1969; Senewiratne, 1975a, 1975b; Smith, 1988). In the past, health workers have migrated to developed countries, which have relied on skilled personnel from the developing world (Senewiratne, 1975a, 1975b). Indeed, the term ‘brain drain’ has been described as a 'peculiarly British invention' coined in the mid-1950s to capture the social and professional impact of British medical graduates leaving the country to seek opportunities in North America, Australia and New Zealand (Wright et al, 2008; Mackay, 1969). In 1972, about 6% of the world’s physicians were located outside their countries of origin, mainly in the USA, UK and Canada (Ioannidis, 2004). In the UK in 1969, 24% of the total stock of 66 000 active doctors were estimated to have qualified overseas, of whom two-thirds came from the developing world (Senewiratne, 1975a, 1975b). By 2010, 37% of the doctors registered in the UK trained overseas, almost half were from India or Africa (Blacklock et al, 2012). In the brain drain, the USA is described as the ultimate destination and low- income central African countries as most affected (Mullan, 2005; Mills et al, 2008).

1.2 Policy dialogue on health worker migration

Over the years, countries and the international community have explored many policy options to stem the tide of health worker migration. In the beginning, the measures tended to be largely restrictive and punitive. For instance countries attempted to prevent their health professionals from leaving by withholding travel documents, strict bonding regimens and even the threat of prosecution (Senewiratne, 1975a, 1975b). In Uganda in 1980s to 1990s, attempts were made to withhold the degree certificate of medical graduates to prevent them from leaving. As the determinants of health personnel mobility became better understood, as well as the reality of a globalised world, the strategy changed from restriction to managed migration (Aly and Taj, 2008). The policy options shifted from country-specific punitive measures to regional and global options.

The complexity of the issue was ably captured by Ahmad (2004) as:

> *… growing recognition, in both developed and developing world, of the dangers posed by indiscriminate recruitment of skilled health professionals. Despite the awareness of the risks, little effort has been made to solve the problem. Regardless of one’s point of view in the debate, the fundamental issue is the same: should skilled*

migration be left completely to market forces or should some form of intervention be introduced?

The engagement on the issue evolved over the years, with destination countries taken to task and reference to 'rich countries looting health workers from poor countries' (Johnson, 2005), perverse subsidy from poor to rich countries (Mackintosh et al, 2006), and 'poaching' of health workers from poor countries (Robinson and Clark, 2008). There was also appreciation of the right of the health professionals to move, ethically and without harm to either the migrant health worker or the country of origin. This came to be referred to as ethical recruitment (Pond and McPake, 2006). A concern was the finding that health workers often faced exploitation through unfair wages or outright discrimination (Buchan and Dovlo, 2004; Martineau and Willets, 2006).

The new terminology – ethical recruitment, health workers' rights and just returns – changed the discourse in favour of asking the developed world to manage health personnel migration for the mutual benefit of both countries and the health workers. Active recruitment was condemned. Terms such as reverse brain drain, brain circulation and brain gain became more common in policy discourse, recognising the changing patterns and the possible effects of health worker mobility (Saravia and Miranda, 2004; Willets and Martineau, 2004).

The migration of health workers assumed new profile after the adoption of the MDGs, which demanded functional health systems and workforces, and following a Joint Learning Initiative and the publication of the World Health Report on health workers in 2006. In a robust debate in the pages of the *British Medical Journal* (BMJ), for instance, recruitment of health workers was referred to by one discussant as 'the Great Brain Robbery' (Patel, 2003), although this view was not without contrary views (Mellor, 2003).

In 2004 the WHO assembly of health ministers (World Health Assembly) asked the WHO Director General (DG) to develop a code. The process was protracted, until in 2010 the Code was adopted. The expectation was that by 2012, a lot would have been done and member states would report on it. The Code requires that countries report on progress to the Secretariat, and appoint designated national authorities to oversee implementation of the Code. By September 2012, 81 countries had appointed designated national authorities, and 48 had reported to the Secretariat. Among those, one African country had submitted a report, and only 13 had designated authorities (WHO, 2013).

African effort contributed to the adoption of the Code, but the vibe and flurry of activity that characterised its development are no longer felt – leading to question why. This review seeks to gauge from existing literature (policies, official documents, published materials including peer review publication) the extent to which the policy interests of African countries were reflected in the diplomacy around and content of the code and the factors affecting this. We are implementing follow-up interviews to understand the role and limitations of the Code as a soft law instrument in addressing health system issues.

The literature review was undertaken at the end of 2012. The report presents the methods and analytical framework for the review. The findings are divided into the context of health worker migration over the years, intentional responses to health worker migration, the African response to health worker migration, bilateral agreements and codes, and finally the findings on the context of the WHO Code are reviewed. The discussion attempts to analyse the Code in the context of historical and more recent developments.

2. Methods

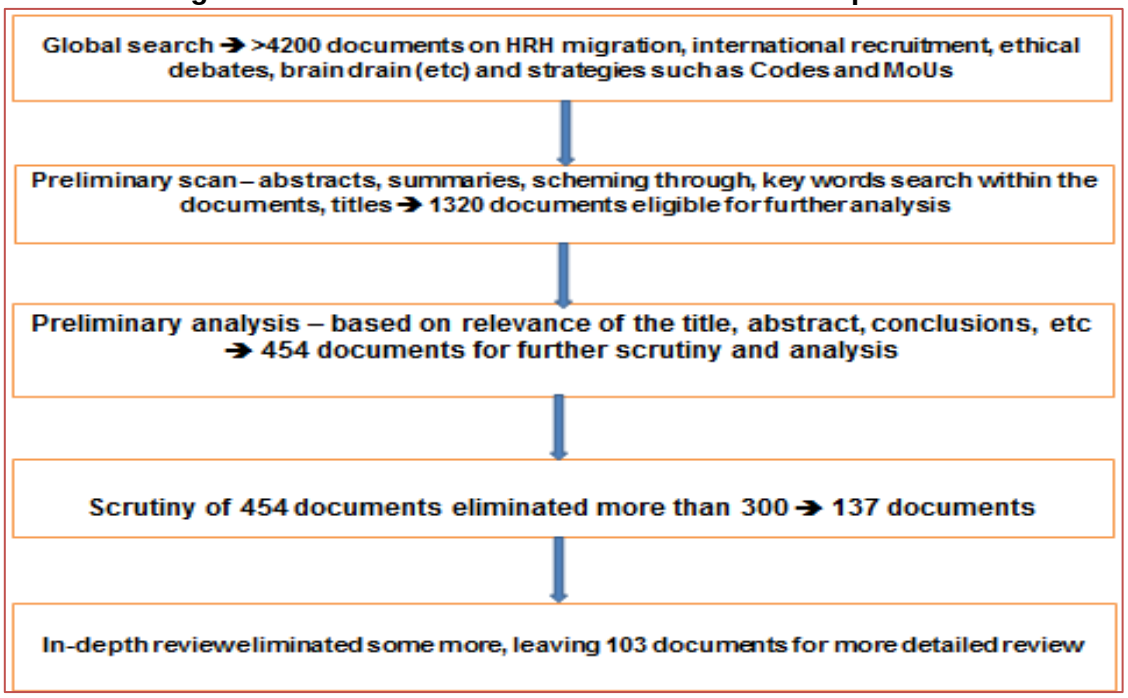
2.1 Search strategy

A review of the literature on codes of practice, and bilateral and multilateral agreements, was undertaken, with a focus on those with implications for the health work force. The review included codes and agreements and literature on them. The search for relevant literature focussed on published and grey literature at global, regional and at national levels in the 16 ESA countries. Search terms were applied in internet search engines – Google and Google Scholar, Pubmed/Medline; EQUINET database, and on specific websites, including WHO, International Organisation for Migration (IOM), and the Aspen Institute. Literature on the history, policy processes, negotiations, capacity, progress since adoption and any scientific papers related to the Code were actively sought out.

The literature search was iterative. It was initially restricted to 1970 to 2012 (inclusive), but widened beyond that time frame through a snowballing technique. Defined key words for the search engines included HRH / health worker AND migration OR compensation OR negotiation OR brain drain OR Codes of Practice OR ethical recruitment OR active recruitment OR bilateral agreements. Relevant documents were analysed and further references followed up using a snowballing strategy. In the search, health worker and health personnel or health professionals were used interchangeably or sequentially to avoid missing out any pertinent documents through use of only one set of terms. Similarly, HRH and health worker, health personnel or health care worker were all included in the search.

Any official documents that have been developed in response to or in fulfilment of the WHO Code were scrutinised, as were scientific papers written on the Code. The review explored questions on how the Code was initiated, negotiated and adopted, and how the role players changed over the period it took to develop the Code. To the extent of available documents, it explored how much African role players contributed to the processes, content and final form of the Code. Common themes are identified, and the review is reported from the perspective of history, development/negotiation process, adoption and post-adoption phases, with any milestones noted.

Figure 1: Literature search and document review process



The initial trawl drew in more than 4,200 documents, which upon initial scanning left about 1,320 eligible documents for further scrutiny. Preliminary analysis of the 1,320 documents about 454 directly spoke to the issues at hand and, of those, 137 documents were relevant enough to be analysed in depth. Another 34 documents were excluded as they did not adequately relate to the analysis, hence the review was conducted on 103 documents. The literature review is, however, based on much more than the 103 documents because some of those that may not have been directly relevant for the review of policy and strategy on migration and recruitment were informative in other aspects of the problems of health worker migration and retention, in keeping with the iterative style of the review and report. A summary of the literature search and document review process is presented in Figure 1.

2.2 Analytical framework for the review

The organisation of evidence from the review was broadly guided by the policy analysis triangle of Walt and Gilson (1994), with attention paid to the context, content and process for each initiative identified, and the actors involved. The actors may be individuals, organisations or groups, and these may operate at national or international level (Walt and Gilson, 1994). We adopted the analytical framework for policy analysis for the review of the literature, given our interest in the changing context that determined the direction of the developments, the content of the policy options and the process(es) through which the various options were developed. We explored the primary drivers of the various initiatives, and the role of the actors at all levels – individual, organisational, national or international. The dynamic nature of the issue has meant that the players have been changing over the years. Within countries the organisations, some organisations, such as Realising Rights and the Health Worker Migration Initiative were relatively late entrants on the scene, but played a pivotal role.

3. Findings

The findings from the review present the **context** of health worker migration over the years, and the changing focus and international interest in the issue. The next two sections address the **main actors** – at the international level and within Africa – followed by a look at some of the **processes** (bilateral agreements) with relevance to the Code, and then finally the **content** of the Code is addressed. None of the elements of the triangle are mutually exclusive; for instance, the content of the Code cannot be divorced from the actors responsible for its final content, nor from the process of negotiation that shaped its development.

3.1. Health worker migration and national responses

The changing interest in and approaches to health worker migration comes out clearly through the literature, and one constant has been that a number of English-speaking developed countries, especially the UK, USA, Canada, Australia, New Zealand and Ireland, have always relied heavily on foreign health personnel, especially doctors and nurses (Senewiratne, 1975; Ojo, 1990; Humphries et al, 2009, 2012, Wanless, 2002, Buchan and Dovlo, 2004). For instance, by 1969, the UK had 25% of their doctors as foreign trained. Canada by 1975 relied on foreign trained doctors to the tune of 33% of the total doctor workforce (Senewiratne, 1975a, 1975b), remaining fairly high at about 23% (McIntosh et al, 2007). The USA has always had many migrant health workers (Meija et al, 1979; Mullan, 2005; Wright et al, 2008; Shuval and Bernstein, 1997; WHO, 1973). For instance, it is reported that the USA admitted more than 60,000 foreign medical graduates between 1963 and 1979, that Canada recruited 12,000 international medical graduates between 1961 and 1975, and that Great Britain licensed 12,640 foreign-trained physicians between 1966 and 1974 (Shuval and Bernstein, 1997; Wright et al, 2008).

The movement of professionals has been facilitated by globalisation and increasingly porous country borders (Pond and McPake, 2006; Pagett and Padarath, 2007). The factors contributing to the outflows of health professionals and the patterns of such movements have also been the subject of many papers (Pang et al, 2002; Saravia and Miranda, 2004; Sharma et al, 2012). Arah et al (2008) suggested that those from wealthier systems, who were able to afford it, moved, rather than poorer people (Arah et al, 2008). That view disregards the significant movement of health professionals from low-income communities and countries, such as from the Democratic Republic of Congo and Zimbabwe in the recent past (Stilwell et al, 2004; Mullan, 2005; Chimbari et al, 2008).

The magnitude of outflows and the costs of migration from ESA countries has been difficult to quantify due to lack of reliable data. Some attempts have been made to provide estimates of numbers and the costs attached to the losses of health professionals. In a study conducted in 2004, it was shown that by employing 293 Ghanaian doctors the UK was saving on training costs of £65 million (Mensah et al, 2005). Muula et al (2006) estimated that Malawi lost $9,330 in training costs for each enrolled nurse-midwife that emigrated, and $31,726 for each degree nurse-midwife; while the projected life-time losses were respectively in the range of $71,000 to $7.5 million and $241,000 to $25.6 million. It was also estimated that the cost to Malawi of training one medical doctor was $56,947 and that lost investment over the working life of a doctor that emigrated soon after graduation would be in the range of $433,000 to $46 million (Muula and Panulo, 2007). For Kenya, Kirigia et al (2006) came to the conclusion it cost Kenya $65,997 to train one doctor and $43,180 to train a registered nurse. The corresponding figures for lost investment were $517,913 and $338,868 for each migrating doctor and nurse, respectively (Kirigia et al, 2006). A more recent study in nine sub-Saharan African countries - Ethiopia, Kenya, Malawi, Nigeria, South Africa, Tanzania, Uganda, Zambia and Zimbabwe - Mills et al (2011) estimates that costs in lost investment in the education of a doctor ranged from $21,000 for Uganda to $58,700 for South Africa, with estimated total loss of returns from investment in doctors working destination countries at $2.17 billion in 2010. In that study, the major losers were Zimbabwe and South Africa, while the main beneficiary destination countries were the UK and the USA at $2.7 billion and $846 million, respectively (Mills et al, 2011). Elsewhere, the investment that source countries forego in the outflow of their health workers has been termed a ‘perverse subsidy’ (e.g. Mackintosh et al, 2006), with losses from Africa estimated to be in the region of $500 million annually (JLI, 2004; Pagett and Padarath, 2007).

The basis for the calculations used to arrive at the numbers above have been contested on the basis of the assumptions used to estimate the numbers, the training costs, interest rates and duration of stay, and the disregard for the flow of resources in the opposite direction, from the destination countries to the source countries (e.g. Clemens, 2011). Notwithstanding those potential sources of inaccuracy, the point has been made through those studies that African countries lose significant resources (human and financial) through the migration of health professionals. It is the numbers that are in contention.

The literature and international discourse have been heavily biased towards migration of doctors and nurses, with little mention of other health professionals (e.g. Meija et al, 1979; Mullan, 2005; Wright et al, 2008; Senewiratne, 1975a, 1975b). Whether that reflects the lower number of other health professionals migrating or the fact that the impact of the latter is less obvious is not clear. Perhaps it could be in fulfilment of the adage, “Until the lion has his or her own storyteller, the hunter will always have the best part of the story”, in other words, “The tale of the hunt would be different if the lion (instead of the hunter) told the tale”. The medical and nursing fraternity have contributed most to what is written on the issue, and the two professions tend to be much stronger in most countries.

As alluded to above, whereas in the beginning the reactions tended to be characterised by anger at the migrating doctors, with punitive action suggested, over the years the approach

became more benign and in some cases out right permissive. Some countries started training for export (Kanchanachitra et al, 2011; Lorenzo et al, 2007; Connell, 2010; Eckhert, 2002, 2010; Kline, 2003; Aiken et al, 2004; Dimaya et al, 2012). Within Africa, at the height of the brain drain from Ghana there was an expansion in nurse training as nursing was seen as a sure ticket to emigration (IOM, 2012). Additional schools sprung up to meet the demands for nurse training slots, and the new trainees saw nursing as their ticket out of Ghana. In the Philippines, there were many reported cases of doctors and other health professionals training as nurses to gain entry into the USA (Chan, 2004).

As noted by Connell (2010), not all countries, particularly in the Asia-Pacific, sought to prevent migration, citing examples of India, Philippines and China as countries that purposefully export workers. The latter author joins others (e.g. Henderson and Tulloch 2008; Wilbulproprasert and Pengpaiboon, 2003) in stressing the need for integrated packages of policies that span the economic and social issues and that extend beyond the confines of the health sector. The author highlights the economic costs of sending countries and the recognition that recruitment is accelerating, raising renewed interest in compensation for the loss of investments in training and of human capital (Connell, 2010). Connell observes that the recipient countries have no interest in putting in place compensatory mechanisms, often arguing that migration is freely chosen, markets operate in this way and there is no means of knowing how long migrants will stay despite strong ethical arguments in favour of restitution. The author suggests that this makes financial compensation to source countries for losses of workers difficult to implement, and that compensation is inherently impossible as long as ethical arguments confront political realities (Connell, 2010).

Connell also discusses the WHO Code from a historical perspective, from around 1999, noting the contribution of the Commonwealth Code (2003), the Pacific Regional Code (2007). He accepts the view espoused by others that codes are not legally binding, and hence have limited effect. He affirms the view that without bilateral or multilateral codes and agreements health migrants remain free to move and suggests that the role of private recruiters will be enhanced while recruitment will be driven underground. More collective action on codes of practice is necessary although it seems presently improbable. The author makes a strong case for bilateral agreements and memorandums of understanding (MoUs) in that they offer some hope for more effective managed migration (Connell, 2010).

The attention paid to the issue seems to have gained momentum at the turn of the century, especially after the Millennium Declaration, the realisation that health was a developmental issue, and that health workers play a central role in the health of nations (Serour, 2009). With this, discourse changed to ensuring adequate workforce for countries with high disease burdens. The policy content has also changed, from the punitive and draconian measures suggested in the 1970s (Senewiratne, 1975a; 1975b) to the current ‘managed migration’ options. One still finds highly restrictive measures, such as those contained in the South African policy (see below).

The ethical voice was a significant development in the discourse on health worker migration, with calls for attention to the needs of source countries, and calls against active recruitment (Bundred and Levitt, 2000; Muula et al, 2003; Singh et al, 2003, McElmurray et al, 2006). Bundred and Levitt (2000) asked: *who are the real losers*? and argued that low-income source countries dealing with even heavier disease burdens suffered greater losses. They challenged recruitment from low-income countries as unethical. There was also a call for the WHO to convene a stakeholders’ meeting to look for solutions, and to establish an international code on ethical guidelines for recruiting physicians from less-developed countries. The driving force for that call was the fear that health care for the poorer countries would completely disintegrate in the face of unchecked migration of skilled health professionals (Bundred and Levitt, 2000).

McElmurry et al (2006) suggested that nurse migration policies and procedures could be developed to satisfy primary health care (PHC) ethics if they build enhanced skills, better health outcomes for home country, community participation and involve clear and equitable financial arrangements. Migrant nurses should, it was argued, enhance their competencies for performance back home, and not only the gain for the recipient country. At the same time some voices were against any form of restriction of health worker mobility (Aly and Taj, 2008).

The British Medical Journal (BMA) called on the rich countries to stop recruitment from low-income countries (Johnson, 2005). According to Johnson (2005), although the developed countries of the North "… were giving aid with one hand, they were robbing African countries with the other by siphoning off their most precious resource – trained doctors and nurses (Mackintosh et al, 2006). Stilwell et al (2003) called for evidence to guide the ethical recruitment of health personnel.

Dovlo (2005) observed that international agreements on managing recruitment were more effective between low- and middle-income countries. For example, South Africa successfully banned recruitment from within Africa, even while richer countries opted for less effective voluntary codes of conduct. Dovlo called for policies to moderate the loss of trained health workers from poor countries to stop medical training subsidies from poor to rich countries. Although mildly worded, Dovlo's call was interpreted as a call for restriction or banning of health worker migration by Aly and Taj (2008), and opposed on grounds of international law protecting the rights of individuals to move freely (Aly and Taj, 2008). Senewiratne (1975a) also saw it as futile for countries to refuse health professionals exit from their home countries, "creat[ing] a group of disgruntled and dissatisfied doctors who are of little use in the running of an efficient health service" (Senewiratne, 1975a, 1975b).

The discourse on health worker migration was often emotive. One study commented that "the haemorrhage of health professionals from African countries is easily the single most serious human resource problem facing health ministries today" (Sanders et al, 2004). Chen and Boufford (2005) termed the phenomenon as "fatal flows" and charged that 'the movement of physicians from poor to rich countries is a growing obstacle to global health.' The outflows of skilled people with financial gains for rich countries and losses for poor countries, was described as "quite appalling" (PHR, 2004; Mackintosh et al, 2006); as an "annoying subvention" (Agwu et al, 2009] and as "reverse foreign aid" (McArthur, 1999). Mass emigration of health professionals from less-developed countries resulted in greater pressure on those remaining in these countries (Sielounou, 2011).

There has, however, been no unanimity in the use of various terms for the migration of health professionals. Marchal and Kegels (2003) questioned the use of the terms brain drain or professional mobility, since either term may be appropriate in certain circumstances. Dodani and LaPorte (2006) also advocated for a linguistic shift from "human capital flight" and "brain drain" to "professional mobility" or "brain circulation", arguing:

> *It is time to bury the archaic concept of brain drain and turn to assessing the performance of health professionals and systems, wherever they are in the world. The turn of the 21st century has not only brought technology, but also modes by which scientists around the world can be connected in no time. In this globalized world the physical location of a person may or may not have any relation to the ability to make an impact on human health. Health professionals in the developed world may have most of their work portfolios in the developing world. Easy communication, quick travel, and greater collaborations between developed and developing world are increasingly more common and we need to develop ways in which foreign professionals can contribute to their countries of origin.*

Internationally less strident language was used, with fewer expectations expressed of support to source countries. Although the migration of health professionals has been longstanding, in the past two decades there has been an increasingly strong voice for ethical recruitment to protect health systems in source countries, while also respecting the right of the health professionals to move. The Code had its beginnings shaped by such voices, based on the need for collective global action.

3.2. International responses

Chen and Boufford (2005) note that: 'Managing international medical migration ultimately will require global political consensus.' The search for that consensus is arguably not over. Countries affected by health worker migration have put in place measures to try to stem the outflows (Chimbari et al, 2008; Dambisya, 2007) and have taken their case to international and global arenas (Chen and Boufford, 2005). The South African High Commissioner to Canada reportedly publicly accused the Canadian provinces of decimating the health workforce in South Africa (Ehman and Sullivan, 2001). Following that diplomatic spurt, Canadian provinces indicated that they had stopped recruiting from South Africa, in line with ethical recruitment codes that proscribe raiding from less-developed countries. Observers of the trends in recruitment of foreign doctors to Canada however were sceptical of the delivery on this (Shuchman, 2008a, 2008b; Ehman and Sullivan, 2001).

Pressure from developing countries contributed to the UK Code for the National Health Service (NHS). The UK Code, however, allowed private recruitment and those recruited privately still found themselves in the NHS (Carlile, 2004). Smith and Henderson-Andrade (2008) in a report on the migration of the health workforce called for co-operative agreements and ethical recruitment practices to protect the rights and safety of migrant workers and to overcome such defects of existing codes.

A MoU between the UK and South Africa had some effect in reducing the inflows of South Africa health personnel into the UK. Subsequent to the agreement, South Africa sent medical teams to the UK for limited periods in a managed migration of skilled health workers. The UK-South Africa MoU recognised various international codes of practice issued by WHO, bilateral and multilateral agreements and recruitment protocols, particularly in the context of the Southern African Development Community (SADC) and the African Union. Subsequently in 2004 the World Health Assembly called for the development of similar measures internationally, as detailed below,

Commonwealth countries took this forward through the Commonwealth Code, a non-binding code of practice to guide ethical recruitment from member countries This was adopted at the pre-WHA Commonwealth Ministers Meeting on 18 May 2003 in Geneva. The Commonwealth Code is voluntary. It seeks to discourage targeted recruitment of workers from countries experiencing shortages, safeguard the rights of recruits and professional conditions in the destination country, and discourage recruitment of health care workers with an outstanding obligation to their country (with health workers responsible for providing this information).

The Commonwealth Code suggests ways to mitigate the impact of health worker migration, with compensation to source countries through transfer of technology/skills, training programmes and facilitating return of migrant health workers. Many of the same principles informed the subsequent WHO Code adopted in 2010.

Pagett and Padarath (2007) note that a weakness of the Commonwealth Code was that only the ministers present at the meeting signed and that no provisions were made for others to sign at a later stage. Notably, there were no signatories from developed countries, presumably due to reluctance to commit to compensation or reparations (Pagett and

Padarath, 2007; Nullis-Kapp, 2005). It has also been suggested that the developed nations, including Canada and Australia, did not sign the Commonwealth Code because the situation prevailing then favoured them (Bach, 2003).

The impact of the Commonwealth Code was difficult to assess. The number of foreign registered/trained health professionals in the UK (at least) did not reduce until late 2000s. Other indirect evidence based on adverts for doctors in South Africa show that efforts at active recruitment continued until 2007 or thereabouts when they declined (Dambisya and Mamabolo, 2012). Active recruitment from South Africa to the UK continued up to 2007 in spite of the MoU between the UK and the Commonwealth Code. As suggested by Dambisya and Mamabolo (2012:671):

> *The considerable decline of UK advertisements may be more due to geopolitical changes in Europe than to the HRH crisis in developing world. With expansion of the European Union (EU), health professionals from Eastern Europe could work in the EU, including the UK, which was obliged to employ them ahead of applicants from elsewhere, including SA.*

Political developments in the EU may have had a more profound effect on limiting recruitment from South Africa than the commitments in the NHS Code, Commonwealth Code and MoU (between UK and South Africa) together (Costigliola, 2011; Avgerinos et al, 2004). Connell et al (2007) observed that whereas many countries attempted to implement national policies to manage migration or mitigate its harmful effects, recipient countries were reluctant to establish effective ethical codes of recruitment or other forms of compensation or technology transfer (Connell et al, 2007).

With entry into force of the Lisbon Treaty, the EU is compelled to ensure that its policies and practices on recruitment and retention of health workers do not undermine progress on the health MDGs (Webb, 2011). In 2005, the EU adopted a programme of action to combat diseases of poverty that included a separate section devoted to addressing the human resources crisis.

> *The lack of trained health providers undermines efforts to scale up the provisions of prevention, treatment and care services. The EU will support a set of innovative response to human resources crisis. At regional level the EC will use its support for the AU and the New Partnership for Africa's Development (NEPAD) to help ensure a strong African leadership in the formulation and co-ordination of a response to the human resources crisis* (European Commission, 2005:

Individual EU countries have offered support for strengthening HRH. France supports 20 countries mostly from Africa with about 30 projects either entirely dedicated to health workers or including a component on this. France has signed nine bilateral agreements on migration flows with countries in Francophone Africa to date. Some of the ratified agreements (i.e. Senegal, Benin and Congo) address the issue of migration with a comprehensive approach and a particular focus on health professionals and support for HRH development (Dhillon et al, 2010).

Non-state actors, such as the World Organisation of Family Doctors (WONCA) and the International Council of Nurses (ICN) have added voices on the issue. In 1997, WONCA adopted the Durban Declaration, which called upon governments and medical councils of developed countries to review their policies on recruiting doctors from less-developed countries. Further action from WONCA came in 2002 through a Code of Practice for the International Recruitment of Health Care Professionals: The Melbourne Manifesto, adopted at the fifth WONCA World Rural Health Conference, Melbourne, Australia, on 3 May 2002. The Melbourne Manifesto called for recipient countries and source countries to take responsibility for their health workforce development – the former by ensuring that they

produce sufficient numbers to satisfy their demands and the latter to establish why their health professionals were leaving and address the issues (WONCA, 2002). The principles of the Melbourne Manifesto are as shown in Box 1.

Box 1: Principles of the WONCA Melbourne Manifesto, 2002

We assert that:

1. It is the responsibility of each country to ensure that it is producing sufficient HCPs for its own current and future needs; is retaining them; and is planning for both rural and urban areas.
2. International recruitment is related to an inability on the part of individual countries to satisfy their own workforce needs.
3. The principles of social justice and global equity, the autonomy and freedom of the individual, and the rights of nation states, all need to be balanced.
4. Integrity, transparency and collaboration should characterise any recruitment of HCPs.
5. International exchanges of HCPs are an important part of international health care development.
6. Countries that produce more HCPs than they need may continue this contribution to global health care.

WONCA also suggested that developing countries should be supported to recruit from developed countries to provide short-term opportunities for HCPs with clinical, educational, management, research and other skills to assist in the development of health care services. The call by WONCA included the call for redress in quite clear language: 'the gaining country should be prepared to reimburse the cost of medical education… this cost should be chargeable for a number of years after graduation, and could be administered by WHO.' (WONCA, 2002: 2)

ICN, International Council of Nurses, represents 130 nursing associations. ICN acknowledges the adverse effect of international migration on health care quality in low-income countries. Its position statement was used by the American and the Canadian nursing associations to lobby for ethical international recruitment and to prevent untrained migrants from working in high security areas in the USA and Canada (Martineau and Willets, 2006). In 2007, ICN reviewed and revised its position statement on ethical recruitment. While it reiterated its previous stance that career mobility was important both for nurses to further their careers and for the profession to respond to changing health needs, it also now included:

- condemnation of recruiting nurses to countries where authorities have failed to implement sound human resource planning and to address problems causing nurses to leave the profession and that discourage them from returning to nursing;
- denunciation of unethical recruitment practices that exploit nurses or mislead them into accepting job responsibilities and working conditions that are incompatible with their qualifications, skills and experience;
- recognition of the benefits of circular migration and calls for mechanisms to support nurses who wish to return to their home countries;
- a call for regulated recruitment based on ethical principles and sound employment policies on the part of governments, employers and nurses, thus supporting fair and cost-effective recruitment and retention practices (ICN, 2007).

The Joint Learning Initiative, a collaboration of more than 100 global health leaders, identified strategies to strengthen the workforce of health systems. The work of the JLI was unique in the sense that the collaboration adopted equity in global health as the basic value underlying its endeavours. The JLI raised the profile of health workers at global level, identified the need for health workers in Africa due to AIDS, the brain drain and

underinvestment in health workers and the greater negative impact on lowest income countries (JLI, 2004). The JLI report informed the World Health Report 2006, which in turn spawned initiatives such as the WHO Code.

Other actors kept the pressure on receiving countries. In 2008 Hoag warned Canada against reliance on foreign graduates, stating that 'the targeted recruitment of health workers from developing world through advertisements in local journals and onsite dinner-and-drinks information sessions is widely frowned upon. Several organisations, including the World Health Organisation, have launched efforts to encourage the ethical recruitment of health workers' (Hoag, 2008). Martineau and Willets (2006) noted the priority given to the issue by WHO, citing 'the damage to the health systems which serve poor communities by the relentless recruitment of skilled… health personnel… to places where the pay is better….' These authors called for an extension of the 2003 Commonwealth Code from Commonwealth countries to global level.

As attention to the issue rose, so did debate, with some countries such as India and the Philippines seeing it as enabling outflows of "excess" skills, arguments that remittance returns benefited low-income households and countries, while African countries saw an opportunity to restrict outflows or to obtain just returns from emigrating health workers. The WHO Code built on these debates and principles put forward in the NHS and Commonwealth Codes and the statements from WONCA and ICN. The ethos of ethical recruitment, recognising both the rights of the individual and the need to protect the health systems in source countries, was brought into the negotiations for the WHO Code.

3.3 African response

As the region in the eye of the HRH storm, African stakeholders played a significant role in shaping the responses through bilateral agreements, engagement at the Commonwealth level, positions adopted at regional economic blocs, and through their engagement in the development of the Code.

Within the region, South Africa responded to pressure from SADC and the OAU (as it was then), and developed a policy limiting recruitment from other African countries, the policy on foreign health workforce. The challenge for the South African position came from the mass exodus of health professionals from Zimbabwe and from neighbouring countries that sent their students for further studies in South Africa. The South African Foreign Health Workforce Policy aims to promote high standards of practice in the recruitment and employment of health professionals who are not South African citizens or permanent residents (foreign health professionals) in the health sector in South Africa. The policy aims at precluding the active recruitment of health professionals from developing world unless there are specific government-to-government agreements to allow and support such recruitment. The policy applies to all provincial departments of health, agencies involved in recruiting health professionals to be employed in South Africa as well as private health care providers (NDOH, 2010).

By not recruiting from other African countries, South Africa was responding to complaints that it was poaching health workers from countries that had lower heath worker densities. It was a significant move because South Africa is not only a destination country, but also a transit country and a source country for health workers (Mullan, 2005; Ncayiyana, 1999; Arah et al, 2008; Dambisya and Mamabolo, 2012). Notwithstanding that policy, South Africa by end of 2011 still relied heavily on health personnel from other African countries (Bateman, 2011). The challenge for this policy option came with the massive influx of health workers, among other migrants, from Zimbabwe, especially as the Zimbabwe situation deteriorated in the 2000s (Chikanda, 2005, 2006; Connell et al, 2007).

South Africa has sought to overcome the shortfall occasioned by the moratorium on recruitment from SSA countries through bilateral agreements with Cuba, Iran and Tunisia; and has remained a destination country for migrant doctors from eastern Europe.

Regional organisations within Africa, notably the Africa Union (AU), the New Partnership for Africa's Development (NEPAD), SADC ministers, ECSA HC all took positions on the issue of health worker migration from the region. The documents on some of the initiatives were not accessible, but their contents were noted in secondary sources. African country concerns, expressed through their ministers of health, motivated the Commonwealth Code on ethical recruitment of health personnel discussed earlier. African health ministers similarly pushed for the 2004 WHA Resolution that mandated the WHO Director General to develop the global code of practice (Chen and Buofford, 2005, Taylor and Dhillon, 2011).

Pagett and Padarath (2007) reviewed how African countries had used the codes of practice, bilateral, multilateral and regional agreements and strategies to prevent, prohibit, curb or manage migration of health workers and/or promote their retention and production both globally and regionally. The authors reported that the existing frameworks and codes had been unable to stem the tide of health worker outflow to the North. They observed constraints, including:

- weak or non-existent frameworks for implementation;
- their voluntary and nonbinding nature; with no mechanism for sanctions for noncompliance;
- no advocacy processes on the codes;
- inadequate data collection and monitoring systems;
- no bodies established for oversight over the instruments; and
- sustained push factors driving migration and northern health worker shortages unaddressed, leaving the drivers unaffected.

The authors suggested a more holistic approach combining the various instruments and moves to improve health worker conditions and curb the demand.

African voices contributed to the development and lobbying for the WHO Code as one part of a wider and more effective approach (Taylor and Dhillon, 2011).

African Union (AU) responses

The African Union provided direction on the migration of health workers through the Health Strategy 2007-2015, which contains provisions on health workers and HRH migration. The strategy

- urges countries to conduct migration and retention studies of health workers and explore the possibility of establishing networks for training health workers;
- aims to facilitate a common African position on migration of health professionals and to lead engagement with OECD countries on the impact on Africa's health systems (AU, 2007.

The strategy sought a lifting of expenditure ceilings, called for health workers trained with public funds to offer compulsory community service, sought funding for the development of health workers in Africa and, to reduce migration of health workers out of the continent, an endowment fund. It advocated for western governments to increase investments in the training of their own health care workers to address the gaps in their countries and thus reduce the pull factors in developed countries and for African countries to address the push factors by putting in place mechanisms that value, respect, motivate, adequately compensate, professionally develop and equip the health workforce.

The strategy explicitly addressed ethical recruitment:

> *The African Union needs work towards ensuring ethical recruitment within the continent and by developed countries, by insisting on agreements that take into account the investment made by African countries as well as the rights and freedoms of individuals. Countries should address the causes of migration and conduct migration and retention studies of health workers and should also improve the conditions under which health professionals and other health workers operate. African countries should work together to produce the health workers we need and to develop a common African curriculum* (AU, 2007:12-13).

It urged that:

> *The African Union should facilitate a common African position on migration of health professionals and lead engagement with OECD countries to overcome the devastating impact this is having on Africa's health systems (*AU, 2007).

The African Union, therefore, provided an over-arching framework for countries and regional organisations within the continent to work towards solutions to the problem of health worker migration. We did not find documentary evidence of the extent to which the AU countries used the AU Health Strategy objectives to advance the agenda on HRH migration, including the development and adoption of the WHO Global Code. However, commitments at that level influenced activities at other levels, such as the ECSA Strategy on HRH (see below) that made reference to the AU strategy as informing its intentions (ECSA HC, 2008). Some of the efforts of two regional organisations in the ESA region (ECSA HC and SADC) are highlighted below.

Responses through ECSA HC

ECSA HC is an inter-governmental organisation with ten member states – Kenya, Lesotho, Malawi, Mauritius, Seychelles, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. Its mandate is to promote and encourage efficiency and relevance in the provision of health services in the region. Over the years, ECSA HC has addressed the issue of HRH migration, as is evident through the resolutions of the Health Ministers Conference (see ECSA HC at www.ecsa.or.tz). At the 34th Regional Health Ministers' Conference (2001), the ministers adopted Resolution 3 that underscored the need to protect the human rights of health professionals who emigrate, and urged member states, *inter alia*, to:

- Develop a memorandum of understanding to harmonise, professional, educational and training standards in the region;
- Establish a mechanism to facilitate the exchange of health expertise within the region;
- Train higher numbers of middle level health professionals;
- Improve working conditions; and
- Ensure the protection of human rights of health workers who emigrate.

The Resolution urged the secretariat to:

- Document the extent of the problem of brain drain in the region and facilitate the exchange of information and experiences;
- Collaborate with regional and international agencies in advocating for the development of compensatory mechanisms for member states that are severely affected by the brain drain; and
- Facilitate the establishment of a database of available human resources for health in the region (ECSA HMC, 2001)

At the 2003 RHMC (38th HMC, Livingstone, Zambia), which was held after adoption of the Commonwealth Code, ECSA health ministers acknowledged the importance of the Commonwealth Code and stressed the need for countries to sign legally binding agreements to give effect to aspects of ethical recruitment and compensatory arrangements. Resolution

3 of the 38th RHMC expressed concern about the levels of attrition of health care workers in the region, recognised the push factors that fuel attrition, and urged member states to:

- Develop and sign legally binding agreements with other governments in the region and overseas regarding migration of human resources from the region, especially relating to aspects of ethical recruitment and compensatory arrangements;
- Put in place strategies and mechanisms to improve the value placed on health workers, and improve motivation and retention as a matter of priority;
- Encourage donors and co-operating partners to support human resource needs of member states;
- Incorporate human capacity development needs in future proposals for funding from sources such as the Global Fund and related aid instruments.

The 38th RHMC urged the secretariat to:

- Document and disseminate current best practices and guidelines on legally binding agreements among member states and developed nations on the ethical recruitment of human resources;
- Produce and disseminate information on the various strategies and options including financial and non-financial incentives on staff motivation and retention;
- Collaborate with WHO and other international agencies involved in HRH development in the region to ensure complementary actions towards addressing the HRH crisis (ECSA HC, 2011).

The health worker crisis was on the agenda of the 40th HMC, 2004. The ministers recognised the previous resolution and adopted a further resolution on promoting the retention of health professionals through improving the conditions of service and through addressing safety at work and the workforce health programmes. Member states were also urged to establish or strengthen HR units within ministries of health for effective management of human resources. The momentum and focus on HRH within the ECSA processes was reflected in the 2006 HMC (42nd HMC) Resolution 4 that recognised previous resolutions on the issue, and called for implementation, monitoring and evaluation of the previous resolutions on health worker migration and retention. The resolution reiterated previous calls for member states to develop systems for compensation and for adopting a "common position on ethical recruitment", coupled with development of financial and non-financial incentives to retain HCWs in the region. On this occasion, the ministers urged the Secretariat to develop guidelines for ethical recruitment and compensation for health workers (ECSA HC, 2004).

At the 44th HMC, 2007, Resolution 7 called for countries, within the context of national HR policies and strategies, to develop mechanisms for harnessing the potential resource of health workers from the diaspora and retired workers; to support and endorse policies and protocols to manage and mitigate the costs of migration; and for the secretariat to document and disseminate best practices and guidelines on legally binding bilateral agreements among member states and developed nations on the ethical recruitment of human resources. The 2008 HMC (the 46th) emphasised the importance of managing migration and the development of HR policies for scaling up HRH. At that meeting, the ministers adopted the ECSA HRH strategy, a comprehensive document with policy options for both the member states and the Secretariat. The ECSA HRH strategy included a focus management of HRH migration, including research; establishing functional health workforce observatories; stronger human resource information systems (HRIS) and health management information systems (HMIS); better retention of existing health workers through country action on financial and non-financial incentives; policies that value health workers, including health worker health programmes; attraction of inactive health workers back to service; and better managed health worker migration through country-specific responses to migration, including the involvement of the diaspora (ECSA HC 2008). ECSA HC undertook to assist member

states to develop and/or strengthen health management systems and to support research and information to develop measures to support implementation of the strategy.

In March 2012 ECSA HC, with the Rockefeller Foundation and in response to country demand, organised a multi-stakeholder workshop to disseminate the Code and consult with countries in the ECSA sub-region on its implementation (ECSA HC, 2012). The workshop identified the need for:

- technical support to countries to disseminate and implement the code;
- operational research to support countries in implementing the code; and
- a mechanism for countries to share information on the minimum data set required to implement the code and for countries to comply with the reporting on the code.

Responses through SADC

At the April 2001 Annual Health Sectoral Meeting held in Gaborone, Botswana, SADC member states expressed concern about the high numbers of nurses being recruited out of the region (cited in Pagett and Padarath, 2007). In June 2001 SADC health ministers issued a statement condemning active recruitment of health workers out of the region (Pagett and Padarath, 2007). The statement noted that recruitment by developed countries was an indication of poor planning for HRH needs by the North and could be seen as looting from the poor countries, as happened during colonialism. It was termed immoral, possibly racist and was noted to further entrench inequitable wealth and resource allocation between South and North. The ministers called for regional and international action to stem the tide of active recruitment, specifically mentioning the need for the Commonwealth to develop a code of conduct that discourages active recruitment (Pagett and Padarath, 2007).

Within the SADC region, a migration dialogue for southern Africa in November 2004 adopted strategies for:

- retention of health workers through remuneration and benefit packages; enhancement of training through multilevel and sector organisations;
- implementation of monitoring and evaluation systems on strategies;
- research into the extent and impact of migration (e.g. cost/benefit analysis);
- government engagement in research; and
- internal co-ordination of migration management and private agency partnerships to mitigate the effects of migration.

Towards the last stages of the development of the Code it was not possible to discern SADC's voice from others. No definite position taken by SADC as a bloc was documented on the issue. However, the organisation had contributed to a momentum that resulted in the initiative for the Code and SADC member states remained active in the negotiations.

3.4 Bilateral agreements

Of the instruments preceding the WHO Code, perhaps the most reviewed has been the 2001 UK Department of Health Code of practice for NHS employers involved in the international recruitment of healthcare professionals. A prior code on nursing recruitment had not received publicity. The 2001 UK Code became functional in 2003, published a list of countries from which active recruitment was prohibited and in 2004 issued an updated Code for the international recruitment of health personnel (Martineau and Willet, 2006; Blacklock et al, 2012). These ethical guidelines had little or no impact, but other initiatives, such as changes in immigration law, admission of new member states to the EU and the signing of bilateral agreements such as between UK and South Africa were reported to have had greater impact (Blacklock et al, 2012). The MoU between the UK and South Africa, described earlier and signed in October 2003 led to sharing information, officially negotiated placements of South Africa workers in the UK for limited periods of time, and of UK workers in rural areas in South Africa. The MoU did not stop individual health workers from applying

to the NHS directly, provided they were not recruited by an NHS-approved agency. The UK holds bilateral agreements with other countries, including China, India and Philippines, allowing active recruitment (Blacklock et al, 2012).

Between African countries, Namibia and Kenya signed a MoU on technical co-operation in health on 12 June 2004 and renewed it on 1 April 2009. The MoU includes guidelines for the temporary movement of health workers from Kenya to Namibia, upon a request from Namibia. Under the agreement, Kenya would be responsible for all the salaries of the workers during their sojourn in Namibia, while Namibia would provide transportation, health coverage, accommodation and living allowances (MoU, 2004). The MoU resulted from the inability of Kenya to employ all its health workers, particularly nurses, whilst still producing many from training institutions, and Namibia's shortage of nurses to staff many of its facilities was to the mutual benefit of both countries. The MoU prohibits the Namibian government from entering into contracts of employment with Kenyans seconded under the MoU to guarantee their return once their tour of duty ends. One facet of the Kenya-Namibia agreement is the undertaking of Kenya to open up its training institutions to Namibian students in health care fields. This MoU pre-dates the WHO Code and is believed to have influenced the latter. It is unclear whether the WHO Code has since strengthened this MoU.

Kenya has subsequently signed a similar MoU with Lesotho for the deployment of Kenyan nurses in Lesotho. At the same time Lesotho also has an MoU with Zimbabwe through which Lesotho students study medicine at Zimbabwe medical schools.

Regarding training, South Africa has an MoU with neighbouring southern African countries that do not have medical schools for the training of their doctors, provided that the trainees return to their home countries immediately after they complete their studies. Such trainees are not permitted in terms of the Foreign Health Workforce Policy (alluded to above) to do internships in South Africa except with express permission of their home government. Those that receive postgraduate/specialist training do so through super-numeral posts that do not enable them take up paid employment. Once they complete their training they are expected to leave South Africa without the possibility of registration and employment as specialists. What this policy does is to close the opening that training provides for emigration of health workers.

Ghana has also implemented various innovations designed to develop its health workforce and incentivise skilled health workers to remain in Ghana. Ghana formed an international medical partnership (Aspen Global Health and Development, 2012) and partnered with various medical schools in the USA on training doctors.

Dhillon (2011) noted that such bilateral agreements provide an important means to implement the WHO Code Objective 3 and identified numerous instruments and agreements on health workers:

1. Philippines–Bahrain, MoU
2. Philippines–United Arab Emirates, MoU
3. Philippines–Province of Saskatchewan, Canada, MoU
4. Philippines–Government of Manitoba, Canada, MoU
5. Philippines–Government of British Columbia, Canada, MoU
6. Philippines–UK, MoU (no longer in force)
7. UK–SA, MoU 2003 (no longer in force)
8. UK–SA, MoU 2008 (revision of the 2003 one)
9. Sudan–Saudi Arabia Co-operative Agreement
10. Namibia–Kenya, MoU 2004 (no longer in force but a new one was signed in 2009)
11. India–Denmark Labour Mobility Partnership, MoU
12. France–Benin Accord concerning migratory flows and co-development
13. France –Senegal Accord on concerted management of migratory flows

14. ASEAN Mutual Recognition Agreement on medical practitioners
15. ASEAN Mutual Recognition Agreement on nursing services
16. ASEAN Mutual Recognition Agreement on dental practitioners
17. Japan-Philippines- economic partnership agreement
18. US-China Climate Change, MoU
19. Japan-Indonesia, MoU.

The author singles out various examples of innovation in these bilateral agreements:

- Philippines–Bahrain: encouraging joint venture and investments in health facilities (training hospitals and research institutions) develop HR through scholarships;
- Philippines–Saskatchewan: companies employing workers under the MoU to support though contributions/donations to improve education and training of youth in the Philippines;
- Philippines–Manitoba: co-operate in exploring projects to support HR development in the Philippines;
- Kenya –Namibia: Kenya to facilitate admission of Namibian health-related students at Kenya's academic institutions;
- France–Senegal/ France-Benin: health sector co-operation, creation of migration observatory, exchange of information, reintegration of health workers, leveraging diaspora, reducing transaction costs of remittances, matching diaspora development efforts in affected areas.

Outside the Africa region, Connell (2010) cites examples of MoUs between Spain and UK, and UK and the Philippines. He links the ASEAN Mutual Recognition Agreement to bilateral MoUs for formulating goals for regional co-operation through the exchange of services but also points out their short comings in the lack of built-in controls.

Bilateral agreements have stronger enforceable relevance. The positive view of bilateral agreements is reflected in the wording in the WHO Code, which advocates for bilateral agreement for its implementation (WHO, 2010). At the time of the review it was not apparent to what extent the Code had spawned more bilateral agreements.

4. Negotiating the WHO Code

Building on this background, at the WHA in May 2004, member states adopted resolution WHA 57.19 mandating the WHO DG to develop a (voluntary) code of practice on international recruitment of health personnel in consultation with member states and other relevant partners (Dayrit et al, 2008). The initiative for the resolution was attributed to the intervention of African ministers of health (Pagett and Padarath, 2007; Gilson and Erasmus, 2005). The next year, at the 2005 WHA, African health ministers tabled a draft resolution that called upon the WHO DG to ensure implementation of the 2004 resolution (Pagett and Padarath, 2007).

4.1 Process and actors in the negotiations

In May 2007, the Health Worker Migration Policy Initiative (HWMPI) was established to find practical solutions to the worsening problem of health worker migration. It supported WHO in drafting a framework for an International Code of Practice on Health Worker Migration, in fulfilment of the 2004 resolution. In September 2008, WHO published the first draft of the Code for comment, incorporating principles from existing bilateral agreements, MoUs and national and regional codes. It was buttressed by views from a web-based multi-stakeholder global dialogue, and the work of the Health Worker Migration Policy Initiative and the GHWA global HRH forum in Kampala earlier that year (Dayrit et al, 2008).

A significant actor in the development of the Code was the Health Worker Migration Global Policy Advisory Council, which worked with other partners from February 2008. The Council had many activities that fed into the development of the Code, including journal articles by the chair/co-chair of the Council and inputs into the draft of the Code. A multi-stakeholder meeting was held in preparation for the May 2010 WHA where the Code was ultimately adopted. In between the major activities, the co-chairs of the council – Hon Mary Robinson and Dr Francis Omaswa – wrote to the WHO DG urging adoption of the Code as a matter of urgency (Aspen website). In the aftermath of the Code's adoption, the Council has remained actively engaged on the Code, and is reported to be

> …*working to ensure the Code helps to mitigate the negative effects of health worker migration via successful implementation. For example, the Health Worker Migration Initiative co-sponsored a side event at the 63rd WHA, an open meeting to discuss the role of civil society in implementing the Code*.

This is one actor in the development and adoption of the Code that remains committed to its implementation (Taylor and Dhillon, 2011).

Taylor and Dhillon (2011) provide a comprehensive account of the development of the Code, including issues that only those privy to the actual processes would be aware of. For instance, issues of compensation and language that would have had more teeth had to be watered down in the face of opposition from developed countries, many of them leading destination countries. In their account, when the African voice was regained during the final drafting committee process, it was possible to influence language to provide for monitoring and reporting mechanisms that the louder voices from the North had opposed. From the Taylor and Dhillon account, one gets a glimpse of how the roles of the different actors changed as the Code evolved, and a distinct understanding of how the geo-political environment influenced the processes. Clearly, without the change of heart brought by the administration of US President Barak Obama, many issues in the Code would have remained contentious, and there may not have been a Code by May 2010. For those involved in the development of the Code since 2004, the turning point and moment of hope came when the US sent a government representative to the consultation in Madrid – and during that meeting noted that the US government had no major objection to the content of the draft code, and subject to a few changes would have no problem endorsing it at the WHA (Taylor and Dhllon, 2011).

4.2 Iterations of the content in the negotiations

In the discussions that led to calls for the WHO Code, Ahmad (2004) suggested that its main objectives should be to:

- link international migration to the health policy goals of individual countries;
- identify countries from which recruitment may be less harmful;
- regulate the international movement of health workers in a way that allows a sending country to produce the extra manpower needed to meet the demands of a receiving country, without injuring its own health system;
- safeguard the rights of recruits in the host country;
- set appropriate guidelines for bilateral agreements on compensation between source and receiving countries.

Reading through the Code adopted in 2010 one notes that most of those ideas were retained, although regulation of international movement is not explicitly included, given support for the human rights of the health worker to move freely, including from bodies such as ICN (ICN, 2001, 2008). As the WHO Global Code of Practice developed through consultations, certain shifts in content and emphasis occurred.

When the first draft of the Code was opened up for public (Internet) discussion, and contributions invited for comment, about 75 comments were received, and of those only six were from the African continent, largely from non-government organisations (NGOs), with only one government comment, from the Namibian Ministry of Health and Social Services (WHO, n.d.). The Africa governments, however, had the opportunity to make substantive inputs into the draft of the Code through the Regional Committee for Africa. In the report to the executive board of January 2010, and the revised draft submitted then, the Secretariat referred to amendments made following inputs from the Regional Committee for Africa (WHO, draft code, 2009). In many instances, these were subsequently included in the final draft discussed at the WHA in May 2010, and are reflected in the final Code.

The first draft version issued for public comment and consultation (2008) had 11 articles, namely objectives; nature and scope; guiding principles; recruitment practices; mutuality of benefits; national health workforce sustainability; data gathering and research; information exchange; implementation of WHO Global Code of Practice; monitoring and institutional arrangements; and partnerships, technical collaboration and financial support. The language used in many of the articles was prescriptive and direct – for instance, "destination countries *should* work with source countries…", and emphasised the needs of developing countries and countries with economies in transition in a number of articles (WHO, draft code, 2008)

A major revision, after public consultations and inputs from the Regional Committees, was the inclusion of a Preamble (WHO, revised draft code, 2009). That version also included 11 articles: objectives; guiding principles; migrant health personnel: responsibilities, rights and recruitment practices (new wording); mutuality of benefits; national health workforce sustainability and retention (reworded); data gathering and research; information exchange; implementation of WHO Global Code of Practice; monitoring and institutional arrangements; and partnerships, technical collaboration and financial support. Much of the language was toned down, for instance, instead of "...should increase their technical and financial support to assist… taking into consideration the needs of developing states and countries and countries with economies in transition that are experiencing health worker shortages" the statement became "….. be encouraged to provide technical and financial support to those countries..." (WHO, revised draft code, 2009).

Summarising the draft code revision process for the executive board, the Secretariat noted that all six regional committees had discussed the key issues of the draft Code, including objectives and guiding principles, mutuality of benefits, national health workforce sustainability, data gathering, research and information exchange; and implementation mechanisms (WHO Report to the EB, 2009). A major change introduced during the revision was the need for a balance between the rights, obligations and expectations of source countries, destination countries and migrant health personnel, ensuring that migration has overall a net positive impact. The revised draft therefore recommended that member states strengthen the balance between the rights of health personnel to leave the countries and the protection of health systems while alluding to self-sustainability by member states. The revised draft included a requirement for member states to report on implementation of the WHO Code, and less prescriptive language used throughout (WHO, 2010).

In resolution AFR/RC59/R6, the Regional Committee for Africa supported the finalisation of WHO Global Code of Practice. The Secretariat report quotes the Regional Committee for Africa as acknowledging the importance of the draft of the WHO Code, and as having asked for a progress report from the Regional Director at the 60th session the next year. This indicated that the interests of the collective of ministers of health from WHO-AFRO region were included.

The final version of the WHO Code differs from the draft discussed by the executive board in a number of areas. The Preamble was shortened and the final version of the WHO Code has

10 instead of 11 articles. Under 5.3 of the December 2009 draft, the regional committee is cited as having suggested inclusion of preventing brain drain, that reference was dropped all together in the final version. Similarly the article entitled mutuality of benefits was deleted (title) although much of the content of this section was transferred to other parts of the Code. The same happened to the article on "national health workforce sustainability and retention," which was reworded "health workforce development and health systems sustainability". Interestingly, whereas "mutuality of benefits" was dropped, article 5 (5.1) states: "the health systems of both source and destination countries should derive benefits from the international migration of health personnel." The spirit of mutuality of benefits was thus maintained, but in less direct language. The other significant change to the draft was a shift of responsibility for ensuring comparable and reliable data from Member States to WHO in the final version.

On the face of it, therefore, it would appear that most of the issues raised were captured in the final code. However by deleting specific reference to mutuality of benefits, the message was sent that whatever reference to benefits was retained was not as significant. Curiously, all three versions of the WHO Code, the two drafts and the final, make no specific reference to compensation, which was the starting point for the African call for a code of practice on international recruitment. Also noteworthy is the fact that the second draft and final versions make reference to ethical principles or ethical recruitment more often than did the initial draft, which mentioned it in only one instance. In that respect, then, the WHO Code may have become stronger in language calling for ethical conduct regarding recruitment of health personnel – the ultimate aim of a voluntary code of practice.

The institutional and legal arrangements for implementing and monitoring the WHO Code are laid out in the several articles (WHO, 2010). Each member state is required to designate a national authority responsible for the exchange of information on implementation of the code and inform WHO accordingly. It is the designated authority that is responsible for communicating directly with other designated authorities and WHO Secretariat and is responsible for submission of reports. The reporting period was established as every three years, but with an initial report within two years after adoption of the Code. WHO is expected to establish, maintain and publish a register of designated national authorities.

As a step in the implementation of the Code, member states are encouraged to incorporate the Code into applicable laws and policies, and asked, 'to the extent possible,' to encourage and promote good practices among recruitment agencies, by using only those agencies that comply with the guiding principles of the Code. The institutional and monitoring provisions are included in Article 9 – reiterating the reporting requirement for member states and asking the DG to keep under review the implementation of the Code, the DG to support information exchange through the designated authorities, and the DG to periodically report to the WHA.

The final article on partnerships, technical collaboration and financial support calls for collaboration among member states and other stakeholder to strengthen their capacity to implement the objectives of the Code. Similarly it encourages "international organisations, international donor agencies, financial and development institutions, and other relevant organisations" to provide technical and financial support toward implementation of the Code, and to support health systems strengthening. There is also encouragement for member states to examine ways of supporting developing countries and countries with economies in transition to strengthen their health systems (WHO, 2010).

In keeping with its status as a voluntary, non-binding code, the WHO Code does not contain any explicit language on the legalities, except to ask that member states implement the provisions to the extent possible or align it with existing legal and policy frameworks. Mackey and Liang (2012) describe the Code as international soft law that is a relatively flexible non-binding instrument that does not include enforceable provisions and lacks incentives for

participation by high-income countries. As a non-binding code it aims to maximize benefits and minimize negative factors of healthcare worker migration, protect the rights of individual health worker migrants, and strengthen health systems (WHO, 2010). It also encourages the development of bilateral and multilateral agreements to support these overall goals (McColl, 2008).

The effectiveness of this form of international soft law is being critically tested now. Preliminary empirical studies report the large majority of high-income countries, including Australia, Canada, United Kingdom, and the USA, have not made meaningful progress in changing or influencing policies as a result of the Code (Edge and Hoffman, 2011). Two years after adoption of the Code, 69 countries had designated representatives to assess the Code provisions, and only Norway had taken steps to implement the Code (Taylor et al, 2011). We were not able to access country reports submitted to the WHO Secretariat, as required by the Code, a gap that will have to be filled through the next phase of the study.

5. Discussion

Through this review we have provided an overview of the documented context of the health worker crisis and the contribution of health worker migration. We have provided some insight to the response to migration by stakeholders at the global/international level, within Africa, and by specific countries through bilateral agreements. The review also presents a glimpse into the processes and role players that shaped the development of the Code, the changes in drafts that took place as the Code was negotiated and reflects briefly upon what has happened since the Code was adopted. The study being implemented is looking further into this to learn about the role and relevance of soft instruments like the Code and the role of monitoring processes in diplomacy.

We used the policy triangle to explore the context, content and process related to the Code. Our approach relied on documents that were accessible via the Internet, hence we missed out on country reports to WHO Secretariat (which are restricted access), and any reports on some of the codes and agreements that were not in the public domain via the Internet. Those knowledge gaps will be the subject of our engagement with stakeholders at national level and through policy dialogue forums.

The context of high, health worker migration south-to-north and a realisation that such mobility undermined health systems led to calls for attention to the issue, as did a perception of net negative outflows of resources from low- to high-income countries through this. Significant evidence was gathered in the JLI and other processes to spotlight the crisis. The countries most affected by the crisis found voice in the international arena and, in the process, shaped the Commonwealth Code and subsequently called for the WHO Code.

The Code was developed through negotiations at various levels – hence common positions adopted by African health ministers provided the momentum for the Commonwealth Code, which in turn was a precursor to the WHA resolution calling for the Global Code. The WHO Secretariat then enlisted the collaboration of other stakeholders, including GHWA, HWAI and the Health Workforce Migration Policy Initiative (HWMPI) in developing the draft. The draft was subject to extensive consultation, and many inputs were received and amendments made. There were also crucial consultations, including one just before the 2010 WHA, where strategies were agreed on how to proceed at the WHA. There was also support and encouragement from other global processes, including the G8 Summit in 2009, where WHO was asked to develop a Code that promoted an equitable balance of interests among health workers, source countries and destination countries (Khadria, 2010).

Over the years, the actors in developing the Code have included core ministries of health from the developing world who initiated calls for action on the HRH crisis. The global community – in the form of researchers and experts (e.g. through the JLI and HWAI), and professional organisations such as ICN and WONCA – have kept the focus on the issue as well. Individual health workers contributed over time, through engagement with policy makers and through contributing to the debate on the HRH crisis. At the microlevel, the specific actors (individuals) may have changed, but the roles may not have changed, though this was not clear through the review.

As aptly stated by Taylor and Dhillon (2011), the Code provides a global architecture that includes ethical norms and institutional and legal arrangements to guide international co-operation on the issue of health worker migration and serves as a platform for continuing dialogue.

The dialogue in the lead up to the Code development, during its draft stages, up to the last drafting process at the WHA in May 2010, helped keep the issue of health worker migration and the crisis high on the global political and development agenda. This made discussion of the health worker crisis a mainstream issue and ensured that resource mobilisation for the health workforce was not a peripheral issue. As observed by Dr Mubashir Sheik of the Global Health Workforce Alliance:

> *At the global policy level, the need to strengthen the health workforce was highlighted as a precondition to improve health outcomes by nearly every health and development event in the past few years, from G8 and African Union summits to international conferences on AIDS and on maternal, newborn, and child health* (Sheik, 2011).

It became common language to refer to lack of skilled health workers as a binding constraint to development, linking low HRH densities to challenges in many countries in attaining the MDGs (JLI, 2004; Chen and Boufford, 2005; Dovlo, 2005; Dayrit et al, 2008; Labonte et al, 2007). The use of language such as “brain drain”, “looting skilled health workers”, “perverse subsidy of the North by the South”, “the North giving with one hand and taking away with another” – all contributed to the force of a justice perspective and moral argument.

Connell and Buchan (2011) note the complex ethical, financial and health questions in context of the brain drain. They argue that the right to health does not simply involve nation states’ obligations, but also obligations in countries recruiting health workers, raising considerations of transnational social justice. They cite compensation payments, encouraging return of overseas migrants, stimulation of remittances flows, twinning institutions in the North and South and the code of practice for recruitment.

Provisions of the Code called for strengthening national health workforces, for bilateral co-operation, and for collaboration across countries to ensure access to skilled health workers globally. There is a significant difference in the ability to leverage these provisions between countries. No documentation was found indicating that those with weaker capacity had yet used the Code to bargain for a better deal with countries with stronger capacities. Agreements within Africa reported in this review include such provisions, but were negotiated before the WHO Code.

Earlier instruments and position statements from African countries (e.g. SADC and ECSA HC pronouncements) explicitly called for compensation. The calls for reparations/compensation aimed to reverse the reverse foreign aid from poor to rich countries (PHR, 2004). Some civil society organisations played a stronger role in the development of the Code, including Realising Rights and HWAI, and these organisations also promoted ethical recruitment (Taylor and Dhillon, 2011). Civil society was in favour of

some form of compensation. The reluctance of the countries in the North to accept any language that included compensation led to the watering down of the Code. Compensation and reparations were suggested as a reason for why Canada, UK and Australia did not sign the Commonwealth Code (Nullis-Kapp, 2005; Bach, 2003; Pagett and Padarath, 2007).

During the negotiations, one of the last clauses to be dropped was one referring to mutuality of benefits. Countries in the North were also not eager to accept the provisions on reporting on the Code, and only did so as a compromise (after winning the deletion on mutuality of benefits), and in response to sustained pressure from the African countries (Taylor and Dhillon, 2011).

The non-binding nature of the Code is a weakness, but was a reflection of the political forces, with many northern countries unwilling to support a legally binding instrument, in part due to the complexity of the issue of health worker migration. The draft published by WHO drew heavily on existing codes and bilateral agreements, which were also voluntary and non-binding. The paper reports on the constraints to enforcement from other voluntary codes that have no legal status, no sanctions for non-compliance, no data collection and monitoring systems and no formal watchdog bodies. The WHO Code does address some of these shortfalls. However, Connell and Buchan (2011) argue that more may be achieved through countries working together than through the global instruments such as the WHO Global Code.

The Code does provide an ethical standard, has raised global awareness of the ethical considerations in the recruitment of health workers, and brought the issue of health worker migration into mainstream discussions. To the extent that the Code now imposes an ethical standard, the implementation and monitoring process will determine its usefulness, as will the engagement by civil society to ensure accountability in implementation of its provision and intentions.

It is early days yet. There are many possible reasons for the relative lull in reporting and implementation observed in 2012/3. Some argue that it reflects that migration did not have the level of negative impacts as portrayed (Clemens, 2007). It may reflect the range of initiatives already in place to alleviate the crisis in the most hard-hit countries. There may be disillusionment in the weaker formulation on mutuality of benefits, compensation and its voluntary and non-binding nature. The reasons will need to be obtained through follow-up study and interviews. The extent to which the final Code as adopted represents the expectations of African countries, the factors affecting its implementation and the usefulness of the current monitoring and reporting process to raise and address impacts of health worker migration on health systems will be explored in the next phase of the work.

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7. Abbreviations

ACHEST	African Center for Global Health and Social Transformation
AIDS	Acquired Immune Deficiency Syndrome
ASEAN	Association of South-East Asian Nations
AU	African Union
BMA	British Medical Association
DG	Director General
ECSA HC	East, Central and Southern African Health Community
EQUINET	Regional Network for Equity in Health in east and southern Africa
ESA	East and Southern Africa
EU	European Union
GHWA	Global Health Workforce Alliance
HCP(s)	Health Care Professional(s)
HCW(s)	Health Care Worker(s)
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HRIS	Human Resource Information System
HWAI	Health Workforce Advocacy Initiative `
HWMPI	Health Worker Migration Policy Initiative
ICN	International Council of Nurses
IMF	International Monetary Fund
IOM	International Organisation for Migration
JLI	Joint Learning Initiative
MDGs	Millennium Development Goals
MoU	Memorandum of Understanding
NDOH	National Department of Health (South Africa)
NEPAD	New Partnership for Africa's Development
NHS	National Health Service (UK)
OAU	Organisation of African Unity
OECD	Organisation for Economic Co-operation and Development
PHC	Primary Health Care
SADC	Southern African Development Community
SSA	Sub-Saharan Africa
UK	United Kingdom
UN	United Nations
USA	United States of America
WHA	World Health Assembly
WHO	World Health Organisation
WONCA	World Organisation of Family Doctors

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity-oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair financing of health systems
- Valuing and retaining health workers
- Organising participatory, people-centred health systems
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET from the following institutions: TARSC, Zimbabwe; CWGH, Zimbabwe; University of Cape Town (UCT), South Africa; Health Economics Unit, Cape Town, South Africa; MHEN Malawi; HEPS and CEHURD Uganda, University of Limpopo, South Africa, University of Namibia; University of Western Cape, SEATINI, Zimbabwe; REACH Trust Malawi; Min of Health Mozambique; Ifakara Health Institute, Tanzania, Kenya Health Equity Network; and SEAPACOH

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