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Implementing the WHO Global code of Practice on the International Recruitment of health Personnel in Africa

The World Health Organisation (WHO) Global Code of practice on the international recruitment of health personnel was adopted by the 63rd World Health Assembly in May 2010 in response to the intensifying movement of health workers, especially from low to high income countries. This movement of health workers aggravates inequity, particularly with regard to the number of health workers relative to health need. While the subcontinent accounts for 24% of the global burden of disease, it has only 3% of health workers globally. The WHO Code is a voluntary ethical framework to guide member states in the ethical recruitment of health workers between countries and regions. This policy brief looks at the developments in Sub-Saharan Africa since the adoption of this code with regards to its implementation. It presents the activities required to monitor its implementation and what actions have so far been implemented.

Motivations and demands from Africa on health worker migration

The migration of health personnel has increased in recent decades for a variety of reasons, particularly to seek better employment opportunities and living conditions. African countries lose many qualified health personnel through migration due to "push factors" of unsatisfactory working conditions, poor salaries, few career prospects, safety concerns, and lack of management and support. The 2006 WHO World Health Report highlighted a global shortage of almost 4.3 million health personnel. The report identified 57 countries, 36 of them in Sub-Saharan Africa, facing a severe shortage of health personnel. The outmigration of health workers adds to these shortages. At the same time, high income countries facing the demands of ageing populations and increased need for chronic care have high demand for health workers. With inadequate training to meet this demand, many high income countries have made significant savings on the potential costs of training health workers to meet this demand, while benefiting from public sector investment in health worker training in Africa, by employing health personnel migrating from low to high income countries. A recent paper by Mills et al (BMJ 2011;343:24 November 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 $2.16m for Malawi to $1.41bn for South Africa, and with South Africa and Zimbabwe having the largest losses as a share of Gross Domestic Product. 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.

African countries have in the past made several submissions and recommendations at international level on health worker migration. For example, the Regional Health Ministers Conferences of the East, Central and Southern African Health Community (ECSA HC) and the March 2008 Kampala Declaration and Agenda for Global Action, resolved or demanded for:

i.   Governments of receiving (destination) countries to notify governments of sending (source) countries on the number of health workers employed, their professional status and their contractual rights and obligations, and to provide equal treatment to health workers recruited from ECSA states as for local health workers;

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ii.   Support for ECSA states to register and monitor their health workers;

iii. Restrictions on unethical health personnel recruitment and employment practices;

iv.   Compensation, including through through investment and tax remittance arrangements, for the losses to African countries for the loss of health professionals trained in Africa who migrate permanently to other countries;

v.   Technical and resource support to health professional training in Africa, and

vi.   External funding support to health programmes in a manner that integrates with national financing arrangements and avoids outflows of critical health personnel from public health services to non state programmes.

These demands and concerns led to a number of initiatives and non binding codes at international level, including the Commonwealth Code of Practice for the International Recruitment of Health Workers and the United Kingdom National Health Service Code of Practice for the International Recruitment of Healthcare Professionals.

The Code of Practice on the International Recruitment of health workers

Responding to the health worker crisis facing mostly low income countries, and the need for a multilateral response to the migration of health workers, the World Health Assembly 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. WHO initiated a multi-stakeholder process in 2008, with drafts developed and reviewed through national and regional consultation in all six WHO regions. The Code of Practice on the International Recruitment of health workers was debated and adopted at the 2010 World Health Assembly. The resolution marked the first time that the World Health Assembly 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 Code of Practice is a voluntary instrument that lays down global principles and practices around the international recruitment and migration of health personnel. It consists of the preamble and first three articles covering objectives, nature and scope, and guiding principles giving the context of the instrument. Article 4 of the Code, on responsibilities, rights and recruitment practices, identifies the ethical responsibilities of stakeholders to ensure fair recruitment and equitable treatment practices for the health workers who would have migrated. This includes the need for recruiters and employers to be aware of and not seek to recruit health workers with existing domestic contractual obligations. The health workers themselves are also obligated to be transparent about their contractual obligations.

Article 5 on Health workforce development and health systems sustainability:

i.   discourages active recruitment from countries with critical health workforce shortages;

ii.   encourages utilization of Code norms as a guide when entering into bilateral, regional, and multilateral arrangements to further international cooperation and coordination;

iii. identifies the need to develop and support circular migration policies between source and destination countries;

iv.   encourages countries to develop sustainable health systems that would allow for domestic health services demand to be met by domestic human resources;

v.   emphasizes the importance of a multi-sectoral approach in addressing the issues; and

vi.   places particular focus on the need to develop health workforce policies and incentives in all countries that support the retention of health workers in underserved areas.

Tracking and reporting on action on the code

As a voluntary instrument, the Code will have effect if there is no plan to monitor its implementation and track the action being taken by WHO member states. Members states will report to the WHO Secretariat on the code every three years, beginning in 2012. Its contents are considered as dynamic, subject to review.

The code in Article 6 calls for 'comparable and reliable' data collection for ongoing monitoring of health worker recruitment and migration and reporting to the WHO secretariat every three years. This is an important means to promote implementation and accountability, Early government and wider stakeholder engagement is thus expected to ensure that the monitoring is both feasible and effective. The first global review of this reporting is timed for the 2012 WHA.

It is thus important to identify useful indicators to track the implementation of the code. Those proposed below could be used for reporting purposes especially at the forthcoming WHA in May 2012:

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

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

iii. Is there policy and practice encouraging circular migration (i.e. migration within countries in east and southern Africa and return migration from destination countries)?

iv.   Is there a data collection system on health worker migration flows that also maps the destination countries?

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

vi.   Is there collaboration of source countries and destination agencies or countries to sustain human resource development and training, including through negotiation of compensation modalities?

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

viii. Are there any new development assistance efforts (including mechanisms for compensation) to support coordination and collaboration on health worker migration between destination and source countries?

In monitoring implementation of the code there could be an annual scorecard of performance of countries against agreed key indicators and documentation of best practice cases and other documents to encourage action.

Actions taken and future steps

The Code has only recently been agreed to and there is still need to popularise it at national level with various stakeholders to help in its implementation. African countries need to spearhead the communication and advocacy work for this. It will, however, be two years in May 2012 since the adoption of the code and there should be progress to report on in relation to recruitment and migration of human resources for health.

According to Article 7.3 of the Code on information exchange, *"For purposes of international communication, each Member State should, as appropriate, designate a national authority responsible for the exchange of information regarding health personnel migration and the implementation of the Code. Member States so designating such an authority, should inform WHO."*

As of June 2011, 48 countries had thus far reported their National Authority in relation to the code to WHO, with 13 countries from Sub-Saharan Africa as indicated in the table overleaf.

Reporting on the National Authority to the WHO has primarily come from developing countries. This suggests the importance of the Code to these countries, but also indicates a need for greater reporting from destination countries, particularly those that are most common recipients of health worker migration from east and southern Africa.

At minimum reporting on the Code calls for countries
● to create or strengthen Country Multi-stakeholder Alliances (CCF) to lead implementation of the code
● to strengthen HWF Information Systems (in country system observatories)
● to develop long term strategies for managing health worker migration, while acting on short term priorities and conducting frequent reviews to track progress.

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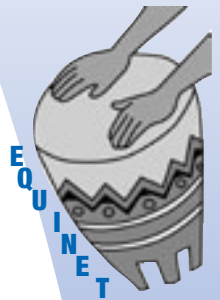
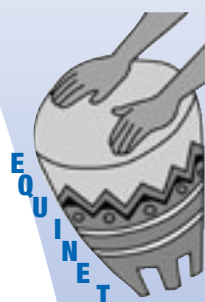| African countries-ECSA	Other African Countries
Kenya	Congo
Mauritius	Cameroon
Swaziland	Sudan
Uganda	Ghana
Democratic Republic of Congo	Mauritania
Angola	Rwanda
Namibia	
Other Developing Countries	**Developed countries**
Saint Vincent and the Grenadines	Austria
Saudi Arabia	Belgium
Singapore	Finland
Thailand	Netherlands
Yemen	Portugal
Republic of Korea	Russian Federation
Albania	Hungary
Armenia	Latvia
Belarus	Lithuania
Chile	Maldives
Colombia	Mexico
Cyprus	Monaco
Czech Republic	Myanmar
El Salvador	Nicaragua
Estonia	Oman
Georgia	Paraguay
Guatemala	Qatar

Source: Zurn P. 2011

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