The engagement of east and southern African countries on the WHO Code of Practice on the International Recruitment of Health Personnel and its implementation

Yoswa M Dambisya[1], Nancy Malema[1], Charles Dulo[2], Sheillah Matinhure[3], and Patrick Kadama[4]

[1]University of Limpopo, South Africa
[2]Mustang Management Consultants, Kenya
East, Central and Southern Africa Health Community, Tanzania
[4]African Center for Global Health and Social Transformation, [3]Uganda











Regional Network for Equity in Health in East and Southern Africa (EQUINET)

EQUINET DISCUSSION PAPER 103
June 2014

With support from IDRC (Canada)

Table of contents

Executive summary **2**

1. Background **4**

2. Methods **7**
2.1 Literature review 7
2.2 Fast-talk session 8
2.3 Survey 8
2.4 Country case studies 9

3. Findings **11**
3.1 Policy interests of African countries and the Code 12
3.2 Use and implementation of the Code in east and southern Africa 16
3.3 Monitoring the Code 22
3.4 Other findings 23

4. Discussion **23**
4.1 Policy interests of African countries and the Code 23
4.2 Use and implementation of the Code in east and southern Africa 24
4.3 Monitoring the Code 28
4.4 Learning from South Africa's response 28

5. Conclusions **29**

6. References **31**

Abbreviations **34**

Cite as: Dambisya YM, N Malema, C Dulo, S Matinhure, P Kadama (2013) 'The engagement of east and southern African countries on the WHO Code of Practice on the International Recruitment of Health Personnel and its implementation', EQUINET Discussion paper 103, EQUINET, Harare.

Acknowledgements
The authors wish to acknowledge the contributions of Dr Rene Loewenson and Bente Molenaar in the design, input to background country case study reports and to Andreas Papamichail and Rene Loewenson in the conceptualisation and first drafting of this synthesis report.

We thank the respondents and key informants through all the processes for their time and valuable information and Rose Kumwenda Ngoma for her assistance with the Malawi country study. The final report has been peer reviewed by Ron Labonte, Magda Awases and Chantal Blouin whose inputs are most appreciated. This report is part of the EQUINET programme on global health diplomacy co-ordinated by Training and Research Support Centre with Carleton University and supported by the IDRC, Canada.

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 synthesis report 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 African policy actors and stakeholders within processes of health diplomacy. This includes work on the Code that seeks to address how the policy interests of African countries informed the Code, and how the Code has been used, implemented and monitored in countries in the ESA region, particularly in relation to the concerns that motivated the Code.

The report compiles evidence from various research strategies undertaken to examine the above issues surrounding the WHO Code. These were:

i. an extensive review of literature on codes of practice, bilateral and multilateral agreements pertaining to human resources for health, and scientific papers relevant thereto in 2013;
ii. a 'fast-talk' session at the 66th World Health Assembly in May 2013 involving stakeholders from African countries to gauge views and concerns relating to the Code;
iii. a region-wide questionnaire survey implemented in 2013 to obtain views of government informants on issues affecting and measures for managing health workers, including migration of health workers in ESA countries; and
iv. three country case studies undertaken in Kenya, Malawi and South Africa concluded in 2014 to provide an in-depth exposition of perspectives on the Code and its implementation.

By the time of this study, regional stakeholders did not view external migration as amongst their biggest concerns in terms of the crisis of human resources for health (HRH). Rather, concerns pertained to issues of internal migration (rural to urban and public to private) and absolute shortages of health professionals. It must, however, be taken into consideration that data on health worker migration are not readily available, as admitted by stakeholders, which may have resulted in an under-appreciation of the gravity of the problem. Nevertheless, it appears that external migration and active recruitment of health professionals are not currently as large a concern for the policy actors interviewed as it was ten years ago, when countries in the region first made the call for regulation of such recruitment.

Respondents to the research had been involved at variable levels in the diplomacy surrounding adoption of the Code. Some raised concerns about the final provisions of the Code, including its lack of provisions for compensation or specific provisions on resource transfers, and its voluntary, soft law, nature. The views expressed suggested that African policy interests were not all included in the Code, or not included to a sufficient extent. This was further indicated by content review of the Code against positions stated during the negotiations.

In terms of implementation of the Code, there was some variability across the case study countries. In terms of dissemination and understanding of the Code, Kenya had widely disseminated the Code amongst relevant stakeholders. In Malawi and South Africa there was little, if any, dissemination and knowledge of the Code. The regional questionnaire similarly indicated relatively low levels of dissemination to relevant stakeholders.

Even in those countries that had disseminated the Code, there was limited report of measures to implement it. Only one country in the region reported having a designated national authority to guide Code implementation and report on its progress. Respondents highlighted various barriers to Code implementation, including:

- lack of regional coordination;
- lack of strong leadership on the Code from the WHO;
- perceptions of inadequacy of the Code;
- lack of preparedness for its implementation;
- poor mobilisation of national level stakeholders;
- little publicity as to the progress of Code implementation;
- burn out of those involved in the negotiations for the Code;
- overburdened HR departments; and
- a high turnover among key role players.

Many respondents pointed to the signing of bilateral agreements in 'the spirit of the Code' as a positive response to health worker migration. This positive response can partly be attributed to the Code. The Code itself advocates for bilateral agreements to aid its implementation, and, given that bilateral agreements have stronger enforceable relevance, they may be important means for achieving Code objectives. Furthermore, many of the respondents expressed concern about compensation to source countries and that bilateral agreements may be a useful tool for accessing compensation.

Given the lack of implementation of the Code, reporting on its progress was also minimal. One issue is the lack of data on health workers, which is a hindrance in tracking Code implementation and fully appreciating the extent and impact of health worker migration. Further, as with implementation, a major obstacle is the lack of a clear focal point or responsible authority dealing with the Code.

Outside of the Code, South Africa appears to have had some success in addressing the issue of health worker migration, and may be a useful example for other countries in the region to learn from. South Africa appears to have stemmed active recruitment of its health care professionals, in part, by introducing an Occupation Specific Dispensation. This has kept many health care professionals in the country by substantially increasing wages to incentivise staying in South Africa to work.

Nevertheless, given the dynamic nature of health worker migration flows in the region, including South Africa, we suggest that the Code be seen as a mechanism through which to manage future HRH challenges. Evidence from the research shows that implementation and monitoring of the Code have been severely lacking since its adoption. Implementation plans, issues and capacities may need to be given more attention in future global health negotiations, if a global instrument like the code is to have positive effect. This includes appointing designated authorities to drive implementation and reporting processes and strengthening responsible departments in ministries of health, together with greater involvement of regional organisations such as ECSA HC, SADC, Economic Community of West African States ECOWAS, WHO in plans for implementation and of civil society and academia in tracking and supporting implementation.

1. Background

The global shortage and maldistribution of key health workers has been most marked in sub-Saharan African countries, with severe implications for the region as a whole. It is 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). As such, 37 of the sub-Saharan African (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; 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). Under-investment in the social sector, which accelerated in the 1980s and 1990s as part of the structural adjustment programmes of the Bretton Woods institutions (IMF/World Bank), 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 seeking greener pastures became more appealing for health workers from the region (Kuehn, 2007). In addition to the problems prevailing 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).

In addition to the severe implications for health in the region, a recent paper by Mills et al. (2011) reported that African countries lost an overall estimated return from investment for all doctors currently working in destination countries of US$2.17bn, with costs per country ranging from $2.16mn for Malawi to $1.41bn for South Africa. South Africa and Zimbabwe face the largest losses as a share of gross domestic product (GDP). Simultaneously, there was a significant cost benefit to destination countries in recruiting migrant doctors, with a cost benefit in the United Kingdom of $2.7bn and in the United States of $846mn. Other studies have also shown considerable human and financial costs to African countries as a result of health worker migration (JLI, 2004; Kirigia et al., 2006; Mensah et al., 2009; Muula and Panulo, 2007; Muula et al., 2006; Pagett and Padarath, 2007). Mackintosh et al. (2006) have termed the investment that source countries forego in the outflow of their health workers a ‘perverse subsidy’. While the data produced have been contested in some quarters (Clemens, 2011), it is not only the numbers that are in contention; indeed Clemens (2011) argues that outward HRH migration creates a net benefit even for source countries. The conclusion remains the same: African countries lose significant resources, both human and financial, due to the migration of health professionals. The HRH crisis is thus multi-faceted, with a range of factors contributing to its perpetuation.

This migration of health professionals from low-income countries with high-disease burdens and low densities of health personnel eventually attracted international attention. It became the subject of research and discourse in global diplomacy, such as at the World Health Organisation (WHO), United Nations 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).

African countries were at the forefront of raising the issue of health worker migration as documented in EQUINET Discussion paper 26 by Gilson and Erasmus (2005) and other papers (Chen and Buofford, 2005; Taylor and Dhillon, 2011). Diplomatic efforts to address the issue gathered pace in 2001 as discussions within the Southern African Development Community (SADC) led to a strongly worded ministerial statement which argued that "the active and vigorous recruitment from developing countries…could be seen as looting from these countries and is similar to that experienced during the periods of colonisation when all resources, including minerals, were looted to developed countries" (SADC, 2001). Following this, a long diplomatic process was begun across a range of regional and international institutions, as this timeline of key developments illustrates:

- **2002:** A consultative meeting in early 2002 with African ministers of health at which the WHO, World Bank and UNESCO agreed to set up a task force on HRH development in Africa that would, among other things, assist countries with strategy development and monitoring of health workers.

- **2003:** The 2003 New Partnership for Africa's Development (NEPAD) Health Strategy, calling for the development of an international agreement that would underpin an ethical recruitment approach, complemented by actions to ensure availability and retention of health staff and to counter the push factors in migration.

- **2003:** Ministers of health from the Commonwealth adopt a code of practice for the international recruitment of health workers and a companion document that fleshes out the relatively brief code of practice (Commonwealth Secretariat, 2003).

- **2003:** African ministers of health, at the 53rd session of the WHO Regional Committee for Africa, pass a resolution to table a resolution on HR migration at the 57th WHA.

- **2004:** African ministers of health in the 2004 World Health Assembly (WHA), call for, among other things, strategies to address the negative consequences of migration and policies to enhance retention and bilateral agreements for the creation of exchange programmes, as a way of managing migration. The WHA in 2004 adopted Resolution 57.19 mandating the director-general of the organisation to oversee the development of a non-binding code of practice on the international recruitment of health workers in consultation with member states and other relevant partners.

- **2004:** Discussion of the African HRH crisis within the high-level forum on the health MDGs held in Abuja, Nigeria, in December 2004.

- **2005:** A meeting of SADC in early 2005 identifying HRH issues as one of the top priorities for the region.

- **2005:** African ministers of health at the 2005 WHA supporting a resolution, tabled by South Africa on behalf of the African health ministers, calling on the WHO director-general to ensure full implementation of the 2004 resolution.

- **2003-2010:** The East, Central and Southern African Health Community (ECSA), formerly the Commonwealth regional health community secretariat, discuss and adopt resolutions related to health workers in meetings from 2003-2010 (ECSA HC, n.d., 2008, 2009, 2011 and 2012)

- **2008:** A WHO initiated multi-stakeholder process is undertaken in 2008, with drafts developed and reviewed through national and regional consultation in all six WHO regions.

- **2010: '**The Code of Practice on the International Recruitment of Health Workers' debated and adopted at the 2010 World Health Assembly. The resolution marked the first time that the WHA had invoked the constitutional authority of WHO to develop a non-binding Code since the 1981 'International Code of Marketing of Breast Milk Substitutes'.

'The WHO Code of Practice on the International Recruitment of Health Workers' (hereinafter referred to as 'the WHO Code' or just 'the Code') was thus adopted in May 2010 after a decade of diplomacy. It is a voluntary instrument that lays down global principles and practices around the international recruitment and migration of health personnel. The objectives of the WHO Code are:

1. To establish and promote voluntary principles and practices for the ethical international recruitment of health personnel;
2. To serve as a reference for member states in establishing or improving the legal and institutional framework required for the international recruitment of health personnel;
3. To provide guidance that may be used where appropriate in the formulation and implementation of bilateral agreements and other international legal instruments;
4. To facilitate and promote international discussion and advance co-operation on matters related to the ethical international recruitment of health personnel as part of strengthening health systems.

While the African voice was instrumental in the development and lobbying for the adoption of the WHO Code, it is not clear to what extent African countries have been prepared for, and capable of, implementing and monitoring it. By September 2012, 81 countries had appointed designated national authorities, and 48 had reported to the secretariat. However, among those, only one African country had submitted a report and only 13 had designated authorities (WHO, 2013). Implementation is not just a question of the Code being applied domestically, but also a question of utilising the Code as a negotiating tool in global health diplomacy with a view to seeking the fulfilment of the spirit and the letter of the Code. The optimism and flurry of activity that characterised the development of the WHO Code have been conspicuously absent in implementing and monitoring it – leading one to question whether African countries perceive the Code as a sufficient response to their concerns. If it is viewed as sufficient, then why have those countries that pushed for the creation of the Code relaxed their efforts since its adoption?

To examine these issues, the following questions guided this study on the engagement of sub-Saharan African countries on the Code:

1. To what extent were the policy interests of African countries incorporated (or not incorporated) into the Code through African diplomacy around the Code;
2. What were the perceived factors affecting how well African policy interests were present in the final draft of the Code?
3. To what extent do countries in east and southern Africa see, and how are they using and implementing, the Code as an instrument for negotiating foreign policy interests related to their HRH concerns?
4. What are/were the motivations, capabilities and preparations for using the monitoring of the Code to engage in the diplomatic environment on African policy interests related to their human resource for health (HRH) concerns?

This synthesis report compiles evidence across a range of processes undertaken as part of this comprehensive study of the Code and its application by sub-Saharan African countries. The report proceeds as follows. Section 2 describes the methods used across the six processes undertaken in this study. These were: a literature review on codes of practice on international recruitment of health professionals in global health diplomacy, a fast-talk session undertaken at the World Health Assembly in May 2013, a regional questionnaire survey on involvement in negotiation, use and uptake of the WHO Code, and three country case studies undertaken in Kenya, Malawi and South Africa on their role in negotiation and use of the WHO Code. Section 3 presents the findings from the six processes, organised by the three main research questions listed above, with an additional category for any other findings. Finally, Section 4 offers a discussion of the findings laid forth in Section 3.

This work forms part of the 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 broad aim of the programme is to identify factors that support the effectiveness of global health diplomacy in addressing selected challenges to health strengthening systems in eastern and southern Africa, disseminate the learning and use this to strengthen the capacity of African policy actors and stakeholders within processes of health diplomacy.

2. Methods

The study was undertaken after obtaining ethics clearance from the University of Limpopo (Turfloop Campus) research ethics committee (TREC), while permission and verbal consent were obtained from all informants. The different approaches were intended to help arrive at a comprehensive picture by triangulating evidence from country studies, policy survey and dialogue and desk review.

2.1 Literature review

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 national levels in the 16 ESA countries.

Literature on the history, policy processes, negotiations, capacity, progress since adoption and any scientific papers related to the Code were sought out. 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 players contributed to the processes, content and final form of the Code.

The review was conducted on 103 documents, covering the period 1970-2012, and was ultimately based on 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. 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. A full account of the methodology for the literature review has been presented separately (Dambisya et al., 2013).

2.2 Fast-talk session

The 66th World Health Assembly (WHA66, May 2013) marked three years since the WHA had adopted the Code and the first occasion for the WHO secretariat to report on progress in its implementation.

Ahead of WHA66, the EQUINET GHD team working on Code implementation had the opportunity to interact with policy makers from the ESA region to gauge their views and identify any issues of concern they had on the Code. The team used that, together with the preliminary work done up to that point, to identify four broad questions for exploration using a 'fast-talk' – question and answer – style of informal exploration in interactions with stakeholders during the Assembly. The broad questions were adapted from the main questions for the study, but for brevity were rephrased to focus on: (i) the barriers countries were facing in implementing the Code; (ii) what had enabled those who had made progress in implementing the Code to do so; (iii) what inputs countries needed to benefit from the Code; and (iv) what HRH recruitment/ migration/ retention issues countries were facing that are not reflected in the current content of the Code.

The team provided information on the questions and used this to inform and engage African countries and others at the WHA.

To that end, an opportunistic approach was adopted, where stakeholders were engaged as the chance arose during the course of the assembly. In the process, brief discussions were held with about 15 stakeholders from the region and from international organisations; none of the 15 stakeholders was subsequently included in the survey or country study interviews. In addition, a side session was held where an EQUINET brief was presented. This meeting was used to delve into the identified question areas during the presentations and ensuing discussions. Notes were taken during the fast-talk sessions

2.3 Survey

A 33-item semi-structured questionnaire was used to obtain views of key informants from countries in the region. The questionnaire explored various areas to address the three research questions. The questionnaires were self-administered and took approximately 25-35 minutes to complete. The intention was to obtain the views from HRH directors/managers from the 16 countries covered by EQUINET in the east and southern Africa region (Uganda/Kenya in the north to South Africa in the south). Responses were received from 14 respondents from nine out of 16 countries (56%). The poor response rate to the survey could be because countries had not appointed focal points or designated authorities specifically to deal with the Code and, as became apparent in the country studies, those approached may not have had the answers to most the questions asked. The perception that migration of health professionals was no longer the problem it was 10 years earlier may also have contributed to the apathy in the countries.

The 14 respondents from nine countries are shown in *Table 1*. The questionnaire did not receive a response from the following countries: Angola, Botswana, Democratic Republic of Congo (DRC), Malawi, Mozambique, Namibia, and Zambia. Whereas that may be a limitation of the survey, more than half the target countries responded, providing a basis for analysis alongside other findings from other components of the study. Any bias on account of the no response from some countries will similarly be balanced out by other aspects of the study.

Table 1: Questionnaire survey respondents

Country	Number of respondents
Kenya	2
Lesotho	1
Mauritius	1
Seychelles	1
South Africa	1
Swaziland	1
Tanzania	3
Uganda	3
Zimbabwe	1

The original intention was to have one respondent per country. But some respondents felt unable to address all aspects of the questionnaire and recommended that we seek another opinion from the country, hence the multiple responses from some of the countries – which helped triangulate the views.

The questionnaires were sent out first by email using a database of HRH directors/managers obtained from ECSA HC (in the 10 ECSA HC member states). Others were obtained through previous work in the region to the 16 ESA countries, except Angola, DRC and Madagascar where no reliable addresses were obtained. That was followed up by a repeat emailing of the same after two weeks, on two separate occasions. In addition, the questionnaire was uploaded onto the web, and those previously emailed the questionnaire were asked to complete it via the Internet for convenience. The response to both was poor – with only three web-based responses (from two countries) and one response to the emailed questionnaire. The strategy was then changed to get respondents to complete the questionnaire at other meetings – e.g. the GHD preparatory meeting in Malawi (June 2013), a WHO meeting on staffing norms and standards (March 2013) and the WHA (June 2013). Even then, most of those approached felt they were not informed or empowered enough to complete the questionnaire. In many instances, the questionnaire was accepted with the promise that it would be completed by the appropriate person 'back home' and sent back. That did not happen even in a single instance; in spite of various reminders, no completed questionnaire was returned after any of those meetings.

We consider the nine countries to give a reasonably broad spread of the situation in the region. Most of the respondents (11 out of 14) were attached to ministries of health (including a recently retired director of HR), while one was from a university, one belonged to a professional organisation/association and one worked with one of the partner organisations involved in HRH (HRiS). None of the respondents completed the questionnaire fully; all had some missing entries. Even where, "I am unable to answer this question," was an option, some of the respondents chose to leave the question unanswered.

2.4 Country case studies

Three separate country case studies were conducted in Kenya, Malawi and South Africa between April and October 2013. These case studies aimed to provide an in-depth exposition of the perspective from these three countries based on experiences of key stakeholders who were or who ought to have been involved in global diplomacy on HRH, including the Code.

To that end, the studies deliberately targeted those involved in various aspects of HRH. Given the HRH challenges these three countries face, the high cost of HRH migration and the need for a robust HRH to overcome the disease burden and meet targets such as the MDGs, Kenya, Malawi and South Africa were appropriate choices to form part of this study on the WHO Code.

The case studies were qualitative and based on key informant interviews. The study in Malawi was supplemented by a questionnaire survey to ensure maximum response by the stakeholders, some of whom were not available for face-to-face interviews. The original intention was to conduct the study exclusively through face-to-face in-depth interviews, but it proved difficult to get all identified stakeholders for interviews - many opted/suggested that a questionnaire they could complete at their convenience would be more practical.

Informants were drawn from various categories of stakeholders identified through a stakeholder analysis and based on the involvement and familiarity of the (potential) informants with the HRH situation in the country. Some of the informants indicated others who would have information relevant to the study. The categories identified through the stakeholder analysis were:

- Health professionals
- Professional associations/organisations
- Regulatory bodies/councils
- Training institutions
- Government departments responsible for health (ministry or provincial department)
- Recruitment agencies

Table 2 indicates the number of interviews conducted across all three case studies.

In addition to the interviews, nine questionnaire responses were received in the Malawi case study; the other two country studies were based on informant interviews alone.

Interviews were conducted with the help of a standard key informant interview guide, with modifications to suit the category of informant. The interviews were captured on a voice recorder and field notes were written to capture non-verbal cues. In some interviews, however, respondents were reluctant to be recorded so only field notes were taken. Data were anlysed using Techs' open coding method as described in Creswell (2011). The interviews addressed the three research questions listed in Section 1. Thus, questions explored the HRH context in each country, country involvement in development of the Code, knowledge about the Code, progress and processes surrounding Code implementation, and usefulness or otherwise of the Code.

Table 2: Stakeholders interviewed in country case studies

Category of stakeholder/key informant	Country	Number targeted for inclusion	Number interviewed	Number lost to interview
Health professionals	Kenya	2	2	0
	Malawi		2	
	South Africa	12	9	3
Professional associations / organisations	Kenya	2	0	2
	Malawi		2	
	South Africa	4	3	1
Regulatory bodies / councils	Kenya	3	0	3
	Malawi		2	
	South Africa	5	3	2
National Department of Health	Kenya	4	5	1
	Malawi		2	
	South Africa	3	2	1
Recruitment agency	Kenya	0	0	
	Malawi	0	0	
	South Africa	2	1	1
Training institutions	Kenya	2	1	1
	Malawi			
	South Africa	4	2	2
Total number of interviews	Kenya	14	8	6
	Malawi	20	17	3 (9 completed questionnaires)
	South Africa	30	20	10
	TOTAL	64	45	19

3. Findings

Evidence gathered across the various processes used in this study, as described above, illuminates various aspects of the Code and its perception and implementation within the respondent countries. This section synthesises the evidence to draw out common issues across the processes and highlight any differences.

The findings are organised using the three main research questions as outlined in Section 1. They are then analysed and any key points arising from the evidence are drawn out in the corresponding categories in Section 4 of this report.

3.1 Policy interests of African countries and the Code

This section presents the findings of the processes relating to the extent to which the policy interests of African countries were or were not incorporated into the Code in the diplomacy around the Code. Research strategies sought to determine the main policy interests of health services in the region and, subsequently, to examine how the Code does or does not address these interests.

Across the three country case studies, respondents were asked to indicate the most critical issues their respective countries face in relation to HRH, an approach also taken in the survey. In all three countries, respondents and informants raised concerns about rural/urban disparities and absolute shortages of health professionals. This was also true in survey responses and during fast-talk sessions. Various other issues featured in two of the case study countries and in the survey: low salaries, low morale, and low productivity (Kenya, Malawi and survey) and poor facilities and lack of opportunities for qualified personnel (Kenya, South Africa and survey). In the case of South Africa, the lack of opportunies was ascribed to a lack of resources. Furthermore, issues such as low productivity (Kenya and survey), lack of recognition for the work of health care professionals (Kenya), poor living conditions (South Africa and survey) and low output from training institutions (South Africa) were also raised. All in all, a comprehensive list of challenges in HRH emerged through the processes.

External migration (whether to other African countries or outside Africa) did not feature high on the list of priorities for the respondents in the case studies, although it was raised as a concern by informants in Malawi and Kenya, but not South Africa. Rather, internal health workforce migration (rural to urban or public to private) seems to be a bigger concern amongst health professionals in these countries. The survey confirms that rural-urban disparities, low remuneration and absolute shortages are the prime HRH challenges in the region, and that most of the countries in the region did not consider outward migration among the top challenges. Outward migration was in the top three challenges in only two of the nine countries from which survey respondents originated.

That finding, however, must be interpreted with consideration for the admission by most respondents that data on health worker migration were not readily available or accessible. It has been reported elsewhere that the lack of reliable statistics on health worker migration dogs efforts at understanding the extent and consequences of such migration (Dussault and Franceschini, 2006), a view confirmed by this study. The lack of data on health worker migration is not endemic to the African region, as it would appear to be equally grave in developed countries as it is in developing countries (Chikanda, 2006; Connell and Buchan, 2011). Hence, lacking full knowledge of the extent of the problem may have led some respondents to downplay migration as an issue within their countries.

Nevertheless, the sentiment of health worker migration being lower down on the list of HRH challenges appears to be a significant shift from the position(s) adopted by the region about 10 years ago when calls were made for countries in the North to stop stealing health workers from the region (Ehman and Sullivan, 2001; Johnson, 2005; Dodani and LaPorte, 2005; Dovlo, 2005). It also supports, and is complemented by, findings from the fast-talk session where informants were of the view that HRH migration was not the problem it was a decade earlier.

In addition to the determination of the actual health policy interests of respondents summarised above, research also sought to draw out the extent to which the policy interests of African countries were actually reflected in the Code. In terms of involvement in the diplomacy that led to the adoption of the Code, some informants from the case study in Kenya and some respondents to the survey indicated that either they themselves or their country in general had participated in the initiation, negotiation, drafting, and adoption of the Code. This was the case with two informants from the Kenya study and one from the South African study. In the Malawi case study, two respondents to the questionnaire alluded to the fact that Malawi had been involved in the adoption of the Code at the WHA, but the actual role of Malawian actors was not made clear. Furthermore, two key informants mentioned the support Malawi rendered through the Africa Group for the adoption of the Code at the WHA, a point that will be raised again in Section 4.1.

As for the actual content of the Code, the study sought to draw out what, if any, national or regional priorities were overlooked in the final version of the Code. Below is a compilation of all concerns that respondents and informants thought the Code ought to address, or ought to address to a greater extent or more forcefully (*Box 1*). The concerns are drawn from the case studies in Kenya and Malawi and from the survey and fast talk.

Box 1: Areas identified by policy actors that the Code ought to have explicitly addressed*

- Compensation to source countries, including support for training health professionals.
- Migration of health workers (brain drain), including control of number of professionals that migrate from each country.
- Migrant health workers' concerns, such as mistreatment of migrant health workers whose rights are violated, denial of license renewals.
- Strengthen the respective boards and councils to monitor health professionals.
- Issues of equity, transparency and accountability in recruitment and deployment.
- Regional registration and bilateral agreements were not addressed properly.
- Sharing of information between countries.
- Ethical concerns, such as health workers who default on bonding contracts.
- Guaranteed return of health professionals who migrate.
- Bonding and community service arrangements.
- Evidence on the impact of HRH migration on health systems in the region.
- Soft law nature of Code; Code ought to have been compulsory.

Source: From component parts of the study referred to in the text.
*Not necessarily in order of importance, same issues raised in all countries.

In the case study of South Africa, there is limited talk of policy interests in the Code. This absence of policy discourse on the Code could indicate the apparent lack of awareness of the Code, disregard for its effectiveness, or a reduced concern for the impact of health worker migration and thus for the necessity of implementing the Code.

The concerns raised by the case study in Malawi are presented with the caveat that even the respondents admitted to lacking an in-depth (if any) knowledge of the Code. In Malawi, six respondents, including those who did not know (of) the Code, felt that major issues were only partially covered in the Code. A disconnect between knowledge of the Code and perception of its shortcomings also arose in the regional survey. The disconnect is noteworthy, and will be further discussed in Section 4.1, while the issue of knowledge and awareness of the Code relates to implementation of the Code, and will be covered in Section 3.2.

In the Kenya case study, three-quarters of the informants felt that the Code had not addressed those policy concerns, while one-quarter said it was useful to address massive brain drain. None felt compensation had been addressed. Informants in the Malawi case study who were knowledgeable about the Code indicated that whereas the wishes of Malawi and other African countries may not have been reflected in the Code as originally hoped for, the final wording of the Code actually accommodated many African positions, and all concerns expressed were included. That was also evident in the literature review where amendments and wording suggested by the Africa region ministers were used in the final version of the Code (Dambisya et al., 2013). Specifically, the WHO secretariat report to the executive board in January 2010 outlined several changes made to the draft Code, as exemplified in Box 2.

When the survey respondents were asked how useful the Code was in addressing foreign policy issues on health worker migration, seven respondents stated that it was useful and may be effective, three stated that it was “business as usual, no effect”, one respondent was not aware how useful the Code was in this regard, while three respondents left the question unanswered. Specifically, the extent to which foreign policy concerns had been reflected in the Code was viewed in various ways, with two saying they were completely covered, four saying they were partially covered, three saying they were largely not covered, and one indicating that they were not at all covered. One respondent did not know, while three opted to leave the question unanswered. Five respondents made no suggestions as to which policy concerns their countries would like to see addressed and whether the Code did so.

In their examination of the Code, Taylor and Dhillon (2011) provide a comprehensive account of its development, 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 (Taylor and Dhillon, 2011).

Box 2: Partnerships, technical collaboration and financial support

Draft version (August 2008)

Article 11: Partnerships, technical collaboration and financial support
11.2 International donor agencies and financial institutions should increase their technical and financial support to assist implementation of this Code, taking into consideration the needs of developing states and countries with economies in transition that are experiencing health workforce shortages and/or have limited capacity to implement the objectives of this Code.

Draft version (December 2009):

Article 11 – Partnerships, technical collaboration and financial support
11.2 International organisations, international donor agencies, financial and development institutions, and other relevant organisations *should increase* their technical and financial support to assist implementation of this Code and support health system strengthening in developing countries and countries with economies in transition that are experiencing critical health workforce shortages and/or have limited capacity to implement the objectives of this Code. Such organisations and other entities *should co-operate* with countries facing critical shortages of health workers and undertake to ensure that funds provided for disease-specific interventions are used to strengthen health systems capacity, including health personnel development. **[Regional Committee for Africa]**

Final Code:

Article 10 – Partnerships, technical collaboration and financial support
10.2 International organisations, international donor agencies, financial and development institutions, and other relevant organisations *are encouraged to provide* their technical and financial support to assist implementation of this Code and support health system strengthening in developing countries and countries with economies in transition that are experiencing critical health workforce shortages and/or have limited capacity to implement the objectives of this Code. Such organisations and other entities *should be encouraged to co-operate* with countries facing critical shortages of health workers and undertake to ensure that funds provided for disease-specific interventions are used to strengthen health systems capacity, including health personnel development.

Source: WHO, 2010 – Draft and Final Versions of Code

On the face of it, therefore, it would appear that most of the issues raised were captured in the final Code. However, specific reference to mutuality of benefits was deleted, so that the remaining reference to benefits was less explicit on the net returns to developing countries. The reference to the mutuality of benefits in the draft versions and the final version of the relevant article are shown in Box 3.

Box 3: The Mutuality of benefits: Text In the drafts excluded from the final version

First Draft (August 2008):

Article 5: Mutuality of benefits
5.1 In accordance with **the principle of mutuality of benefits**, both source and destination countries, should derive benefits from international recruitment of health personnel.

Second draft (December 2009):

Article 5 – Mutuality of benefits
5.1 In accordance with the **guiding principle of mutuality of benefits, as stated in Article 3** of this code, the health systems of **both source and destination countries should derive benefits from the international migration of health personnel**. In developing and implementing international recruitment policies, Member States should strive to ensure that ***the balance of gains and losses of health personnel migration should have a net positive impact on the health systems of developing countries and countries with economies in transition***.

Code final version (May 2010):

Article 5 – Health workforce development and health systems sustainability
5.1 In accordance with **the guiding principle as stated in Article 3** of this Code, the health systems of **both source and destination countries should derive benefits from the international migration of health personnel.** Destination countries are encouraged to collaborate with source countries to sustain and promote health human resource development and training as appropriate. Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers.

Source: WHO: Draft Code and Final Code Versions.

Further, 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. The evidence gathered across the various components of this study supports the perception that certain policy concerns of African countries were not adequately or satisfactorily addressed in the final Code.

3.2 Use and implementation of the Code in east and southern Africa

In addition to examining if and how sub-Saharan African policy interests were incorporated in the Code, the research sought to draw out if and how countries in the region are implementing the Code to serve their national health interests, and if not what barriers are preventing them from doing so.

The first point of interest in the implementation discussion is whether the Code was widely disseminated amongst stakeholders following its adoption. In the Kenya case study, in addition to the aforementioned informants who participated directly in the diplomacy surrounding the Code, five informants reported having read and knowing the contents of the Code, while only one informant indicated that he/she had heard about the Code but did not know its contents.

Conversely, in the South Africa study, which included health professionals who had emigrated but had returned to South Africa, and officials from professional organisations, the national department of health, and regulatory bodies, only one informant was conversant with the Code; otherwise there was a distinct lack of knowledge of the Code, both contents and intent.This lack of knowledge limited meaningful discussion with the informants on the implications of the Code for policy, and of which concerns were or were not properly addressed by the Code's provisions. Only a single informant felt well informed enough to comment on what solutions, if any, South Africa had implemented or was implementing in the context of the Code to mitigate the effects of migration. The need (or hypothesised need) for compensation was not well explored given the paucity of knowledge of the Code.

In the case of Malawi, many respondents admitted ignorance of matters to do with the Code. Of the nine questionnaire respondents in the Malawi country case study, only one indicated having read and become knowledgeable of the Code contents, while one had seen it (and presumably not read), while seven indicated that they had never seen it or heard of it, or had heard of it but were not aware of its contents. This was the more remarkable in view of the fact that these were mainly members of the HRH technical working group who should have been familiar with the Code. Further, in support of the evidence gathered in the case studies, key informants interviewed during the fast-talk sessions admitted that not much effort had been made to engage various local stakeholders.

Turning to implementation, all informants in the Kenya case study raised the point that the country has not adopted specific processes for publicising, disseminating or popularising the Code or held meetings to support stakeholders' interpretation of the Code. They did note that the implementation of the Code is integrated in the health systems strengthening strategy and is linked to other strategies in the national HRH plan geared towards delivery of the essential health package. Some informants pointed to an International health desk as the focal point for matters relating to the Code, and that this may serve as the required authority under the Code. Other informants did not agree that this body could fulfil those functions. Informants highlighted that the Ministry of Foreign Affairs and the Ministry of Education, regulatory councils and the immigration department had all been exposed to the Code, and that copies of the Code had been supplied to relevant stakeholders either as hardcopy or electronic copy, and that there had been multisectoral consultation on the Code.

Furthermore, it emerged that a debriefing session was held after the 2010 WHA and the Code was discussed as an agenda in the technical working group – the HRH interagency co-ordinating committee (ICC) – a mechanism of the Kenyan Ministry of Health. Additionally, documents to guide the Code's implementation had been developed, such as a guide for partners on HRH migration/retention. There was uncertainty amongst informants as to whether a mechanism is in place to work with a designated national authority, with some referring to the HRH ICC as this authority. Other informants were not aware of this mechanism. The HRH ICC deals with all HRH issues in monthly meetings, and not specifically with implementation of the Code, and it is unclear whether it has been appointed as the designated national authority on the Code. Nevertheless, of all the case study countries, Kenya appears to have taken the most steps to disseminate the Code to most or all stakeholders, even if implementation has been lacking, and no designated authority has been appointed.

Conversely, informants from South Africa highlighted that, to the best of their knowledge, South Africa has, as yet, not appointed a designated authority to guide Code implementation and reporting. The same was the case in Malawi, where no designated authority to co-ordinate the dissemination, implementation of and reporting on the Code has been established. One Ministry of Health respondent was of the view that the HRH Observatory - as a mechanism for promoting, developing and sustaining knowledge on HRH –ought to

play that role, but agreed that apart from the Observatory, no designated authority for the Code was in place. The point emphasised during another of the informant interviews was that no measure had been taken to modify the terms of reference (TORs) for the HR Observatory to include the WHO Code. All in all, the study confirms that Malawi does not have a designated authority for reporting on the Code.

The survey results provided similar evidence. It emerged that only one country from whence respondents originated had a designated national authority for exchange of information on health personnel migration and implementation of the Code. The other respondents indicated that a number of other activities had taken place towards Code implementation, such as briefing respective HRH technical working groups, attendance at regional/international consultations, establishment of a committee for implementation, identification of a focal person to lead implementation, and dissemination of the Code within their respective country's ministries of health. There were seven non-respondents in the survey to questions of capacity for Code implementation, and one respondent who stated that nothing whatsoever had been done. In the same vein, when asked where policy positions had been taken on the Code since its adoption, eight respondents left the question unanswered, while four mentioned the ECSA HC, two mentioned the East African Community (EAC), two mentioned SADC and three mentioned the African Union (AU) – note that there were multiple answers from those who responded to the question.

Similarly, it would appear that the countries had variously used the Code to guide engagement with partners/donors on HRH migration/retention, to raise consciousness among HRH practitioners and other stakeholders, and to mobilise internal resources for HRH development, e.g. training. There were, however, contradictory suggestions among same-country respondents regarding production of policy briefs and other materials for use by stakeholders and the development of bilateral agreements on HRH migration (more on bilateral agreements shortly) in line with the Code – with some saying this had happened, and others saying that this was not the case. Such contradictions perhaps say more about the limited familiarity with issues surrounding the Code at country level, rather than how implementation of the Code itself was being undertaken.

Respondents to the survey from Swaziland and Zimbabwe indicated that implementation committees had been established, with a monitoring mechanism and an implementation strategy. The rest suggested that implementation was (or would be) linked to other strategies, such as retention of scarce skills or as part of health systems strengthening.

Regarding stakeholder involvement for Code implementation, respondents from Zimbabwe, Kenya and Tanzania indicated that efforts had been made to discuss the Code beyond the Ministry of Health – in Kenya with the ministries of foreign affairs, finance, education, labour, planning and national development, the immigration department and regulatory councils; in Tanzania with the ministries of foreign affairs, labour, regulatory councils and the ministry for EAC affairs; and in Zimbabwe with the ministries of foreign affairs, finance, education, labour, and the health services board. The results relevant to Kenya from the survey support the indications from the case study, and further highlight that Kenya appears to have undertaken widespread dissemination of the Code. The other respondents to the survey either left the question unanswered (five respondents) or indicated that there had been no discussions yet (three respondents).

While not necessarily directly attributable to the Code, many respondents across the processes indicated that bilateral agreements have been implemented and pressure on recruiting countries has increased to address some of the issues related to the HRH crisis. Respondents to the survey from South Africa, Zimbabwe, Uganda and Kenya indicated that their countries have signed bilateral agreements with other states.

South Africa has agreements with Cuba, through which Cuba supports South Africa by training doctors and by providing doctors to work in South Africa, and with Tunisia and Iran who provide South Africa with doctors. At the multilateral level, South Africa is a member of SADC, and subscribes to the SADC protocol, which bans the employment (poaching) of health workers from other member states. Supplementary to the evidence from the survey, informants in the case study from South Africa indicated that the SADC protocol and a bilateral agreement with the UK had slowed down outward migration, but also resulted in some of the health workforce returning to South Africa.

The respondent from Zimbabwe indicated that there was an agreement with Cuba through which the latter sends doctors to Zimbabwe. Zimbabwe also cited the SADC protocol as a multilateral agreement. Survey respondents reported that Kenya had bilateral agreements with South Sudan and Namibia, while Uganda had one with South Sudan.

The key informants in the Kenya case study indicated awareness of agreements with Namibia and South Sudan, and further indicated agreements with Lesotho and Botswana. Through the former two agreements, Kenya sends nurses to Namibia and South Sudan, and laboratory support to South Sudan. One informant said that the Code had been used to negotiate one such bilateral agreement and to leverage external resources for HRH development. This is presumably the agreement between Kenya and South Sudan, as the agreement with Namibia resulted from a memorandum of understanding that was signed on 12 June 2004 and renewed on 1 April 2009. Other informants pointed to the use of the Code as a driver for the mobilisation of internal resources and external support from, among others, the United States Agency for International Development (USAID) and the Danish International Development Agency (DANIDA), a point mirrored by one of the Kenyan respondents. The use of the Code in this way will be discussed in Section 4.2.

As for the Malawi case study, some key informants pointed to Malawi's emergency human resources programme as an example of a multilateral agreement on HRH, and commented further that it had benefitted the country. In addition, informants also made reference to agreements with South Africa (in the form of the SADC protocol) and the UK (in the form of the Commonwealth code of practice), which bar these counties from poaching health personnel from each other. From the survey, it emerged that Tanzania had leveraged resources using the Code, though this was not specified. One Tanzanian respondent indicated that additional vacancies had been approved, and that health workers had been offered better salaries using domestic resources leveraged through the Code.
Returning briefly to the survey results regarding bilateral agreements, no details were provided of the Uganda-South Sudan agreement. Further, the rest of the countries from whence survey respondents originated reportedly did not have any such agreements. It bears repetition that the agreements mentioned in any detail were all signed before the Code.

Regarding the contribution of the Code to negotiation/renegotiation of such agreements, only three survey respondents suggested that it had contributed, while the rest of the respondents stated that it had not at all contributed (four respondents) or left the question unanswered (seven respondents). On whether the countries had built relations with any countries outside the region around implementation of the Code, eight respondents indicated that this had not happened, while six left the question unanswered.

In addition to highlighting the actual lack of implementation of the Code, the processes also offered insights into why there has been little or no progress in so doing. Especially informative was the fast-talk session, with supplementary insights offered by the other processes on both regional and national hindrances to Code implementation. The barriers made apparent by the fast-talk session are listed below, supported by evidence from the other processes:

- **Lack of regional co-ordination and a coherent voice from the Africa region** was reported to hamper translation of the Code into national action. This contrasts with the positive progress in the WHO-Euro region where most of the countries appointed designated authorities and reported on the Code following from deliberate efforts on co-ordination. A mechanism similar to that of WHO-Euro through which regional efforts are co-ordinated would have been beneficial in the SSA region.

- **Little publicity** as to what is being done, and by whom. This may understate actual achievements from the Africa region. There is a need to document and disseminate the work happening in the region. A government respondent expressed the view that although countries may not have reported on the Code, many things were being done in line with the objectives of the Code. If this is so, what is the barrier to reporting if implementation is happening?

- **Lack of strong leadership from the WHO**. This would enable member states (and other stakeholders) to unpack the Code into easily digestible and implementable components. The lack of leadership was an issue for many given that reforms at the WHO secretariat had tended to downgrade HRH among priority areas. Directly related to this was the need to strengthen HRH issues at the WHO and simultaneously ensure a stronger Global Health Workforce Alliance to help re-invigorate global efforts on HRH, including on the Code.

- **Perception of the Code** as a watered down document with no real teeth or force. Given its non-binding and voluntary nature, little weight is attached to it by national legal departments. Putting it into operation is left to the respective ministries of health, without mechanisms for sensitisation of a broader range of stakeholders.

- **Lack of preparedness** within the countries, with limited or no mechanisms in place for implementation. The Kenya case study similarly highlighted limited mechanisms for implementation and lack of funding as hindrances to the Code being put to use.

- **Poor mobilisation** of national level stakeholders, including civil society, which some attributed to lack of financial support for sustained activities around the Code. One country delegate indicated that during the development stage for the Code, it was not unusual for countries to be invited to attend meetings to strategise on the next steps, and yet after its adoption such support seemed to have dried up. Given resource constraints within the ministries of health, the lack of follow up was thus seen as unsurprising. Furthermore, civil society in the global South was seen as largely inactive on the Code, and that there was a need for active advocacy and training on the Code. This issue was also raised specifically by informants in the Kenya case study and by respondents to the survey. The survey respondents offered reasons as to why mobilising national stakeholders had failed, which included lack of a clear understanding of the Code, lack of evidence-based information upon which to engage others, the lack of co-ordination from respective ministries of health, and the lack of national ownership of the Code as an instrument for international discourse.

- **Burn out** by those who had driven the negotiations for the Code. Many felt that the negotiations for the Code had been an exhausting process, even for observers. Therefore, a big sigh of relief greeted adoption of the Code. “What happened at the WHA in 2010 was it for the Code”, stated one respondent, “We then went back to other things. For the Code, it was mission accomplished, and we didn’t have any more energy for it.” This suggests a combination of both burn out and fatigue

amongst policy makers dealing with the Code. Perhaps complacency towards Code implementation followed the diplomatic achievement of adopting it.

- **Overburdened HR departments** that were already dealing with other issues found it difficult to accommodate the Code. Some African delegates said that most HR functions at ministries of health were handled by few people, many of whom did not have health backgrounds beyond HR issues. The workload made it difficult for them to accommodate the new area of work, particularly without support for the extra work.

- **A high turnover among role players** in some countries, including ministers, permanent secretaries, directors or HR management that had been champions for the Code, leading to loss of institutional memory. The loss of champions that were passionate about the Code meant in some cases that there was no one to raise the issue when implementation stuttered or failed, and no one to keep the issue on the agenda of relevant processes such as HRH technical working groups. This issue was also raised specifically by informants in the Kenya case study and by respondents to the regional survey.

In addition to the above factors affecting implementation drawn from the fast-talk session, the other processes highlighted some additional issues:

- From the **survey**, when pressed on the major challenges to implementing and reporting on the Code, there were six non-respondents and 17 suggestions by those who responded. The most commonly cited challenge for non-implementation was that the Code had not been disseminated and was largely unknown. That was followed by the lack of a focal person to drive the process, lack of information on the magnitude of migration at country level, lack of political support and high turnover of top Ministry of Health officials and low capacity of the country to recruit graduates such as doctors.

- In **Kenya**, informants highlighted that Kenya passed its new constitution in August 2010, barely three months after the Code was adopted. This, they argued, led to a shift in focus and attention since workers within the health services were now required to deal with implementing the constitution. Staff in the Ministry of Health were also now involved with devolution of the health sector to conform to the new constitutional dispensation. Informants raised various other impediments including lack of transparency, communication, and interest, changes in responsibilities, and choice of people who attend international meetings. Informants also noted that government operated with little interagency communication and that implementing the Code needs good co-ordination. They also stated that the Code has not been domesticated through local legislation. Other obstacles included lack of a monitoring and evaluation framework, discussed further in Section 3.3.

- According to the **Malawi** case study, the major challenges that Malawi has faced in implementing the Code were a lack of knowledge about the Code and lack of a designated authority to co-ordinate the dissemination, implementation of and reporting on the Code, as reported above. Similarly, there had been no interagency discussions between the Ministry of Health and other government departments on the Code. A lack of resources to effect new commitments was also cited.

As for enabling factors, no success stories from the SSA region were shared at the fast-talk session at the WHA. However, policy makers from African countries agreed that options raised in the literature would be helpful, including: dissemination of the Code, strengthening or building on pre-existing arrangements (e.g. bilateral agreements), support from partners

and a more active civil society movement. Fast action after the 2010 WHA was also seen as a missed opportunity that could have aided Code implementation.

3.3 Monitoring the Code

This study also sought to draw out the extent to which countries in the east and southern African region are motivated, capable, and prepared to monitor implementation of the Code and use knowledge gained from monitoring to engage in the diplomatic environment on African policy interests on health workers. As became apparent from the findings laid out in Section 3.2, actual implementation of the Code has been extremely limited since its adoption in 2010. It stands to reason that monitoring of the use of the Code has also been very limited, however some issues did come to light from the key processes.

It became apparent that information and data on HRH were not always accessible in the respondent countries. As such, from the process surrounding the fast-talk session at the WHA, the WHO secretariat indicated that the challenges experienced by member states in establishing reliable, quality information bases were a hindrance to tracking Code implementation. This problem was echoed in the survey results and in the country case studies. In the survey, when asked questions regarding the availability of information on HRH migration, one respondent indicated that such information was readily available and easily accessible, four indicated that it was available but not accessible, while six respondents indicated that there was no information on HRH migration in their countries. Similar patterns emerged from the country case studies.

In Malawi, to the question on availability of information on HRH, the questionnaire respondents were evenly divided between those who stated that this was readily available and those who stated that it was available but not accessible. From the key informant interviews, it was apparent that up-to-date HRH information was not always available when needed, and often not in usable forms.

In Kenya, five informants indicated that such information was readily available and easily accessible, while the rest indicated that it was not. These responses were evenly divided between MoH and non-MoH respondents, with some commenting that the information was not user friendly. Informants raised various challenges faced by Kenya for reporting on the Code, particularly the lack of information. Single respondents raised other barriers, including lack of clear information on where to report, limited incentive to report and lack of a clear reporting framework. Evidently, for the Code this may imply that these respondents are not aware of the monitoring and reporting framework developed by the WHO.

For the South Africa case study, some respondents suggested that the regulatory councils should have accurate numbers on the migration of health professionals. However, when informants from the regulatory bodies were interviewed, the only numbers/trends they had knowledge of were pertaining to those health professionals seeking certificates of good standing or verification of their qualifications, with the intention to migrate, and not on actual numbers of health workers who have migrated. That was the case with both the pharmacy council and health professions council of South Africa, the two regulatory bodies interviewed.

Regarding reporting, the main issues that emerged from the regional questionnaire survey were lack of a focal person or responsible authority, lack of access to data on migration and that the Code was unknown to stakeholders. Three respondents indicated that the challenges were similar for implementation and reporting. To the direct question of how ready the countries were to report on the Code in May 2012, there were eight non-respondents. Of the six that gave an answer, three stated that the report was not ready but the process had started, and that there should have been a report after May 2012; one stated that the process only started after May 2012; one was not sure what had been done; and one respondent stated that he was not in a position to answer the question.

Clearly, the Code has not been fully domesticated in the region, with poor dissemination of its provisions and poor stakeholder participation. All in all, evidence from the processes indicated that lack of information on HRH migration is a major challenge – which may partly explain why, for example, most responses to the questionnaire survey did not include HRH migration among the top three HRH challenges. Furthermore, this indicates the weakness of monitoring systems and thus of applying such systems to the Code, with consequences for the implementation of the Code for addressing policy concerns.

3.4 Other findings

In addition to the findings presented in sections 3.1, 3.2 and 3.3, the processes offered some additional insights, which, although not directly correlating to the key research questions, warrant mentioning.

First, it emerged from the South Africa case study– as previously noted – that the Code had not been widely disseminated or implemented, if at all. However, a major issue raised by the informant interviews was that of working conditions for health care professionals in South Africa, specifically related to pay and how it affected the migration of the work force. Whereas other factors contributed, it would appear that for most of the respondents who had migrated money was a, if not the, major factor – the combination of poor pay, the prospect of retiring without any money and the gravity of multiple financial obligations all combined to inform the decision to migrate. The minimal concern indicated by informants in the South Africa case study for external migration as a critical threat to HRH could thus be attributed to a 'turning of the tide' in the wake of the introduction of occupation-specific dispensation (OSD).

OSD was designed as a public, service-wide generic solution to human resource constraints being experienced in several services sectors in relation to remuneration of professionals (NDoH, 2012). Its conception, negotiation and implementation all seem to have been driven by domestic forces, with no apparent influence from international initiatives. Regarding its application to the health workforce, it should be borne in mind that health workers were considered as one sector in the public service; the OSD was not designed specifically for health workers, and had no direct links to the developments around the Code under discussion. OSD greatly improved pay levels for health professionals, including substantial increases in the take-home pay for nurses, and a doubling of wages for some cadres of the health service. The OSD is credited with encouraging health workers abroad to return, with encouraging some (nurses) to move from the private to the public sector and to better retention of the workforce. Informants who had not emigrated from South Africa rated the OSD highly as a measure/response that helped better the lot of health workers. Interestingly, however, for all the success attributed to the OSD, it was not mentioned by the returnee health professionals interviewed for this study. In contrast to the views of some informants, these health workers' reasons for returning do not seem to have included the OSD at all.

Second, regarding what form of compensation, if any, should be received for HRH migration from receiving/destination countries, in the Malawi case study questionnaire the most commonly suggested forms of compensation were non-financial. Rather respondents, including informant interviewees, supported further training to improve Malawi's training capacity and to develop a mass of specialist cadres to offer specialist services.

4. Discussion

4.1 Policy interests of African countries and the Code

The findings on policy interests perceived as being crucial by the various actors in this research offer a range of insights into the extent to which policy interests of African countries were or were not brought into the Code. From the three country case studies and the survey

it appears that the issue of health worker migration is not amongst the most critical HRH challenges in the region. This is not to say that it is not an issue, of course, but internal migration appears to be a bigger concern than external migration, as do issues such as absolute shortages and a general lack of resources (to improve facilities, pay, employment opportunities, training etc.). This finding is presented with the caveat that data on the impact of external migration are lacking, which may have led to the downplaying of the problem.

Even if it is not the most critical concern, external migration is still an issue, and one that the Code aimed to alleviate. Across the region, actors raised various concerns they thought the WHO Code ought to address and does not, or at least ought to address to a greater extent than it does. This includes:

- Compensation to source countries, including support for training health professionals;
- The concerns and violations of rights of migrant health workers, as elaborated in Section 3; and
- Availability of evidence on the impact of HRH migration on health systems in the region – which in turn makes it difficult to bargain for policy space and negotiate for redress.

There is some dissatisfaction with the final provisions of the Code. As Taylor and Dhillon (2011) point out, one of the last clauses to be dropped during Code negotiations was one referring to mutuality of benefits. Also, no reference was made to compensation, despite this being a key driver for African diplomacy on the Code. 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 achieving the deletion of clauses on mutuality of benefits), and in response to sustained pressure from the African countries (Taylor and Dhillon, 2011). These inadequacies (or perceived inadequacies of the Code) may explain the implementation deficits expressed in Section 3.2 and discussed in Section 4.2 below.

An interesting point that emerged from the findings in the Malawi case study was that informants pointed to the support rendered by Malawi officials to the Africa Group at the World Health Assembly. This raises the question of how (or whether) working through the Africa Group enabled or masked the preparedness of individual countries for follow through on the Code. In other words, did forming a united African voice mean that country-specific concerns were not sufficiently addressed? Is forming such a voice a necessity for African actors to be heard in the global health diplomacy arena? Each country, such as Malawi, will need to identify which components of the Code they will need to emphasise, and through which mechanisms to best address their specific concerns and issues.

Further, also in the case study from Malawi, even those who were not aware of the contents of the Code found it somehow inadequate to the HRH concerns of Malawi. Therefore, the views on the Code in its present form are to be interpreted cautiously, as some of those who indicated that they did not know much about the Code offered suggestions on what it should have included. This is a noteworthy observation, and rather difficult to explain. It may reflect the confusion on what the Code is all about and what it is supposed to achieve and how. Clarity in this regard will only come from dissemination and engagement with the many stakeholders on the issue, and proper planning and processes for Code implementation. Nevertheless, such suggestions are important to the extent that they communicate the wishes of the country stakeholders regarding solutions to HRH migration.

4.2 Use and implementation of the Code in east and southern Africa

The lack of knowledge or understanding of the Code's content and intent made discussions of the preparedness of the individual countries for implementation of the Code difficult to broach. Across the processes little or no efforts have been made to disseminate the Code or

its contents to local stakeholders. The notable exception to this is the Kenya case study, through which it became apparent that Kenya's Ministry of Health and various stakeholders have an intimate knowledge and understanding of the Code. In the other countries the question arises of whether this is unique to the Code or whether there is a lack of co-operation on such issues in other areas. The widespread knowledge of the OSD in South Africa, for example, indicates that health professionals are well aware of national agreements. The Code, conversely, is seemingly forgotten.

As for Kenya, despite the reportedly widespread dissemination and understanding of the Code, stakeholders agree that little or nothing has been done to implement it, an outcome largely attributed to competing interests and changes in focus in national priorities. There is a sense that the promulgation of the new constitution shortly after the adoption of the Code is a key reason for this, as set forth in Section 3.2.

The interaction with policy makers through the fast-talk sessions confirmed that the major barrier to implementation of the Code included lack of preparedness, poor mobilisation at country level, over-burdened HR departments, and lack of national champions to drive Code implementation and reporting. As stated by a key informant:

> *You get back from the World Health Assembly full of morale, many new ideas, but also many tasks generated. As you settle down, you realize that the work you left pending before the World Health Assembly is waiting for you. And the work plans do not include the new issues for the remainder of the year. Before you know it, a year is gone with little action.*

The interactions also confirmed *a priori* suggestions on what ought to be done to ensure implementation of the Code. Many policy makers, through the fast-talk interactions, agreed that a lot could and should be done. It is hoped that the interaction will bear fruit in the form of concrete action at national level. Perhaps three years after adoption is too early to judge the fortunes of the Code, but the low levels of activity regarding the Code are nevertheless noteworthy. There was, however, a perception that action on issues identified as shortfalls would improve the possibility of African countries using the Code to their benefit, as noted in fast-talk sessions (Dambisya, 2013).

Some informants expressed the view that countries were, in fact, implementing the Code in various ways, or at least taking steps in line with the objectives of the Code. Here it is worth mentioning the Code as a negotiation tool. For example, the impact of the bilateral agreements highlighted in Section 3.2 and pressure on recruiting countries were deemed to have had some success in addressing the HRH crisis by various sources across the processes. There is a sense that some of this success comes as a result of the Code. The Code itself advocates for bilateral agreements to aid its implementation (WHO, 2010), and, given that bilateral agreements have stronger enforceable relevance, commentators like Dhillon (2011) see them as important means for achieving the Code's objectives. It appears that some countries are seeing the Code as a guideline for such agreements. For example, an informant from the South African Department of Health stated the following:

> *It's true we have a lot to do… we have a long way to go. Honestly, with what South Africa is already doing – what with the bilaterals, enforcement of our own policy on no poaching, and requiring applicants from other countries to get clearance from their governments, …you can see that we are implementing the spirit of the Code....*

Similarly, an informant from Malawi stated the following regarding implementation of the Code and the readiness of Malawi to report on the Code:

> *…in all honesty, we have not done anything directly related to the Code. But when looking at the Code you can see that we are doing things expected from the Code… the discussion on support for training, our strategic direction on HR, all those are in the spirit of the Code. Yeah, but not because of the Code, perhaps. I don't know how to frame this….*

While confirming the lack of dissemination and understanding of the Code, this suggests that the process for negotiating and adopting the Code has created a more enabling environment for negotiations on bilateral agreements, even if the specific clauses of the Code were not engaged. Likewise, informants from Kenya and Malawi indicated that the Code had been used to lever external resources to deal with various HRH issues, including the training of health personnel. Particularly in Malawi, some informants thought that as a result of the Code external partners were more likely to provide increased resources, that there was more urgency globally to address HRH problems, that a number of agreements had been negotiated in favour of Malawi, and that there was more willingness on the part of some partners to work with Malawi to address HRH.

These suggestions must be seen in perspective, as they were made largely by those who did not know about the Code – as briefly touched upon in Section 3.2 – and yet still attributed such developments to the Code. This attribution does not stand to scrutiny given that what were cited predated the Code. If, however, steps are being taken to implement the Code, we may question why there is a lack of reporting on its progress and success.

Another point in relation to bilateral agreements relates to the issue of compensation. As was made apparent in Section 3.1, many of the actors involved in this study regarded compensation as a key concern. Bilateral agreements are seen as a useful way of accessing compensation, but so far none have been concluded between countries in the region and recipient countries of African health workers outside Africa. Connell (2010) observes that recipient countries have no interest in putting in place compensatory mechanisms, often arguing that migration is freely chosen, that markets operate in this way and that there is no means of knowing how long migrants will stay, despite strong ethical arguments in favour of restitution. Connell 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). Northern countries seem to prefer using development aid to address health worker issues rather than bilateral agreements. This suggests that African countries have not been able to use the Code as a negotiating tool in health diplomacy to pursue their own policy interests, at least not to the extent intended in the build up to the Code's adoption.

Nevertheless, Dhillon et al. (2010) do highlight that individual European Union (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). So, while it appears that some countries have struggled to use the Code as a diplomacy tool, this is not always the case.

Conversely, the case of South Africa suggests that inactivity in relation to the Code may be down to other factors than an inability to use it as a diplomacy tool. Informants were unanimous in stating that South Africa still faced many HRH challenges, ranging from shortages, rural-urban maldistribution and low training capacity, as seen previously, but not health worker migration. The sum total of the findings would suggest that measures other than (and which predated) the Code might have had the effect of mitigating the effect of

health professional migration and in stemming the outflows, perhaps to the extent that it is no longer an issue in the country. While admitting that there may be some migration still happening, it emerges clearly from the interviewees that it is no longer the problem it was in the mid-2000s. However, in terms of advocacy and further use of the Code for health diplomacy, it is significant that a country such as South Africa, a major contributor during the development processes for the Code, has made little effort, if any, to disseminate, publicise or implement the Code.

Similarly, Malawi was involved, especially through WHO AFRO and the Africa Group at the WHA, in development and adoption of the Code, but has taken no apparent direct action to implement the Code since its adoption. Notably, Malawi has not appointed a designated authority for Code implementation and reporting, and even members of the HRH technical working group are unaware of the Code contents/context, with many admitting they have not seen or heard about it.
Generally, this lack of knowledge of the Code across the region was a remarkable finding. The respondents were high profile HRH practitioners in their respective countries, and the lack of knowledge at the top level of health policy implies that the problem is even worse beyond the officials in the HRH departments at the ministries. It emerges clearly from the survey that little effort was made to disseminate the Code after its adoption; consequently, many stakeholders have no knowledge of its contents.

To further underscore this point, at the fast-talk session African civil society organisations highlighted the lack of civil society involvement and the need for continuing civil society engagement to galvanise action for Code implementation. While acknowledging the enormity of the task ahead, these organisations expressed a sense of optimism. Despite the slow start in the first three years, the view was that the kind of mobilisation that contributed to the adoption of the Code was needed now to get countries in the region to implement and monitor the Code.

As laid forth in the findings in Section 3.2, the lack of a focal point and the lack of dissemination are major challenges. The lack of political will to implement the Code seems paradoxical, given that the Code had the support of political leaders within health (i.e. ministers) at its adoption. This may be linked to the high turnover of health ministry officials (including the ministers) in most countries. The lesson here may be that countries in the region need to develop strong institutions for implementation of international obligations, such as the Code, to ensure implementation regardless of turnover of key officials and stakeholders.

Buchan (2010), Connell (2010) and Connell and Buchan (2011) express some reservations on the potential for success of codes of practice, including the WHO Code of Practice. Connell argues 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 the Code will drive recruitment underground. In Connell's view 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 as they offer some hope for more effective managed migration (Connell, 2010).

On the one hand, the lack of progress in domestication, implementation or reporting on the Code, coupled with the emerging view that HRH migration may not be seen as a top priority HRH challenge for countries in the region, would tend to bear out the caution suggested by those authors. On the other hand, given the voluntary and non-binding nature of the Code, and given the experience from the only other WHO Code – on breast milk substitutes – whose success took many years from its adoption, it is early days yet to judge the success or otherwise of the Code.

4.3 Monitoring the Code

In terms of monitoring the Code, it stands to reason that little has been accomplished, given the lack of implementation of the Code. Some issues emerged from the findings however. An obstacle to implementing and monitoring the application of the Code in the region is the lack of data on HRH in general. Either such data are not available or when they are they are not in a usable form. As with implementation, a major challenge to monitoring the Code is the lack of a focal person or responsible authority to drive the process. A government respondent at the fast-talk session said that although countries may not have reported on the Code, many things were being done in line with the objectives of the Code. If this is so, and the Code or its objectives are indeed being implemented, then what are the barriers to reporting on this progress?

In sum, it is a curious finding that following a long and intense diplomatic struggle to get the Code adopted, countries in east and southern Africa have taken so few (apparent) steps towards implementing the Code and reporting on its progress.

4.4 Learning from South Africa's response

Experiences from South Africa may prove instructive for the region, and are therefore included in this report, as the country appears to have had some success in addressing the HRH crisis. The notable reduction in migration from South Africa may be partly due to geopolitical changes in Europe. Expansion of the EU and opening up of the UK and Ireland to health workers from the newer EU bloc members meant, for example, that South African nurses were no longer recruited into the UK National Health Service (Costigliola, 2011). That was coupled with international pressure through the Commonwealth Code of Practice on Ethical Recruitment of Health personnel, (Commonwealth Secretariat, 2003), bilateral agreements, such as the one between the UK and South Africa, and the attention associated with the development of the WHO Global Code – all of which had a net effect of reducing recruitment from South Africa. Dambisya and Mamabolo (2012) showed a dramatic reduction in foreign advertisements for doctors from South Africa in arguably the most widely read medical journal in South Africa over the six years up to June 2012, relative to the situation up to 2004. The recruitment agent interviewed indicated that they were no longer free to advertise their operations and relied on word of mouth, which indicates that the South African government has taken a strong stance on active recruitment and 'poaching', an important finding supporting the notion that there has been a decline in active recruitment from South Africa.

Notable among the responses mounted by the South African government was the introduction of the OSD. In reviewing the scheme, George and Rhodes (2012) note that: "…the OSD has made significant progress in reducing the gap between salaries of HRH in South Africa and the rest of the world." As observed by our informants, with the reduction in pay differential it was no longer as attractive to leave the country to work abroad. Other countries in the region should emulate the South African experience in regard to health worker migration by narrowing the gap between local salaries and what obtain abroad, if they are to keep their health workers motivated and working in their home countries.

Given the dynamic nature of health worker migration flows, countries in the region, including South Africa, ought to activate implementation of the Code as an ultimate mechanism through which to manage future HRH challenges. For example, Obamacare may raise demand for health workers. It also remains to be seen what the long-term effects of global recession and cutbacks will be. Nevertheless, the domestic responses made by South Africa, though not necessarily in the context of the Code, and the apparent 'turning of the tide' in the HRH crisis provide room for optimism and may offer lessons for other countries planning to tackle domestic HRH challenges.

5. Conclusions

The main messages from all the processes are that countries in the ESA region have not made much progress in implementing and monitoring the Code, or using it in their engagement in global health diplomacy, and that the Code remains largely unknown in the region. The major barriers to implementation of the Code included lack of preparedness, poor mobilisation at country level, overburdened HR departments, and lack of national champions to drive Code implementation and reporting. Much of that inertia would appear to be due to lack of a focal person or due to overwhelmed HR departments that have not found the space or time to undertake Code implementation processes such as dissemination of the Code. The lack of progress in this regard suggests waning political will on issues of HRH migration within the region.

Though the study was largely negative on the central questions on the Code, it brought to light a number of fundamental issues related to the HRH challenges in the region, especially absolute shortages, rural-urban disparities and low capacity to produce more health professionals. Whereas health worker migration continues to be an issue, it is not regarded among the top priority HRH concerns for ESA at the moment. The South Africa study illustrated that the drivers of health worker migration appear to have been largely financial, and that measures taken to address such migration included financial incentives through OSD and regional protocols that limited latitude for active recruitment, coupled with changing market factors, especially in the EU.

The evidence gathered across the processes supports the conclusion that whereas in the main African interests were reflected in the final wording of the Code, elements, especially on compensation and mutuality of benefits, were not included. That seems to have led to perceptions by some stakeholders that the Code did not meet the expectations of the African countries. Dissemination of the Code would help raise such misgivings and address them. The research suggests that implementation plans, issues and capacities may need to be given more attention in future global health negotiations, if a global instrument like the Code is to have a positive effect.

The processes also raised suggestions on what ought to be done to ensure implementation of the Code. The realisation by many policy makers, through these interactions, that there was a lot to be done, and much that could be done in the context of the Code, was one development that ought to bear fruit in the form of concrete action at national level. Perhaps three years after adoption is too early to judge the fortunes of the Code, and with renewed vigour, it should be possible for countries, especially in the African region, to explore ways of utilising the Code to their benefit.

The key processes and evidence gathered support the following **recommendations:**

i. Countries in the region, indeed all African states, ought to, without further delay, appoint designated authorities, in line with the Code, to drive the processes for implementation and reporting on the Code. That should be accompanied by deliberate efforts to strengthen the HR departments within ministries of health to take on the additional tasks, including sound HR information systems.
ii. WHO should take leadership and support member states in the implementation and monitoring of the Code, through activities such as holding Code-specific dissemination meetings and technical support to individual countries in the processes for Code implementation and monitoring.
iii. Regional organisations/regional economic blocs such as ECSA HC, SADC, ECOWAS, West African Health Organization (WAHO) and the AU should play a more active role in bringing the countries together to understand and plan for implementation of the Code;

that should be accompanied by technical support to the countries, in collaboration with WHO. That will ensure the emergence of a regional voice and momentum for Code implementation and monitoring.

iv. The civil society movement in Africa should be mobilised to play a greater role in advocacy for implementation of the Code, supported by evidence and in collaboration with other national stakeholders.

v. Academic and research institutions should undertake research to generate evidence and data on the extent and impact of HRH migration to inform decision making in the region.

vi. A commitment should be made by member states, supported by WHO and regional organisations, to ensure that ESA countries report on Code implementation within the year 2014 – that will galvanise action on all the other recommendations.

vii. The finding in this report should be widely disseminated in policy forums and through other appropriate formats such as policy briefs and scientific paper publications.

6. References

1. Anand S and T Bärnighausen (2004) 'Human resources and health outcomes: Cross-country econometric study', *Lancet* 364:1603–9.
2. Buchan J (2010) 'Can the WHO Code on international recruitment succeed?' *BMJ* 340:791-3.
3. Chen LC and JL Boufford (2005) 'Fatal flows – doctors on the move', *New England journal of medicine* 353:1850-2.
4. Chen LC, T Evans, S Anand et al. (2004) 'Human resources for health: Overcoming the crisis', *Lancet* 364:1984-90.
5. Cheng MH (2009) 'The Philippines' health worker exodus', *Lancet* 373:111–2.
6. Chikanda A (2006). 'Skilled health professionals' migration and its impact on health delivery in Zimbabwe', *Journal of ethnic and migration studies* 32:667-80.
7. Clemens M (2011) 'No, British Medical Journal, the emigration of African doctors did not cost Africa $2 billion'. Blog at: http://blogs.cgdev.org/globaldevelopment/2011/11/no-british-medical-journal-the-emigration-of-african-doctors-did-not-cost-africa-2-billion.php; accessed 25 February 2013.
8. Commonwealth Secretariat (2003) *Code of practice for recruitment of health workers,* Commonwealth Secretariat: London.
9. Connell J (2010) Migration of health workers in the Asia-Pacific Region. Human Resources for Health Knowledge Hub, University of New South Wales; available at: http://www.hrhhub.unsw.edu.au/HRHweb.nsf/resources/3_Migration_Web_20100112.pdf/$file/3_Migration_Web_20100112.pdf
10. Connell J and J Buchan (2011) 'The impossible dream? Codes of practice and the international migration of skilled health workers', *World medical & health policy* 3(3).
11. Costigliola, V (2011) Mobility of medical doctors in cros-border healthcare.' EPMA Journal 2: 333-339; 2011
12. Creswell JW (2011) *Qualitative inquiry & research design: Choosing among five approaches*. SAGE Publications: Los Angeles.
13. Dambisya YM (2007) 'A review of non-financial incentives for health worker retention in east and southern Africa', *EQUINET Discussion Paper* 44, 2007. Available at: http://www.equinetafrica.org/bibl/docs/DIS44HRdambisya.pdf.
14. Dambisya YM (2013) 'Report on the fast talk session on the WHO Global Code of Practice on the International Recruitment of Health Personnel. EQUINET, Harare, mimeo.
15. Dambisya YM and MH Mamabolo (2012) **'**Foreign advertisements for doctors in the South African medical journal from 2006 to 2010', *South African medical journal* 102:669-72.
16. Dambisya YM, Kadama P, Matinhure S et al. C (2013) 'Literature review on codes of practice on international recruitment of health professionals in global health diplomacy', EQUINET Discussion paper 97, EQUINET, Harare.
17. Dhillon IS (2011) 'Health worker migration and bilateral agreements: Reflections on potential role', Presentation at meeting of the Ibero-American Network on the migration of health professionals, November. Available at: http://www.observatoriorh.org/sites/default/files/webfiles/fulltext/ivenc_migra_uru_nov11/IbadatDhillon.pdf.
18. Dhillon IS, Clark ME and Kapp RH (2010) 'A guidebook on bilateral agreements to address health worker migration.' Washington DC: Aspen Institute.
19. Dodani S and RE LaPorte (2005) 'Brain drain from developing world: How can brain drain be converted into wisdom gain? *Journal of the royal society of medicine* 98:487-91.
20. Dovlo D (2005) 'Taking more than a fair share? The migration of health professionals from poor to rich countries', *PLoS medicine* 2(5):e109.

21. Dussault G and MC Franceschini (2006) 'Not enough there, too many here: Understanding geographical imbalances in the distribution of the health workforce', *Human resources for health* 4:12.
22. East, Central and Southern Africa Health Community (ECSA HC) (n.d). 'Resolutions of the Health Ministers Conferences 1999 – 2007' ECSA HC, Arusha, Tanzania. Available at www.ecsa.or.tz.
23. East, Central and Southern Africa Health Community (ECSA HC) (2008) Resolutions of the 46th Health Ministers Conference, Seychelles. ECSA HC, Arusha Tanzania. Available at www.ecsa.or.tz.
24. East, Central and Southern Africa Health Community (ECSA HC) (2009) Resolutions of the 48th Health Ministers Conference, Mbabane, Swaziland, ECSA HC, Arusha, Tanzania. Available at www.ecsa.or.tz.
25. East, Central and Southern Africa Health Community (ECSA HC) (2011). Resolutions of the 52nd Health Ministers Conference, Mombasa, Kenya, ECSA HC, Arusha, Tanzania. Available at www.ecsa.or.tz.
26. East, Central and Southern Africa Health Community (ECSA HC) (2012). Report on a round table (dissemination*)* meeting for partners, the directors' joint consultative committee, and the human resources for health technical working group (TWG). Available at: http://www.ecsa.or.tz/downloads/Report%20of%20the%20Round%20Table%20Workshop%20to%20Disseminate%20the%20WHO%20Code%20on%20HRH%20Migration.pdf.
27. Eastwood JB, RE Conroy, S Naicker et al. (2005) 'Loss of health professionals from sub-Saharan Africa: The pivotal role of the UK', *Lancet* 365:1893-1900.
28. Ehman A and P Sullivan (2001) 'South Africa appeals to Canada to stop recruiting its MDs', *Canadian medical association journal* 164:387-8.
29. Gilson L and E Erasmus (2005) 'Supporting the retention of HRH: SADC policy context', *EQUINET Discussion Paper 26*. EQUINET and Health Systems Trust: Johannesburg.
30. Hagopian A, MJ Thompson, M Fordyce et al. (2004) 'The migration of physicians from sub-Saharan Africa to the United States of America: Measures of the African brain drain', *Human resources for health* 2:17.
31. Hongoro C and B McPake (2004) 'How to bridge the gap in human resources for health', *Lancet* 2004 (364):1451–6.JLI (Joint Learning Initiative) (2004) *Human resources for health: Overcoming the crisis*. Global Equity Initiative,Harvard University Press: Cambridge, MA.
32. Johnson J (2005) 'Stopping Africa's medical brain drain', *BMJ* 331:2-3.
33. Kirigia JM, AR Gbary, LK Muthuri, J Nyoni and A Seddoh (2006) 'The cost of health professionals' brain drain in Kenya', *BMC health services research* 6:89.
34. Kuehn BM (2007) 'Global shortage of health workers, brain drain stress developing world', *Journal of American medical association* 298:1853–5.
35. Labonte, R, C Packer, N Klassen et al. (2007) 'The brain drain of health professionals from sub-Saharan Africa to Canada: Some findings and policy options', *African migration and development*, Paper 2. Idasa: South Africa, and Queens University: Canada.
36. Mackintosh M, K Mensah, L Henry et al. (2006) 'Aid, restitution and international fiscal redistribution in health care', *Journal of international development* 18:757–70.
37. Mensah K, M Mackintosh and L Henry (2009) 'The "skills drain" of health professionals from the developing world: A framework for policy formulation'. Available at: www.medact.org/content/Skills%20drain/Mensah%20et%20al.%202005.pdf, accessed 18 January 2013.
38. Mills EJ, S Kanters, A Hagopian et al. (2011) 'The financial cost of doctors emigrating from sub-Saharan Africa: Human capital analysis', *BMJ* 343:d7031 doi: 10.1136/bmj.d7031.

39. Mullan F (2005) 'The metrics of the physician brain drain', *New England journal of medicine* 353:1810–8.
40. Muula A and B Panulo (2007) 'Lost investment returns from the migration of medical doctors from Malawi', *Tanzania health research bulletin* 9:61-4.
41. Muula AS, B Panulo Jr, FC Maseko (2006) 'The financial losses from the migration of nurses from Malawi', *BMC nursing* 5:9 doi:10.1186/1472-6955-5-9.
42. Mwaniki DL and CO Dulo (2008) 'Managing the migration of human resources for health in Kenya: The impact on health service delivery', *EQUINET Discussion Paper 55*; EQUINET: Harare. Available at: www.equinetafrica.org.
43. National Department of Health (NDOH) (2012) 'Human Resources for Health South Africa: HRH Strategy for the Health sector – 2012/2013 – 2016/17.' Pretoria, South Africa.
44. Oberoi SS and V Lin (2006) 'Brain drain of doctors from southern Africa: Brain gain for Australia.' *Australian health review* 30: 25-33.
45. Padarath A, C Chamberlain, D McCoy et al. (2003). 'Health personnel in southern Africa: Confronting maldistribution and brain drain', EQUINET Discussion Paper 4; EQUINET: Harare.
46. Pagett, C and A Padarath (2007) 'A review of codes and protocols for the migration of health workers', EQUINET *Discussion Paper 50*: HST, EQUINET, ECSA HC: EQUINET, Harare.
47. SADC (2001) 'Statement by SADC health ministers on the recruitment of health personnel by developed countries' [Cited by Pagett and Padarath, 2007].
48. Scheffler RM, JX Liu, Y Kinfu et al. (2008) 'Forecasting the global shortage of physicians: An economic- and needs-based approach', *Bulletin of the World Health Organisation* 86:516-23.
49. Sheikh M (2011) 'Commitment and action to boost health workforce', *Lancet* 379:e2-e3; DOI:10.1016/S0140-6736(11)60023-8.
50. Taylor A and I Dhillon (2011) 'The WHO Global Code of practice on the international recruitment of health personnel: The evolution of global health diplomacy,' *Global health governance* 5(1).
51. Travis P, S Bennett, A Haines et al. (2004) 'Overcoming health-systems constraints to achieve the Millennium Development Goals', *Lancet* 364:900–06.
52. Walt G and L Gilson (1994) 'Reforming the health sector in the developing world: The central role of policy analysis', *Health policy and planning* 9:353-70.
53. Windisch R, K Wyss and K Prytherch (2009) 'A cross-country review of strategies of the German development co-operation to strengthen human resources', *Human resources for health* 7: 46
54. World Health Organisation (2006) *The World Health Report 2006 – Working together for health*, WHO:Geneva. www.who.int/.
55. World Health Organisation (2008) 'The WHO code of practice on the international recruitment of health personnel: Draft for discussion', WHO. Available at: http://www.who.int/hrh/public_hearing/comments/en/index.html.
56. World Health Organisation (2010) 'WHO global code of practice on the international recruitment of health personnel'. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R16-en.pdf.
57. World Health Organisation (2013) 'The health workforce: Advances in responding to shortages and migration, and in preparing for emerging needs', Report by the secretariat to the 132 session of the executive board (EB132)

Abbreviations

AU	African Union
DANIDA	Danish International Development Agency
DRC	Democratic Republic of Congo
EAC	East African Community
ECOWAS	Economic Community of West African States
ECSA HC	East, Central and Southern Africa Health Community
EQUINET	Regional Network for Equity in Health in East and Southern Africa
ESA	East and Southern Africa
EU	European Union
GDP	Gross Domestic Product
GHD	Global Health Diplomacy
HR	Human Resource(s)
HRH	Human Resources for Health
HRiS	HRH Information System
IDRC	International Development Research Centre
IMF	International Monetary Fund
JLI	Joint Learning Initiative
MDGs	Millennium Development Goals
MoH	Ministry of Health
MoU	Memorandum of Understanding
NDOH	National Department of Health (South Africa)
NEPAD	New Partnership for Africa's Development
NHI	National Health Insurance
NHS	National Health Service (UK)
OSD	Occupation-Specific Dispensation
SADC	Southern African Development Community
SSA	Sub-Saharan African
TORs	Terms of Reference
TREC	University of Limpopo Turfloop Campus Research Ethics Committee
TWG	Technical Working Group
UK	United Kingdom
USA	United States of America
USAID	United States Agency for International Development
WAHO	West African Health Organization
WHA	World Health Assembly
WHO	World Health Organisation

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; HEPS and CEHURD Uganda; University of Limpopo, South Africa; University of Namibia; University of Western Cape, South Africa; SEATINI, Zimbabwe; REACH Trust Malawi; Ministry of Health Mozambique; Ifakara Health Institute, Tanzania; Kenya Health Equity Network; and SEAPACOH

For further information on EQUINET please contact the secretariat:
Training and Research Support Centre (TARSC)
Box CY2720, Causeway, Harare, Zimbabwe Tel + 263 4 705108/708835 Fax + 737220
Email: admin@equinetafrica.org
Website: www.equinetafrica.org

Series Editor: Rene Loewenson
Issue editor: V Knight