A review of codes and protocols for the migration of health workers

Catherine Pagett and Ashnie Padarath

EQUINET DISCUSSION PAPER 50

September 2007

Valuing and Retaining our Health Workers

A review of codes and protocols for the migration of health workers

Catherine Pagett and Ashnie Padarath

Health Systems Trust (South Africa)

EQUINET DISCUSSION PAPER 50

September 2007

Valuing and Retaining our Health Workers

TABLE OF CONTENTS

EXECUTIVE SUMMARY

For many health professionals, increased globalisation and internet access in the 21st century are a blessing – now they can pursue career opportunities in the global labour market like never before. But the flow of skilled workers is largely one-way, from poor countries, like those in Africa, to wealthy countries, such as OECD countries in the industrialised North. And this outward migration comes at a cost to their poor home countries: weakened health systems, the erosion of health gains and the loss of intellectual capital. In addition, these countries do not recoup the 'investment' they made when they subsidised the education and training of these health professionals.

Clearly there is a need to find ways of managing this migration so that poor countries do not suffer any further. In the past decade, policy statements, codes of practice and bi-lateral agreements have been developed to:

- address the push and pull factors leading to migration;
- make recommendations for ensuring that recruitment takes place in an ethically responsible and acceptable manner; and
- ensure that the social and economic costs and benefits of migration are fairly distributed between source countries (their countries of origin) and receiving countries (the countries to which they emigrated).

Against this backdrop, the Regional Network for Equity in Health in East and Southern Africa (EQUINET) commissioned the Health Systems Trust (HST) to write this paper, in cooperation with ECSA-HC, a review of current multi-lateral agreements, codes of practice, bilateral agreements, regional agreements, and strategies and position statements that govern the migration of health workers from ESA (East and Southern African) countries. The main purpose of this paper is to provide an overview of the current situation in ESA, so the approach taken here is rather general – these instruments were analysed according to their scope, principles and content, but not according to how they are working in practice. The paper was presented at the EQUINET/ HST/ ESCA HC regional policy and research meeting on health worker migration and retention in ESA, held from March 17 to 19, 2007, in Arusha, Tanzania, where it was proposed that further investigation should be done to find out the how the instruments work in practice.

This literature review was conducted by sourcing government documents, current literature and news bulletins. Information was also provided through email communications with key informants. The document search was performed through online search engines. Additional information was gathered through discussion with key informants and stakeholders at the EQUINET/ HST/ ESCA HC regional policy and research meeting.

The findings of the review have proved to be disappointing. Despite renewed international interest in the ethics of recruiting health workers from poor countries, current frameworks and Codes have clearly been unable to stem the tide of workers flowing to the North (with some exceptions, such as the UK). Key constraints include the following:

- The framework in which to implement the Codes is weak or non-existent.

- The instruments that are being used are voluntary and not legally binding. They have no legal status and so there are no sanctions for non-compliance.

- No one is advocating that countries should subscribe to the Codes.

- There is a serious lack of adequate and effective data collection and monitoring systems.

- No formally constituted bodies exist to perform the role of watchdog for countries that have subscribed to the instruments.

- Codes and frameworks may have only limited impact if the push factors driving migration, as well as health worker shortages in the North, are not addressed together.

1. INTRODUCTION

What are the costs and consequences of the migration of professional health care workers from poor countries to rich countries? This topic is subject to much debate and analysis by researchers. They point out that there are costs that are carried by the health worker's country of origin, in the form of weakened health systems, the erosion of health gains, the loss of intellectual capital and a diminishing return on the investment made by the country when it subsidised the education and training of these workers.

The movement of health professionals (due to exogenous and endogenous push and pull factors) has been facilitated largely by globalisation and increasingly porous country borders, which has resulted in a 'reverse subsidy' from poor to rich countries because knowledge and skills are transferred from the poor country to the rich country. For example, it is believed that the developing world is subsidising industrialised countries by about US$500 million a year in this way. The African Union estimates that it costs US$60,000 to train a general practitioner in Africa and US$12,000 to train a medical auxiliary (JLI, 2004).

Tables 1 to 3 below illustrate recent statistics about the migration of health workers from East and Southern Africa (ESA) to industrialised countries in the North.

Table 1 lists the push and pull factors that promote the migration of health workers from sub-Saharan Africa to rich countries in the industrialised North.

Table 1: Push and pull factors that promote the migration of health workers from sub-Saharan Africa

Push factors (from poor countries)	Pull factors (towards rich countries)
Resource-poor health systems	Available jobs
Low salaries	Good pay
Deteriorating work environments	Regular workload
Inadequate medicine and equipment	Reasonable conditions of work
Poor human resource planning	Economically and politically stable
Political tension and upheaval	country
Gender discrimination	Safe living environment
Lack of personal security	Good quality of life
HIV/AIDS	Better social systems
Poor housing	Better opportunities
Lack of transport	
Diminishing social systems	
(education, pension etc)	

Source: Labonte, Packer et al, 2007

Table 2: The number of ESA physicians working abroad in 2002

Physicians Born in East, Central & Southern Africa (ECSA) Working in the Top Nine Receiving Countries, 2002												
		Top Nine Receiving Countries										
Sending Country	Total Physicians	UK	US	France	Canada	Australia	Portugal	Spain	Belguim	South Africa	Total Abroad	Fraction of Pop
Botswana	598	28	10	0	0	3	0	0	1	26	68	11%
Angola	2,983	16	0	5	25	0	2,006	14	5	31	2,102	70%
Congo, DR	6,199	37	90	139	35	0	42	4	107	98	552	9%
Lesotho	171	8	0	0	0	0	0	0	0	49	57	33%
Malawi	493	191	40	0	0	10	21	1	1	48	293	59%
Mauritius	1,782	294	35	307	110	36	1	0	20	19	822	46%
Mozambique	1,769	16	20	0	10	3	1,218	4	2	61	1,334	75%
Namibia	548	37	15	0	30	9	0	0	0	291	382	45%
Seychelles	170	29	0	4	10	3	0	0	0	4	50	29%
S. Africa	34,914	3,509	1,950	16	1,545	1,111	61	5	0	(-834) †	7,363	21%
Swaziland	186	4	4	0	0	0	1	0	0	44	53	28%
Tanzania	2,620	743	270	4	240	54	1	1	3	40	1,356	52%
Zambia	1,553	465	130	0	40	39	3	0	3	203	883	57
Zimbabwe	3,132	553	235	0	55	97	12	1	6	643	1.602	51%

Table 3: The number of ECSA nurses working abroad in 2002

Nurses Born in East, Central and Southern Africa (ECSA) Working in the Top Nine Receiving Countries, 2002

Sending Country	Total Nurses	Top Nine Receiving Countries									Total Abroad	Fraction of Pop
		UK	US	France	Canada	Australia	Portugal	Spain	Belgium	South Africa		
Botswana	3,636	47	28	0	0	0	0	0	0	5	80	2%
Angola	14,976	22	135	12	10	4	1,639	8	11	0	1,841	12%
Congo, DR	19,257	44	207	206	50	0	9	4	1,761	7	2,288	12%
Lesotho	1,302	5	6	0	0	0	0	0	0	25	36	3%
Malawi	2,248	171	171	0	10	14	0	0	0	11	377	17%
Mauritius	7,160	4,042	107	86	75	195	1	0	22	3	4,531	63%
Mozambique	4,517	12	64	0	10	0	748	2	6	11	853	19%
Namibia	2,806	18	6	0	0	4	1	0	6	118	152	5%
Seychelles	597	80	28	8	30	29	0	0	0	0	175	29%
S. Africa	95,830	2,884	877	20	275	955	58	3	33	-261†	4,844	5%
Swaziland	3,441	21	36	0	10	4	0	0	0	25	96	3%
Tanzania	26,976	714	291	0	75	29	0	1	0	12	1,122	10%
Uganda	10,973	714	291	0	75	29	0	1	0	12	1,122	10%
Zambia	12,097	664	299	0	25	68	2	0	0	52	1,110	9%
Zimbabwe	15,363	2,834	440	0	35	219	14	3	0	178	3,723	24%
Total	221,179	12,004	2,923	332	845	1,553	2,474	22	1,839	451	22,181	10%

- A review of codes and protocols for the migration of health workers

Table 2 shows the number of ESA physicians who were working abroad in 2002. Statistics are provided for the top nine receiving countries, ie: those countries that received the most physicians from ECSA countries.

Table 3 shows the number of ECSA nurses who were working abroad in 2002. Statistics are provided for the top nine receiving countries, ie: those countries that received the most nurses from ECSA countries. Most source countries are in Africa, the Caribbean, South-east Asia and
South Asia, with their workers migrating to destination countries such as Australia, Canada, France, Belgium, the United Kingdom and the United States (JLI, 2004).

In many instances, the pool of available health care workers in source countries has been depleted. The 2006 WorId Health Report estimates the combined shortage of doctors, nurses and midwives in sub-Saharan Africa to be 818,000. (World Health Report, 2006). In 2006, at least 11,000 physicians who were trained in sub-Saharan Africa were licensed and practicing in the UK, USA and Canada (Packer, Labonte and Spitzer, 2006).

Given the far reaching consequences of migration and its impact on human resources for health (HRH) and international health systems, a new trend has emerged to explore ways of managing and curbing migration. The past decade has seen a plethora of policy statements, codes of practice and bi-lateral agreements being developed – all of which in some way or the other attempt to address the push and pull factors leading to migration and which make recommendations for ethically responsible and acceptable recruitment.

Against this backdrop, Regional Network for Equity in Health in East and Southern Africa (EQUINET) commissioned the Health Systems Trust (HST) to produce this review, in cooperation with ECSA- HC of existing codes and protocols in ESA that affect worker migration, focusing on their scope and major policy content. The following instruments were identified as affecting migration, and they will be discussed in detail in this review:
• multi-lateral agreements
• codes of practice
• bi-lateral agreements
• regional agreements
• position statements
• strategies.

This review provides an overview of those instruments in ESA countries that prevent, prohibit, curb or manage the migration of health workers and/ or promote their retention and production, both globally and regionally, highlighting the numbers and procedures for health worker recruitment and employment, in terms of distributing the costs and benefits of migration. Please note that it does not address how the instruments are working in practice.

The review was presented at the annual EQUINET/ HST/ESCA HC regional policy and research meeting on health worker migration and retention in East and Southern Africa, held from 17 to 19 March 2007 in Arusha, Tanzania. At this meeting, it was proposed that further research should be conducted into how the instruments work in practice.

Table 4 provides an overview of the various instruments that will be covered in this review.

Table 4: Instruments that govern the migration and recruitment of health workers from ESA countries

Example of instrument	Type of instrument	Date issued	Forum and major partners
General Agreement on Trade and Services (GATS) Modes 1-4 Health Services	Multi-lateral agreement		World Trade Organisation
Commonwealth Code of Practice for the International Recruitment of Health Workers and Companion Document	Code of practice	May 2003	Pre-WHA meeting of Commonwealth Health Ministers
NHS Code of Practice for the International Recruitment of Healthcare Professionals	Code of practice	October 2001 (last revised Dec. 2004)	UK Department of Health
Melbourne Manifesto – A Code of Practice for the International Recruitment of Health Care Professionals (WONCA)	Code of practice	May 2002	World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/ Family Physicians (WONCA) World Rural Health Conference

Memorandum of Understanding between South Africa and United Kingdom	Bi-lateral agreement	October 2003	South Africa and United Kingdom
Bi-lateral Agreement between the United Kingdom and Philippines	Bi-lateral agreement	2002	NHS and the Philippines Overseas Employment Administration (POEA)
Memorandum of Understanding between Namibia and Kenya on Technical Cooperation in Health	Bi-lateral agreement	2004	The Ministry of Health and Social Services of the Government of Namibia and the Ministry of Health of the Government of the Republic of Kenya
Migration Dialogue for Southern Africa	Position statement	Nov. 2004	MIDSA-Migration and Health Workshop, Cape Town, South Africa
WHO AFRO - Human Resources Development for Health: Accelerating Implementation of the Regional Strategy	Position statement	October 2002	52nd Session of the WHO Regional Committee for Africa, Harare, Zimbabwe
London Declaration	Position statement	April 2005	BMA/ Commonwealth conference on international health workforce.
World Health Assembly Resolution 57.19	Position statement	May 2004	WHO 57th WHA
ESCA Regional Meeting Resolutions	Position statement	Oct. 2001, Nov. 2003, Nov. 2004, Oct. 2001	ESCA 34th, 38th and 40th Regional Health Ministers Conference
International Council of Nurses	Position statement	2002	International Council of Nurses
World Medical Associations statement on Ethical Guidelines for the International Recruitment of Physicians	Position statement	May 2003	WMA General Assembly, Helsinki, Finland

SADC Protocol on the Free Movement of People	Regional agreement	1995	Southern African Development Community
NEPAD Health Strategy	Strategy	2003	African Union
South Africa Department of Health Policy on Recruitment, Employment and Support of Foreign Health Professionals and Recruitment of Foreign Health Professional Guidelines	Strategy / Policy	2006	National Department of Health

2. METHODS

This section outlines the search strategy and sources of information used in this review. Relevant material was found through various types of sources for the purposes of this review. Government documents were used, as well as international agreements, all available current literature, key informants' personal accounts and news bulletins. All information was gathered through:

- internet search engines, including Google, PubMed and Medline;
- email communications with key informants; and
- discussion with informants and stakeholders at the EQUINET/HST ESCA HC regional policy and research meeting.

The paper was externally reviewed and revised with this input.

The codes and protocols reviewed include only those that relate to migration and retention policy and procedures within Eastern, Central and Southern African countries.

3. INSTRUMENTS THAT GOVERN THE MIGRATION OF HEALTH WORKERS

This section reviews the instruments that govern the international, regional and national migration of health workers:

• multi-lateral agreements;

• codes of practice;

• bi-lateral agreements;

• regional agreements;

• strategies; and

• position statements.

3.1 Multi-lateral agreements

A multi-lateral agreement is a trade agreement between three or more countries that is legally binding, which means that commitments cannot be changed without paying compensation to other parties. The General Agreement on Trades in Services (GATS) is an example of a multi-lateral agreement that operates in ESA.

3.1.1 General Agreement on Trades in Services (GATS)

The GATS agreement was adopted in 1995 and is administered by the World Trade Organisation (WTO). Its aim is to liberalise trade in services by encouraging the privatisation of health services and an open market for trade. GATS is the first legally enforceable multilateral agreement for the trade of services, and it includes commitments within almost all service sectors. However, countries are not obliged to make commitments in all sectors (such as health, communication and environmental sectors) and can specify the scope of the commitment within each sector (for example private, public and/or commercial sectors) (Nielson, 2006).

Certain commitments under the GATS agreement pertaining to health services have a clear influence, internally and internationally, on the migration of health workers from the public to the private sector and from the developing to the developed world. These commitments erode restrictions placed on immigration, entry visas and work permits (Sanders and Lloyd, 2005). (Refer to Mode 4 in the service commitments listed below.)

GATS divides the supply of services into four modes:

- *Mode 1:* Cross-border supply: This mode includes telemedicine, tele-education, teleconferencing and subscription to journals and databases on the Internet. It has a limited impact on human resources for health in an international context (Sanders and Lloyd, 2005).
- *Mode 2:* Consumption abroad: This mode includes travelling abroad in the form of health tours to access cheaper health services and seek high-technology treatments.
- *Mode 3:* Commercial presence: This mode allows foreign companies to deliver services locally and includes setting up privately owned or managed hospitals, clinics and health insurance.
- *Mode 4:* Temporary movement of natural persons: These modes refers to the crossborder movement of health professionals either for study purposes or to temporarily provide health services outside their country of origin by filling vacancies abroad. Mode 4 enables the removal of many barriers that impede the movement of health professionals, such as stringent requirements for work permits, visas, and licences to practice etc. It is widely considered to be responsible for facilitating the migration of human resources. (Sanders and Lloyd, 2005).

Countries that enter into health services commitments can make separate commitments to each of the modes (Nielson, 2006). For example, a country may allow foreign health workers to work in the country (Mode 4) but not allow their nationals to receive health care in a foreign country (Mode 2). Distinctions can also be made horizontally within the sector, according to professional designation (Nielson, 2006).

Mode 4, which governs the 'temporary' movement of health workers, raises concerns about the ability of signatory countries to enter into bi-lateral agreements with other countries, thanks to the principle of Most Favoured Nation (MFN). This principle states that any GATS member that grants favourable treatment to any other country must do the same with all other GATS signatories. In other words, if a developing country has signed Mode 4 of the GATS agreement and enters into a bi-lateral with another GATS country, the privileges stated in the bi-lateral agreement must be available to all other GATS countries. The only exceptions occur when a country has taken a MFN exemption or if a regional trade agreement is in effect (Nielson, 2006).

GATS has a well-developed grievance and sanction system known as the Dispute Settlement Process. The dispute settlement committee will hear all disputes but the process tends to favour developed countries, as disputes are lengthy and expensive. Currently, ESA countries that have signed on to GATS commitments include Burundi, Malawi, Swaziland and Zambia.

3.2 Codes of practice

In this section, the following codes of practice will be examined in detail:

- the National Health System (NHS) Code of Practice for the International Recruitment of Healthcare Professionals;
- the Commonwealth Code of Practice for International Recruitment of Health Workers; and
- the Melbourne Manifesto.

Note that all of the codes of practice in operation in ESA countries are non-binding. They constitute 'soft law' and their scope is similar to that of a statement of intent. In other words, the codes make no provisions for sanctions against employers or others who breach the codes, and they offer no incentives for compliance (OCED, 2004).

3.2.1 NHS Code of Practice for the International Recruitment of Healthcare Professionals

In 1999, the first code of practice governing the recruitment of international nurses was developed by the United Kingdom's National Health System (NHS) to investigate complaints by South Africa and the Caribbean about lack of compensation for the recruitment of their health care workers. The UK's Department of Health issued guidelines on the international recruitment of health workers; however, this initial document was limited in scope.

Professionally, it only applied to nurses and, geographically, it only banned the active recruitment of health workers in South Africa and the West Indies. In October 2001, these guidelines were replaced by the Code of Practice for the International Recruitment of Healthcare Professionals (DOH, 2001). It extended the scope to include all health professionals and included a proscribed list of developing countries banned from active recruitment (unless a bi-lateral agreement existed between the governments). However, a major loophole still existed because the 2001 Code did not cover the private healthcare sector, which continued to recruit from the proscribed list (Labonte et al, 2007). This situation allowed the private sector a 'back-door' entry into the public healthcare system. As a result, in December 2004, the NHS revised the Code for a third time and extended the scope of the Code to:

- include agency-recruited temporary and locum healthcare professions;
- enable all healthcare organisations (including the independent sector) to sign up to the principles contained in the within the Code of Practice; and

- mandate the NHS to deal only with recruitment agencies that comply with the Code of Practice for both domestic and international recruitment.

The NHS Code of Practice is the UK's national guideline governing the recruitment of all international health workers. It lists ethical policies and procedures to be followed in international recruitment scenarios, such as targeted recruitment guidelines, education and language proficiency requirements, and employment laws (DOH, 2004).

The guiding principles of the Code apply to all health professionals and all NHS employers are responsible for implementing the Code, including private recruiting agencies working with the NHS.

Although the Code of Practice has been widely welcomed in the public health sector, some limitations still exist. For example, there is still no formal mechanism to ensure or monitor compliance (Padarath et al, 2003). According to a UK Department for International Development (DFID) report, a common misconception by national and international commentators is that the Code 'prevents' the migration of health workers (Buchan and Dovlo 2004). In fact, the opposite is true – one of the overarching principles of the NHS code is that "international recruitment is a sound and legitimate contribution to the development of the health care workforce" (page 7, DOH, 2004). This means that it aims not to prevent the migration of healthcare workers, but to mitigate the effects of recruitment by banning active recruitment in developing countries that do not have a pre-existing agreement for recruitment in place. It states that "active recruitment must be undertaken in a way that seeks to prevent a drain on valuable human resources from developing countries" (ibid).

However, the Code also clarifies that "individual healthcare professionals from developing countries, who volunteer themselves by individual, personal application, may be considered for employment" (ibid). Unfortunately, misunderstandings about the purpose of the Code, combined with a lack of compliance monitoring systems, may only serve to detract attention from promising new methods of recruitment within the UK. International recruitment is dynamic, which requires that the Code is kept under review (Buchan et al, 2004). For example, the use of the internet to advertise jobs on employer and recruitment agency websites does not break the NHS Code of Practice, but it is a form of passive recruitment that contributes to the flow of workers to the UK (ibid). It allows individuals who volunteer themselves by individual application to recruitment agencies to obtain employment in the UK (Packer, Labonte and Spitzer, 2006).

Another limitation of the Code concerns the revisions made to it in 2004. The revisions extend obligations of ethical recruitment to the private sector; however, the process is voluntary and private sector organisations only have to 'sign up' to the principles. While many private sector organisations have done so, others have failed to, suggesting that a loophole still exists for workers to enter the NHS system through the private sector 'back door'. Some countries have addressed this issue. For example, South Africa does not allow migrant workers to move between the public and private sectors or between provinces (DOH, 2006).

On a positive note, it's fair to say that the Code of Practice has positively influenced international agreements and promoted change in the area of health worker migration. Stipulations for bi-lateral agreements in the Code have led to the formation of memoranda of understanding between the UK and South Africa, the Philippines, China, Pakistan and India. These countries are all on the proscribed list for active recruitment, but have mutually beneficial agreements in place with the UK to negotiate the terms of recruitment.

Table 5 describes the Code of Practice for the International Recruitment of Healthcare Professionals in more detail.

Table 5: NHS Code of Practice for the International Recruitment of Healthcare Professionals

Policy scope	Retaining and managing health workers and curbing migration
The NHS Code of Practice applies to the employees andemployers of the NHS, as well as: • agency-recruited temporary and locum healthcare professionals; • enabling all healthcare organisations to sign-up to the principles; and • mandating the NHS to deal only with recruitment agencies that comply with the Code of Practice for both domestic and international recruitment.	The NHS code manages migration and does not promote retention or production of health workers in either the source or destination country. An overarching principle of the Code is that "international recruitment is a sound and legitimate contribution to the development of the health care workforce". It manages the recruitment of international workers into the United Kingdom through principles and best practice benchmarks that forbid the active recruitment of health personnel from developing countries, unless a bi-lateral agreement exists between the two countries.

Policy principles	• International recruitment is a sound and legitimate contribution to the development of the healthcare workforce.
	• Extensive opportunities exist for individuals in terms of training and education and the enhancement of clinical practice.
	• Developing countries will not be targeted for recruitment, unless there is an explicit government-togovernment agreement with the UK to support recruitment activities.
	• International healthcare professionals will have a level of knowledge and proficiency comparable to that expected of an individual trained in the UK.
	• International healthcare professionals will demonstrate a level of English language proficiency consistent with safe and skilled communication with patients, clients, carers and colleagues.
	• International healthcare professionals legally recruited from overseas to work in the UK are protected by relevant UK employment law in the same way as all other employees.
	International healthcare professionals will have equitable support and access to further education and training and continuing professional development as all other employees.
Policy content	The policy lays out best practice benchmarks to ensure the international recruitment works in accordance with the principles of the Code of Practice. The guidelines include:
	• No active recruitment with countries on the proscribed list is allowed without a bi-lateral agreement.
	• International recruitment must follow good and ethical practices.
	• No fees will be charged to health professionals for gaining employment.
	• Appropriate information must be provided to health professionals on their role.
	• All health professionals will be registered with the appropriate UK regulatory body.
	• Safe and effective supervision will be provided.
	• Health professionals require a health assessment and security check.
	• A valid work permit is required before entry into the UK.
	Individual healthcare professionals from developing countries who make individual personal applications, may be considered for employment.

Implementing and monitoring mechanisms	The NHS employers are responsible for implementing the Code. A list of commercial recruitment agencies adhering to the Code is managed by the NHS.
Provisions for grievances and sanctions	If non-compliance by an NHS-approved recruitment agency is suspected, a grievance application can be made to the NHS employers and an investigation of the offending agency will be performed. If found guilty, the offending agency will be removed from the approved list and it will no longer be able to supply workers to the NHS.

3.2.2 Commonwealth Code of Practice for International Recruitment of Health Workers

The Commonwealth Code of Practice for International Recruitment of Health Workers and its associated Companion Document were adopted at the pre-World Health Assembly Meeting of Commonwealth Health Ministers held in Geneva on 18 May 2003. Negotiations between source and receiving countries were held and it was hoped that the Commonwealth principles of co-operation and consensus would spur on all Commonwealth governments to subscribe to the agreement (Commonwealth, 2003a).

The Code is voluntary and associative. In future, it will be extended to non-Commonwealth countries. It provides Commonwealth governments with a framework for the recruitment of international health workers by:

• discouraging the targeted recruitment of workers from countries that are experiencing shortages;

• safeguarding the rights of recruits and the conditions related to their profession in the destination country; and

• discouraging the recruitment of health care workers with an outstanding obligation to their country (however, the health workers carry the responsibility to provide this information).

The Code acknowledges that recruitment can deplete the source country's human resources and negatively impact on its provision of health services. To mitigate these effects, the Code suggests the following:

• Dialogue should be created between developed and developing countries to balance the needs of developed countries to recruit and developing countries to retain staff due to shortages, through contractual agreements such as bonding health workers.

• Bilateral agreements should be drafted to regulate the recruitment process.

All employment agencies must be bound by this Code and governments must set up regulatory systems for recruitment agencies and implement mechanisms to detect noncompliance (Labonte, Packer et al, 2007).

Finally, to strengthen the Code, the Commonwealth suggests ways to minimise the impact of lost health workers on the health systems of their source countries. For example, recipient countries should consider providing compensation or reparation to source countries through:

- the transfer of technology and skills;
- training programmes to enable those who return to bring back new skills; and
- arrangements to facilitate the return of recruits.

The Commonwealth Companion Document contains definitions and detailed guidelines to follow while implementing principles for the ethical recruitment of health workers. The signatories to the Code include all the Commonwealth health ministers who were present at the pre-World Health Assembly meeting of Commonwealth health ministers in Geneva on 18 May 2003. Unfortunately, the signing of the Code was more of a ceremonial affair than a formal acceptance by the countries involved. Only the health ministers present at the meeting were able to sign the Code and no provision was made to allow countries not present at the meeting to do so. As a result, some debate exists about whether the Commonwealth Code applies to those countries that did not sign the Code. Many leading commentators and the World Health Organisation (WHO) have commented on the absence of signatures by developed countries. A 2005 WHO Bulletin stated that developed countries are "reluctant to make a formal commitment to provide compensation or reparations" (page 85, Nullis-Kapp, 2005). Bach (2003) speculates that developed countries did not sign because the current situation benefits them by offering cost-effective recruitment. Although it is uncertain exactly how this Code is implemented by any of the countries involved, it has led to the creation of other agreements and statements on the migration of health workers.

A Canadian study by Labonte and Packer et al (2007) mentions another limitation of the Code – the rights of migrant employees are prioritised over the protection of the health care systems of developing countries. The study also noted that systems for implementing the Code need to be strengthened and that no system exists for monitoring and evaluation (Labonte et al, 2007).

Table 6 describes the Commonwealth Code of Practice for International Recruitment of Health Workers in more detail.

Table 6: Commonwealth Code of Practice for the International Recruitment of Health Workers

Policy scope	Preventing, prohibiting or curbing migration
Commonwealth health ministers signed the Code at the Commonwealth Health Ministers' Conference in Geneva on 18 May 2003. Through the Commonwealth principles of co-operation and consensus, it is hoped that all Commonwealth governments will subscribe to the Code.	The Code encourages the establishment of a framework of responsibilities between governments, recruitment agencies and the recruits. It does not attempt to undermine the right of the health worker to migrate to countries that wish to admit them; instead it seeks a framework that balances the responsibilities of health workers to the country they were trained in and their right to seek employment in other countries. **Management of migration** The Commonwealth Code manages the selection procedures, contractual/job requirements, migrants' rights, compensation to source countries and strategies for addressing the effects of international recruitment. **Retention of workers in source country** The Commonwealth Code of Practice touches on workforce planning and suggests measures countries should take to retain workers, such as: • outlining terms and conditions of service; • monitoring and evaluation of human resource strategies and activities; • increasing the supply of graduates; • focusing on recruitment and retention of staff; • ensuring the ongoing training and maintenance of professional skills; • improving the work environment, giving particular attention to the resourcing and provision of health care at the community level and in rural areas; and • ensuring occupational health and safety. Non-financial incentives should also be considered such as improved infrastructure, appropriate facilities for childcare, transportation, housing and continuing education. Finally, the Code encourages governments to devise methods to collect and analyse data on the movements of national health worker within and outside their borders to inform policy decisions and planning.

Policy principles	The Code lays out guiding principles promoting transparency, fairness and mutuality of benefit to avoid discrimination and dishonest recruitment practices.

Other principles deal with:
- the nature and requirements of the job;
- providing the proper and correct information for recruits on the cost of living and overall country conditions;
- working conditions and terms of employment;
- migrants' rights; and
- the mutuality of benefits. |
| **Policy content** | The content of the Code is detailed in the Companion Document to the Commonwealth Code. It provides definitions and details on the guiding principles and concepts of the Code. The document looks at the status of the Code, compensation agreements within the Code, strategies to address international recruitment, working with private recruitment agencies, selection procedures, workforce planning, application of the Code, the need countries outside the Commonwealth to adopt the Code, and human rights issues. |
| **Implementing and monitoring mechanisms** | The Code suggests the implementation of measures to monitor private recruitment agencies, which do not typically fall under the jurisdiction of the Ministry of Health or its Code of Practice.

The Code suggests that governments enter into agreements with the private recruitment agencies to promote good practice among recruitment agencies by only dealing with agencies who comply with the Code.

Steps are provided that governments can follow when entering into agreements with private recruitment agencies.

To monitor the agreements, governments should:
- design and implement early warning mechanisms to detect non-compliance at any stage;
- develop mechanisms capable of detecting impacts, such as general or specific staff shortages resulting from international development; and
- consider incentives that will encourage recruitment agencies to comply with the Code. |
| **Provisions for grievances and sanctions** | The Code does not lay out any provisions for grievances or sanctions within the Code, largely because the Code is not legally binding. |

3.2.3 The Melbourne Manifesto

The Melbourne Manifesto is a code of practice for the international recruitment of health care professionals that was adopted at the World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/ Family Physicians (Wonca). Its development was instigated by members of the Wonca organisation, including ESA countries South Africa, Zambia and Zimbabwe, and signed at the 5th Wonca World Rural Health Conference held in 2002 in Melbourne, Australia.

The Code has its genesis in discussions on equity and social justice that led to agreement by the delegation to address the ethics of international recruitment. In rural health, the issue of international recruitment is of major concern because the majority of health workers recruited by developed countries are placed in rural communities to address shortages. For this reason, among others, the delegation agreed that a set of guidelines and principles were required to govern the ethical recruitment of health care workers. The Code was given full support, with all but one of the 900 delegates passing the document (Rudasa, 2002).

The Code's purpose is to promote the best standards of health care around the world by calling on countries to use rational workforce planning to meet their needs, while discouraging all activities that could harm another country's health care system (Wonca, 2002). The Code requires all health professionals to focus not only in rural areas within a country, but on any needy area that fails to attract medical professionals and where imported medical professionals help fill the gaps (for example, indigenous areas).

The Melbourne Manifesto's principles focus on the ability of countries to meet the needs for health professionals in rural and urban areas through retention and workforce planning. The Code seeks to balance the principles of social justice and the autonomy of an individual. It acknowledges that the international exchange of health workers is an important part of international health care development to both source and receiving countries. However, only countries with an oversupply of health workers should contribute to the global health care. In all circumstances, integrity, transparency and collaboration should characterise the recruitment of health care workers and a Memorandum of Understanding (MOU) must be signed before one country recruits from another.

The Code is divided into sections that outline effective workforce planning strategies to consider, either when a country is planning to recruit health workers or is experiencing a loss of health care workers. The Melbourne Manifesto provides suggestions to both source and receiving countries on proper human resource planning. For instance, Wonca urges countries that are considering recruitment to ensure available access to an adequate number

of spaces for post-secondary education, to implement incentive programs to work in rural or remote areas, to consider alternative ways to provide care through workforce re-structuring and to use the skills of providers who have already entered the country, but have been unable to find work.

A major benefit of the Melbourne Manifesto is that the guidelines are more specific than those of other codes. Labonte et al (2006) suggest that it is potentially a more useful tool than the Commonwealth Code. However, a common downfall remains that the Code fails to suggest how to properly monitor and evaluate compliance to the Code.

Since the Code's inception, many other new codes and MOUs have come into existence. Numerous recruiting organisations within Australia have adopted its principles and guidelines, such as the Australian Rural and Remote Workforce Agencies Group (ARRWAG) and Rural Doctor's Network of New South Wales. However, private agencies that are not part of the government-supported rural workforce agencies do not support it and are not bound by it (Couper, 2003a).

Couper (2003b) suggests the next steps are to propose an international process for evaluation and monitoring of the international migration of health professionals to inform the Code. However, Wonca does not have the resources to carry out this monitoring process, so it would have to be undertaken by another entity.

Table 7 provides more details about the Melbourne Manifesto.

Table 7: Melbourne Manifesto

Policy scope	Preventing, prohibiting or curbing migration
The Melbourne Manifesto was developed through the instigation of the membership of the Wonca organisation and signed at the 5th Wonca World Rural Health Conference in 2002 held in Melbourne, Australia.	The Melbourne Manifesto is focused on encouraging rationale workforce planning by all countries in order to meet their own needs. The Code suggests that countries considering or benefiting from recruitment should examine their own circumstances and consider how their recruitment policies and practices are affecting developing countries.They should do the following: • Ensure that the number and distribution of undergraduate and postgraduate training posts available within their country are adequate to meet the need. • Improve work conditions and education opportunities to encourage health workers to work in areas of need. • Develop and implement ethical recruitment policies.

Policy scope (continued)	• Build partnerships with educational institutions in lessdeveloped countries. • Consider alternative and innovative ways of providing care in areas of need such as the development of multidisciplinary **Management of migration** Countries that are benefiting from the recruitment of health workers should develop Memoranda of Understanding (MOUs) with countries from which they recruit and should only recruit when a MOU exists. The Code also suggests that developed countries should enter into exchanges with the developing countries to help manage the outflow of workers by providing workers to the developing country for short-term contracts. **Retention of workers in source country (continued)** Developing countries that are experiencing a damaging loss of health workers should explore reasons for this loss and address them by doing the following: • Evaluating training programmes to ensure that there is a correct fit between the skills and knowledge taught and their national needs. • Ensure that working conditions, incentives and educational opportunities are sufficient or acceptable. • Consider alternative and innovative ways
Policy principles	The Code asserts the following: • It is the responsibility of each country to ensure sufficient human resources for health planning. • A balance is needed between social justice and the autonomy of an individual. • Integrity, transparency and collaboration should characterise any recruitment of HCPs. • International exchanges are an important part of international health care development.
Policy content	The Code focuses on the retention and prevention of health care workers through various workforce planning strategies.
Implementing and monitoring mechanisms	There should be an international process in place to ensure the evaluation and monitoring of international migration of HCPs to inform the Code.
Provisions for grievances and sanctions	The Code does not lay out any provisions for grievances or sanctions within the Code, largely because the Code is not legally binding.

3.3 Bi-lateral agreements (Memoranda of Understanding)

A bi-lateral agreement or Memorandum of Understanding (MOU) is a signed agreement between two countries to govern recruitment procedures. The agreement may include information regarding the following:

- how recruitment will be done;
- the benefits to each country;
- the nature and degree of compensation to be paid for health care professionals;
- the protection of recruited health workers under employment laws;
- support, further education and training of recruited health workers;
- support and encouragement of nationals to return to work in their country of origin; and
- monitoring of the MOU and/or code of practice.

In this section, two MOUs will be discussed:

- the Memorandum of Understanding between the United Kingdom and South Africa; and
- the Memorandum of Understanding between Namibia and Kenya on Technical Cooperation in Health.

3.3.1 Memorandum of Understanding between the United Kingdom and South Africa

The Memorandum of Understanding (MOU) between the UK and South Africa has often been cited as a good role model for the management of migration. (WHO Bulletin, 2005). The MOU resulted from a dialogue between the two countries regarding the recruitment of South African health workers. After the implementation of the NHS Code of Practice, the discussions moved to the formation of a Memorandum of Understanding between the two countries. They signed an agreement in October 2003.

The MOU focuses on sharing expertise and information on a range of key areas, including public health, management training and workforce planning through time-limited placements in each other's countries (Chetty and Maslin, 2006). The placements allow for South African health workers to gain clinical experience in the United Kingdom for a limited period of time while UK nationals work in South Africa, particularly in rural areas.

The process is being monitored through countries meeting two or three times a year to discuss the progress of implementation of the MOU. The meetings provide both countries with opportunities to discuss new issues and suggest

future objectives. For example, in preparation for the 2010 World Cup, joint work in emergency preparedness was discussed (Chetty et al, 2006).

It is also important to note that, like the NHS Code of Practice the Memorandum of Understanding does not stop individual health workers from applying to an NHS employer in the UK, provided they have not been recruited by an NHS-approved agency (Chetty et al, 2006).

3.3.2 Memorandum of Understanding between Namibia and Kenya on Technical Cooperation in Health

The Ministry of Health and Social Services of the Government of Namibia and the Ministry of Health of the Government of the Republic of Kenya agreed to a Memorandum of Understanding on Technical Cooperation in Health in June 2004.

The agreement provides guidelines for the temporary movement of health workers from Kenya to Namibia. Namibia, the receiving country, must make a request to the sending country, Kenya, for health workers. The movement of health workers is unidirectional (from Kenya to Namibia) and is referred to as a 'tour of duty' that is of an agreed-upon time between the countries (MOU, 2004).

Kenya is responsible for paying the salaries for all health workers during their tour of duty, while Namibia provides transportation, health coverage, living accommodation and living allowances (MOU, 2004).

The agreement was formed as a result of Kenya's inability to employ all of its health workers in Kenya due to conditions of an IMF agreement that limit the number of health workers in Kenya. Kenya continues to produce a large number of health workers, even though many health workers continue to be unemployed. This arrangement allows for Kenya health professionals to work in Namibia for a set period of time to gain employment, experience and skills, while providing needed health workers to Namibia (EQUINET, 2007).

3.4 Regional agreements

3.4.1 SADC Protocol on the Facilitation of Movement of Persons

The overall objective of this protocol is to eliminate the obstacles to the movement of persons with in the Southern African Development Community and, unlike other instruments discussed, it is a general migration policy that does not strictly address the movement of health workers. The specific objectives as stated in the Protocol are to facilitate:

- entry, for a lawful purpose and without a visa, into the territory of another State Party for a maximum period of ninety (90) days per year for bona fide visit and in accordance with the laws of the State Party concerned;

- permanent and temporary residence in the territory of another State Party; and

- establishment of the worker working in the territory of another State Party.

This protocol allows for the movement of workers within the Southern African Development Community without visa restrictions.

3.5 Strategies

The following two strategies will be discussed in this section:

- the NEPAD Health Strategy; and
- the South African Department of Health's Policy on the Recruitment, Employment and Support of Foreign Health Professionals.

3.5.1 NEPAD Health Strategy

The New Partnership for Africa's Development (NEPAD) Health Strategy has been adopted by African Ministers and the AU. It seeks to "establish or strengthen health systems and services so they can provide effective and equitable health care" (page 11, NEPAD, 2003). NEPAD identifies six sectors as priorities for achieving the goals of the health strategy; a major priority is human resources development, which is aimed at reversing the brain drain.

The health strategy focuses on both retention and migration strategies to mitigate the affects of health worker attrition. For instance, it calls on African governments to "strive to reduce the brain drain" through schemes that increase training and improve salaries and working conditions, and to engage in the development of bi- or multilateral agreements regionally and internationally (ibid). The scope of these agreements would include measures to mitigate the loss of health professionals on the source countries (Labonte et al, 2007). It also suggests that private sector investment, through an "appropriate mix of public-private partnerships in health development policies and strategies", is needed to provide funding and help in the retention of the health care workers.

3.5.2 SA Department of Health's Policy on the Recruitment, Employment and Support of Foreign Health Professionals

In April 2006, the National Department of Health in South Africa approved a policy on the Recruitment and Employment of Foreign Health Professionals in the Republic of South Africa. The Policy's purpose is to regulate the recruitment, employment, migration and support of foreign health professionals' residency status in South Africa (DOH, 2006). The primary aim of the Department of Health is to deploy health professionals to under-serviced and remote areas of the country.

As well as outlining the legal rights of immigrating individuals based on a resident categorization (i.e. permanent with/ without spouse, temporary with/ without spouse), the policy states various requirements, protocols and restrictions to be abided by to gain entrance to South Africa as a health care worker. For instance, the policy forbids the active recruitment of health care workers from other SADC countries, unless through a regulated exchange programme. It outlines education requirements and protocols for job certification and placement in South Africa and states that, through government-sponsored exchange programmes, preference for positions will be given to SADC applicants. Foreign workers may not migrate from one employer to another (public/private) or between provinces (DOH, 2006).

3.6 Position statements

The following section provides an overview of organisations that have issued position statements on the ethical recruitment of health care workers. The position statements include statements from regional and international organisations and have all been formally adopted by their respective organisation. A common thread is found throughout the position statements, as Southern African Ministers have consistently influenced the adoption of other position statements. Finally, the section closes with position statements by two international coalitions for health workers: the London Declaration and the International Council of Nurses position statement.

3.6.1 East, Central and Southern African Health Community (ECSA-HC)

Leading up to the 34th Regional Health Ministers' Conference in Dar es Salaam, Tanzania discussions held at different venues raised the issue of the recruitment of health workers from the developing world. In April 2001, the SADC Annual Health Sectoral Meeting held in Gabarone, Botswana expressed concern about the high numbers of nurses being recruited out of the region. In May 2001, the Pre-WHA Commonwealth Ministers' Meeting in Geneva expressed the same concern regarding the recruitment of Human Resources for Health from developing countries and agreed to develop a task force. Later, in June 2001, the SADC Health Ministers released a strongly

A review of
codes and
protocols
for the
migration
of health
workers

worded statement vilifying the active recruitment of health workers out of the region.

The 34th Regional Health Ministers' Conference was held in October 2001 with the theme: 'Strengthening Health Systems: Challenges and Priorities in East, Central and Southern Africa' (ECSA, 2001). Among other issues, the ESCA Health Ministers tabled the Health Sector Reform and Human Resources Management. The Ministers acknowledged the insufficient number and mix of skilled health workers due to internal and external migration.

They resolved for member states to take action to retain their workers, realising that "disparities in remuneration and poor working conditions are largely responsible for the movement" (ibid). No mention was made to the external causes of migration, such as recruitment; instead, member states were urged to:

- develop a memorandum of understanding to "harmonise, professional, educational and training standards in the region";
- establish a mechanism to facilitate the exchange of health expertise within the region;
- train higher numbers of middle level health professionals;
- improve working conditions; and
- ensure the protection of human rights of emigrating health workers.

Two years later, in 2003, the 38th Regional Health Ministers' Conference was held in Livingstone, Zambia. Discussions again focused on human resources issues, drawing close attention to the increase of health worker attrition. It is important to note that this meeting was preceded by the adoption of the Commonwealth Code of Practice for the International Recruitment of Health Workers. The Ministers were quick to acknowledge the importance of the Code; however, the fact that it was legally non-binding was a point of contention. The Ministers stressed the need for countries to sign legally binding agreements relating to the aspects of ethical recruitment and compensatory arrangements (ECSA, 2003).

In 2006, at the 42nd Regional Health Ministers' Conference in Mombassa, Kenya, Health Ministers recognised that the recommendations made during previous conferences still require implementation and evaluation. The Ministers made recommendations to install systems that will monitor and evaluate the movement of health workers and to develop systems of compensation for the loss of health care workers. The resolution stressed adopting a "common position on ethical recruitment" and development of financial and nonfinancial strategies to retain health workers (ECSA, 2006).

3.6.2 Southern African Health Ministers' 2001 Statement

The Southern African Health Ministers met on 9 June 2001 in Centurion, Pretoria, to renew their concern about the active recruitment of health professionals from their countries by developed countries.

The Health Ministers issued a strongly worded statement, noting that recruitment by developed countries is an indication of poor planning for their human resource needs and that recruitment could be seen as "looting from these countries and is similar to that experienced during periods of colonisation when all resources, including minerals, were looted to industrialised countries" (page 33, SADC, 2001). The statement continued to say that the recruitment of health workers from the developing world is "immoral" and could be viewed as racist, as it "further entrenches inequitable wealth and resources" between developed and developing countries (ibid). The Health Ministers then called for action:

- regionally, to speed up SADC initiatives on intraregional staff exchange programmes and prioritise South-South co-operation on human resources; and

- internationally by the Commonwealth, which should develop a code of conduct that discourages the active recruitment of staff from developing countries and formalises such recruitment through government-to-government agreements.

3.6.3 WHO AFRO: Human Resources Development for Health: Accelerating Implementation of the Regional Strategy

The WHO Regional Committee for Africa prepared a paper, Human Resources Development for Health: Accelerating Implementation of the Regional Strategy, for discussion at the 52nd Session of the WHO Regional Committee for Africa held in Harare, Zimbabwe, from 8 to 12 October 2002.

The paper proposed six priority areas in human resource development for countries to take action on in addressing country-specific realities (WHO-AFRO, 2006a). The six priority areas are:

- a human resource policy
- education, training and skills development
- human resources management
- managing the migration of skilled health personnel
- advocacy
- resource allocation.

The paper outlines the roles and responsibilities of the countries and the WHO to ensure the implementation and development of these priorities. For instance, member states should undertake advocacy to ensure financial resources, foster the return and retention of health workers, disseminate information on the national human resources strategy, and elect a body of ministers from health, education, finance and planning to oversee the implementation of a national programme. All day-to-day management should be the responsibility of a national human resources development division (WHO-AFRO, 2002a).

The roles of the WHO and its partners should be to provide technical support, advocate for support from other sectors and for countries to review their government policies, and establish a task force to provide advice on health worker mobility and brain drain issues.

For monitoring and evaluation, indicators will be identified in the regional strategy and used to monitor individual country progress.

The 52nd session of the WHO Regional Committee for Africa accepted this strategy document and put together a resolution that not only encouraged member states to make human resources for health a priority, but to also consider the moral and ethical implications of health worker recruitment from developing countries (WHO-AFRO, 2002b).

3.6.4 Migration Dialogue for Southern Africa (MIDSA)

The Migration Dialogue for Southern Africa is a body that was formed to facilitate open dialogue and cooperation on migration policy issues within the Southern African Development Community (SADC). The partners of MIDSA include the International Organisation for Migration, which runs the MIDSA Secretariat and convenes MIDSA Steering Committee meetings, the Southern African Migration Project (SAMP), which sits on the steering committee and is primarily responsible for MIDSA's research and information activities, the SADC Ministers of Home Affairs, Immigration and Labour, the SADC Secretariat, the International Migration Policy Programme (IMP), and the United Nations High Commissioner for Refugees (UNHCR).

In November 2004, MIDSA held its ninth workshop in Cape Town, South Africa on 'Migration and Health'. The meeting brought together numerous African governments, the AU, the WHO, UNHCR, the Australian High Commission, the Canadian High Commission, the US Embassy, the Swedish International Development Agency (SIDA), IOM and SAMP.

Presentations on a variety of migration health-related issues were held over the three days. Specifically, the issue of the international migration of health workers, regionally and internationally, was raised by several presenters. Many recommendations regarding the migration of health workers were put forward for consideration by governments, international agencies and civil society organisations (MIDSA, 2004). They include strategies to ensure:

- the retention of health workers through remuneration and benefit packages;

- the enhancement of training through multi-level and sector organisations;

- the implementation of monitoring and evaluation systems to determine the efficacy of current strategies;

- further research into the extent and impact of migration (e.g. cost/ benefit analysis);

- government engagement in research; and

- the internal coordination of migration management and private agency partnerships to mitigate the effects of migration.

The consensus developed at this conference became a precursor to the 2004 World Health Assembly in Geneva.

3.6.5 World Health Assembly (WHA)

The most visible of Human Resources for Health policy initiatives was the intervention of the African Ministers of Health at the 57th World Health Assembly held in Geneva, Switzerland from 17-22 May 2004 (Gilson and Erasmus, 2005). They lobbied for resolutions to mitigate the affects of the migration of health workers.

As a result, a resolution at the 57th WHA urged Member States to develop policies to provide incentives for health workers to remain in their countries; to create bilateral agreements between countries; and for receiving countries to aid in strengthening the health systems of developing countries. Among other items, the WHA requested the WHO to help Member States set up information systems to monitor the movement of health resources for health, to evaluate the effectiveness of international agreements and to include human resources for health development as a top-priority programme at WHO from 2006 to 2015 (WHA, 2004).

Furthermore, the resolution requested the Director-General to establish information systems to independently monitor the movement of international health workers; to support member states in strengthening planning mechanisms and processes; to develop a code of practice on international

recruitment; and to explore possible options to explore adverse affects of migration, such as remittances and trade agreements (WHA, 2004).

The following year, at the 2005 WHA, African Ministers of Health again expressed concern about the continued migration of health workers and noted the lack of action on the 2004 resolution. Subsequently, the African Ministers tabled a resolution drafted by South Africa that called upon the WHO Director General to ensure the 2004 resolution is fully implemented (MOH, 2005).

The resolution led to the release of a 2006 report by the WHO Secretariat at the 59th WHA held in May 2006 in Geneva, Switzerland summarising the work that has been done to accomplish the objectives of the 2004 Resolution. The report gives various examples of research being conducted to increase the knowledge base of migratory flows, the migration process and reasons for migration. It also highlights various collaborations with member states and other organisations to improve policies and strategies in the retention, deployment and migration of health workers and recognises Article I: 2 of the GATS agreement as a possible means to promote 'brain circulation' instead of 'brain drain' (WHO, 2006b).

Furthermore, the Secretariat acknowledges its own work in advocacy highlighting the creation of a global alliance for the health workforce, support of partnerships at global and country levels and collaboration with the International Organisation for Migration (IOM), the International Labour Organisation (ILO), and the Commonwealth Secretariat to work on the migration of health worker issues. However, the report points out that more work is needed on monitoring systems of migratory flows, which still remains a concern (WHO, 2006b).

The discussions at the WHA led to resolution WHA59.23 in which recommendations were made to member states to:

- mitigate the adverse impact on developing countries health care systems from the loss of health personnel through migration by means of receiving countries providing support for the strengthening of source countries' health care systems;
- encourage financial support by global health partners for health training institutions in developing countries;
- promote training partnerships between schools in developed and developing countries;
- develop taskforces to combat the health-worker shortages at a country level; and
- use innovative approaches to teaching in developed and developing countries (WHA, 2006).

In addition, on May 15, 2007, the WHO issued a press release announcing the first meeting of the Health Worker Migration Policy Initiative whose aim it is to find practical solutions to the worsening problem of health worker migration (WHO, 2007). One of the first initiatives of this working group is to support the WHO in drafting a framework for an International Code of Practice on Health Worker Migration, which was called for in the 57th WHA resolution in 2004. The framework of the Code will "promote ethical recruitment, the protection of migrant workers' rights and remedies for addressing the economic and social impact of migration in developing countries" (page 12, WHO, 2007).

Progress on the implementation of these resolutions will be reported at the 63rd WHA in 2010.

3.6.6 The London Declaration

On 14 April 2005, The British Medical Association (BMA) convened an international global health workforce conference in association with the Commonwealth. The conference participants included the American Medical Association, the American Nurses Association, the Canadian Medical Association, the Commonwealth Medical Association, the Commonwealth Nurses Federation, Health Canada, the Medical Council of Canada, the Royal College of Nursing and the South African Medical Association. The participants of this conference formulated and endorsed new principles on the migration of health workers, commonly referred to as the 'London Declaration' (BMA, 2005).

The conference recognised the migration of health workers from developing to developed countries has a severe impact on the health care workforce of developing countries and "the lack of healthcare workers in developing countries is an emergency that demands urgent attention" (page 6, BMA, 2005). The conference agreed to the following four points:

- All countries must strive to attain self-sufficiency in their health care workforce without generating adverse consequences for other countries.
- All countries must commit to a human resources strategy for the next twenty years.
- Developed countries must sign up to ethical recruitment policies.
- Developed countries must end reliance on health staff from developing countries or sign bilateral agreements.
- Developed countries must assist developing countries to expand their capacity to train and retain physicians and nurses to enable them to become self-sufficient by:

- working in partnership with developing countries to ensure health workers have access to needed resources;
- creating and implementing schemes that encourage health professionals to undertake work placements for limited periods in developing countries;
- creating exchange programs between health training bodies, hospitals and clinics in the developed and developing countries; and
- encouraging the IMF and World Bank to relax the financial restrictions on government spending in developing countries to allow for increased investment in health and health professionals.

All countries must ensure that their health care workers are educated, funded and supported to meet the healthcare needs of their population by:

- using incentives to encourage retention and return of health care workers;
- improving productivity by changing the skill-mix of the health care workforce through national reviews of appropriateness;
- Increasing the numbers of mid-level/paraprofessional workers worldwide;
- expanding training centres; and
- getting developing and developed countries to work together to address educational infrastructure needs.

Action to address the skills drain must balance the right to health of populations, and other individual human rights. Governments are responsible to ensure that the right to health of their population is upheld. Health workers should not be prevented from leaving their home or adopted to country to pursue career opportunities or skill development in other countries.

The principles outlined in the London Declaration are one of the most explicit references to the human rights dimension of global health worker migration (Labonte, Packer and Klassen, 2006).

3.6.7 International Council of Nurses Position Statement

The International Council of Nurses (ICN) adopted a position statement on ethical nurse recruitment in 2002. This statement was formed as a means to persuade governments and employers to adopt principles on ethical recruitment (ICN, 2002).

The ICN recognises the importance of career mobility to the nursing profession and society in general; it allows nurses to broaden their skills and contribute to health care globally. Nevertheless, the movement of nurses out

of their country can have drastic affects on the national health care system. This occurs in both the developed and developing world.

It is for this reason that the ICN promotes effective resource planning and condemns active recruitment by countries that do not plan for human resources properly. Recognising that the recruitment of nurses will continue, the ICN position statement outlines a set of comprehensive principles to govern the international and intra-national ethical recruitment of nurses. These include:

• pay equity

• safe working environments

• proper training

• freedom of association

• good faith contracting

• effective human resources planning and development

• credible nursing regulation

• freedom of movement

• access to grievance procedures

• freedom from discrimination

• regulation of recruitment.

Lastly, the ICN states that the credibility, strength and universality of these principles will directly depend on the political will of health sector stakeholders and the regulatory mechanisms introduced for their application and monitoring (ICN, 2002).

3.6.8 World Medical Association Statement on Ethical Guidelines for the International Recruitment of Physicians
The World Medical Association (WMA) statement on the Ethical Guidelines for the International Recruitment of Physicians was adopted by the WMA General Assembly in Helsinki, Finland, in May 2003.

The statement recognises the physician's valid reasons for migrating to developed countries but also recognises the impact that movement has on developing source countries. The impact is further exacerbated by active recruitment of health workers in the developing world, which is a direct outcome of poor human resource planning in developed world.

The WMA recognises an ethical dimension to the issue of health worker migration exists and as a result has developed a statement to guide national medical associations and policy makers on the recruitment of health

professionals (WMA, 2003). The guidelines are framed by three ethical principles: justice, co-operation and autonomy. These ethical guidelines provide the underlying principles of equity of resources, bi-and multilateral co-operation and individual rights, respectively.

The WMA recommendations urge countries to do their utmost to ensure proper human resource planning and to not rely on immigration for health professionals. All forms of recruitment should be done within an existing Memorandum of Understanding between the two countries and nothing should interfere with countries entering into this agreement (WMA, 2003).

Table 8 summarises all the instruments discussed in Section 3.

Instrument	Scope	Legal status	Countries covered
GATS – Health Services Modes 1-4	The GATS agreement administered by the World Trade Organisation (WTO) was adopted in 1995. It aims to liberalise trade in services by encouraging the privatisation of health services and an open market for trade. The agreement covers four modes of supply which govern the provision of health services internationally. These are: • Mode 1: Cross-border supply • Mode 2: Consumption Abroad • Mode 3: Commercial Presence • Mode 4: Temporary Movement of Natural Persons	Legally binding	ESA countries include Burundi, Malawi, Swaziland and Zambia
NHS Code of Practice for the International Recruitment of Health Workers	The NHS Code of Practice applies to the employees and employers of the NHS, as well as: • agency-recruited temporary and locum healthcare professionals; • enabling all healthcare organisations to sign-up to the principles; and • mandating the NHS to deal only with recruitment agencies that comply with the Code of Practice for both domestic and international recruitment.	Voluntary	United Kingdom and Northern Ireland

Instrument	Scope	Legal status	Countries covered
NHS Code cont.	The NHS Code of Practice manages the recruitment of domestic and international workers into the NHS. The Code sets out principles and best practice benchmarks that manage the rights of recruitment workers and that forbid the active recruitment of health professionals from developing countries without an existing bi-lateral agreement.		
Common-wealth Code for the Inter-national Recruit-ment of Health Care Workers	The Commonwealth Code was signed by 21 countries in attendance at the pre- World Health Assembly Meeting in May 2003 and, through the principles of cooperation and consensus, the Code is accepted by all Commonwealth countries. However, this does not mean the countries have implemented the Code. The Code seeks to establish a framework that balances the responsibilities of the health workers to their country of origin and the rights of the health workers to seek employment in other countries.	Voluntary and legally non-binding	Common-wealth countries
Melbourne Manifesto	The Melbourne Manifesto was signed by the membership of the Wonca organisation at the Wonca World Rural Health Conference in 2002. The Melbourne Manifesto focuses on the retention and prevention of health workers through various workforce-planning strategies. The Code encourages both source and receiving countries to ensure rational workforce planning and, if international recruitment is necessary, Memoranda of Understanding or exchanges between the two countries should be implemented.	Voluntary and legally non-binding	Adopted by the Wonca member-ship and implemen-ted by various govern-ment supported recruit-ment organisa-tions within Australia

Instrument	Scope	Legal status	Countries covered
Memorandum of Understanding between Namibia and Kenya on Technical Cooperation in Health	The Ministry of Health and Social Services of the Government of Namibia and the Ministry of Health of the Government of the Republic of Kenya agreed to a Memorandum of Understanding on Technical Cooperation in Health in June 2004. The agreement provides guidelines for the temporary movement of health workers from Kenya to Namibia, outlining the rights and responsibilities of the health workers and government bodies.	Legally binding	Kenya and Namibia
SADC Protocol on the Facilitation of Movement of Persons	The overall objective of this protocol is to eliminate the obstacles to the movement of persons with in the Southern African Development Community.	Legally binding	SADC: Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar (membership pending), Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe

Instrument	Scope	Legal status	Countries covered
NEPAD Health Strategy	The New Partnership for Africa's Development (NEPAD) health strategy has been adopted by African Ministers and the AU. It seeks to "establish or strengthen health systems and services so they can provide effective and equitable health care" (NEPAD, 2003). NEPAD identifies six sectors as priorities for achieving the goals of the health strategy, which includes focusing on human resources development aiming to reverse the brain drain as a major priority. The health strategy focuses on retention and migration strategies to mitigate the affects of health worker attrition.	No status	African Union
Southern African Ministers 2001 Statement	The Southern African Health Ministers met on 9 June 2001 met in Centurion, Pretoria to renew their concern about the active recruitment of health professionals from their countries by developed countries. The Health Ministers issued a strongly worded statement, noting that recruitment by developed countries is an indication of poor planning for their human resource needs and that recruitment could be seen as 'looting from these countries and is similar to that experienced during periods of colonisation when all resources, including minerals, were looted to industrialised countries' (SADC, 2001).	No status	SADC
East, Central and Southern African Health Comm-unity (ECSA)	Resolutions of ECSA Health Community focus on workforce planning and retention of health workers in the region.	No status	ECSA countries

42

Instrument	Scope	Legal status	Countries covered
WHO AFRO: Human Resources Development for Health: Accelerating Implementation of the Regional Strategy	The WHO Regional Committee for Africa prepared this paper for discussion at the 52nd Session of the WHO Regional Committee for Africa in 2002. The paper proposed six priority areas in human resource development for countries to take action on in addressing country-specific realities (WHO-AFRO, 2006a). The six priority areas are: • human resource policy; • education, training and skills development; • human resources management; • managing the migration of skilled health personnel; • advocacy; and • resource allocation. The paper outlines the roles and responsibilities of the countries and the WHO to ensure the implementation and development of these priorities.	No status	Sub-Saharan Africa
Migration Dialogue for Southern Africa (MIDSA)	The Migration Dialogue for southern Africa was formed to facilitate open dialogue and cooperation on migration policy issues within the Southern African Development Community (SADC). The strategies set out to ensure the retention of health workers through remuneration and benefit packages; enhancement of training through multilevel and sector organisations; implementation of monitoring and evaluation systems to determine the efficacy of current strategies; further research into the extent and impact of migration (e.g. cost/benefit analysis); and government engagement in research, internal coordination of migration management and private agency partnerships to mitigate the affects of migration.	No status	SADC countries

Instrument	Scope	Legal status	Countries covered
World Health Assembly	The most visible of Human Resources for Health policy initiatives was the intervention of the African Ministers of Health at the 57th World Health Assembly held in Geneva, Switzerland from 17-22 May 2004 (Gilson and Erasmus, 2005). They lobbied for resolutions to mitigate the affects of migration of health workers. As a result, the 57th WHA resolution urged Member States to develop policies to provide incentive for health workers to remain in their countries; to create bilateral agreements between countries; and for receiving countries to aid in strengthening the health systems of developing countries. Among other items, the WHA requested the WHO to help member states set up information systems to monitor the movement of health resources for health, to evaluate the effectiveness of international agreements and to include human resources for health development as a top-priority programme at WHO from 2006 to 2015 (WHA, 2004).	No status	WHA
The London Declaration	The British Medical Association (BMA) convened an international global health workforce conference in association with the Commonwealth. The conference recognised the migration of health workers from developing to developed countries has a severe impact on the health care workforce of developing countries and "the lack of healthcare workers in developing countries is an emergency that demands urgent attention" (BMA, 2005).	No status	American Medical Ass, American Nurses Ass, Canadian Medical Ass, Commonwealth Medical Ass, Commonwealth Nurses Fed, Health Canada, Medical Council of Canada, Royal College of Nursing & the South African Medical Ass.

Instrument	Scope	Legal status	Countries covered
International Council of Nurses (ICN) Position Statement	The International Council of Nurses (ICN) adopted a position statement on ethical nurse recruitment in 2002. This statement was formed as a means to persuade governments and employers to adopt principles on ethical recruitment (ICN, 2002). The ICN recognises the importance of career mobility to the nursing profession and society in general; it allows nurses to broaden their skills and contribute to health care globally. Nevertheless, the movement of nurses out of their country can have drastic affects on the national health care system. The ICN promotes effective resource planning and condemns active recruitment by countries that do not plan for human resources properly.	No status	ICN
World Medical Association Statement on Ethical Guidelines for the International Recruitment of Physicians.	The statement recognises the physician's valid reasons for migrating to developed countries but also recognises the impact that the movement has on source developing countries. The impact is further exacerbated by active recruitment of health workers in the developing world, which is a direct outcome of poor human resource planning in developed world.	No status	Adopted by the WMA General Assembly in Helsinki, Finland, in May 2003

4. ANALYSIS

In assessing the effectiveness of the various codes and guidelines, there isgeneral consensus that they have played an important role in raising the consciousness and awareness of ethical considerations in the recruitment health workers. Together, the governments and organisations involved have advanced a global agenda and brought this important issue into mainstream debates. However, the various weaknesses and loopholes inherent in the existing instruments render the Codes toothless and represent persuasive moral imperatives rather than obligatory statutory requirements.

Commentators and analysts have identified the following key strengths and weaknesses of the instruments under discussion regarding:

- their legal status
- their content
- lack of enforcement.

4.1 Legal status

Codes of practice are voluntary, associative and legally non-binding. They provide an overarching set of guidelines and protocols to be followed. Because of the non-legally binding status of the Codes, they create false bravado of security. Exacerbating the effects of the non-binding status of the Codes is the poor use of sanctions and monitoring to ensure compliance with them. Willets and Martin (2004) describe it as a 'quick and cheap' strategy to change employment behaviour where, "at best, the instrument sends a message that something is being done to solve the problem; at worst their use is a cynical exploitation of the general sense of goodwill" (page 13, Willets et al, 2004).

The current codes of practice are, however, a starting point for future policies. Current systems for compliance, evaluation, subscription and enforcement are weak at best and must be improved. According to a paper by the Friends of Earth (2002) analysing environmental codes of practice, "if voluntary agreements are to stand any chance of delivering at least some level of compliance there must be monitoring, verification and enforcement".

Bi-lateral agreements provide another option to manage the migration of health workers. This instrument has legal status in contrast to codes of practice and must be honoured by the respective governments. Additionally, these agreements can be drafted to fit the specific needs of both countries and are easier to manage as only two countries are involved in the agreement.

4.2 Content

Outstanding content issues include:

- reparations and compensation
- addressing push factors
- the role of human rights in recruitment.

4.2.1 Reparations and compensation

Compensation for migratory losses by developing countries is a contentious issue in recruitment policy. Most observers believe that's why developed countries, including Canada, UK and Australia, did not sign the Commonwealth Code of Practice (Nullis-Kapp, 2005 and Bach, 2003).

Compensation is a means to reduce the effects of the current state of "reverse foreign aid" (page 31, PHR, 2004) that is occurring between developed and developing countries.

Instead of developed countries sending aid to struggling health care systems in the developing world, the developed country is receiving human resources to support their own health care systems (PHR, 2004). The transfer is an economic loss to both the health and education sector of the developing country. Compensation agreements have the potential to reduce the recruitment of health workers by making it more expensive to undertake (Padarath et al, 2003).

However, in practice, attempts to develop compensatory payments are unlikely to be successful (Dovlo and Martineau, 2004). This is due to the difficulties of calculating compensation for individual workers and monitoring the worker movements, and an overall lack of political support (JLI, 2004). Furthermore, an argument has been made that more reimbursements, or compensations, should not be rewarded to governments that are the often cause of their 'brain drain' through violations of human rights or corruption (PHR, 2004) Currently, no mechanisms are in place to provide compensation to the developing countries, nor is there any political will on the part of the developed world to agree to it. Alternatives such as training, educational exchanges and increased aid have been suggested in lieu of financial compensation.

4.2.2 Addressing push factors

Since introduction of the first code of practice in England in 1999, the migration of health workers from sub-Saharan Africa has increased (Buchan, Parkin and Sochalski, 2003) and available statistics show that the number of losses to the developing countries systems is on the rise (Willets, 2004).

For instance, the House of Commons Hansard (2004) reported that, in 2003, UK work permits were approved for 5,880 health and medical personnel from South Africa, 2,825 from Zimbabwe, 1,510 from Nigeria and 850 from Ghana (Hansard, 2004).

However, current data suggests that the migration of health professionals into the UK is now starting to decline due to an increase production of home-based graduates and a reduction in recruitment activities (Buchan, 2007).

A variety of push and pull factors exist that impact on the recruitment of health care workers (see Table 1, Appendix 1). For instance, a nurse from the Philippines who moves to London is able to make 20 times her income. Addressing the socio-economic determinants of migration can therefore provide substantial insight into developing policy in this regard. Comparing the three codes of practice described in this review, only the Melbourne Manifesto emphasised the importance of self-sustainability over recruitment. For instance, the NHS Code of Practice includes ethical recruitment to as a means to supply their workforce and the Commonwealth Code of Practice only makes mention of retention strategies in the Companion document. Beyond strategies of retention that are mainly focused at developed countries to control their recruiting practices, strategies to address the push factors should also be looked at.

Another issue to consider are the factors affecting the return of diaspora. An ILO working paper questions the feasibility of migrant worker return policies. Bach (2003) suggests return policies are "difficult to manage effectively and the costs of assisted return programmes need to be considered in conjunction with investment in retention, which may be more cost effective" (page 27, Bach, 2003). Participants at a 2002 WHO/ World Bank meeting on Human Resources for Health outlined many challenges faced by returning diaspora workers, including a lack of trust in African governments and cumbersome recruitment processes.

Focusing on the retention of workers before they leave may ensure a longer-term commitment from health workers, instead of creating a 'revolving door' of health care workers in and out of the country. In addition, one of the largest challenges specific to returning diaspora workers is to ensure the returning health workers are placed in a position to use the skills they have acquired abroad (Bach, 2003). If not, high levels of attrition are sure to increase.

4.2.3 The role of human rights in recruitment

Ethical recruitment is a balancing act between an individual's right to mobility and the right to health. Ethical principles set out in policy and agreements should ensure that rights of individual migrants are considered and set conditional parameters to guide the agreements. The doctrine of personal autonomy is a significant consideration in attempting to establish ethical recruitment guidelines, as these could adversely affect rights to freedom of movement and self-determination.

Meanwhile, policy and agreement should also address the right to health and health services for their citizens. The movement of health workers abroad adversely affects the delivery of health care in source countries. It may produce deficiencies in the available health services to local communities and limit the ability of developing countries to move forward with their health development plans (WHO, 2003). A 2003 WHO publication on human rights, health and migration states that "governments have an obligation to ensure that functioning public health and health care facilities, goods and services, as well as programmes, are in sufficient quantity to the population" (page 11, WHO, 2003).

All instruments that govern the migration of health workers should use a human rights framework in the development of principles and conditions in order to safeguard the rights of those that access health services and those that provide them.

4.3 Enforcement

4.3.1 Incentives and sanctions

Few of the international instruments are legally binding on their signatories and therefore do not rely on any formal sanctioning to ensure compliance (McIntosh et al, 2007). It is the responsibility of the implementing country to ensure that the principles of ethical recruitment are upheld. The only example found where sanctions had been put in place to encourage compliance is by the NHS for the code of practice of ethical recruitment. The NHS Code encourages and promotes good practice by only contracting with recruitment agencies that comply with the Code (Buchan and Dovlo, 2004). Although the consequences were superficial, offending recruitment agency were only removed from the approved list of agencies on the website.

4.3.2 Monitoring and evaluation

All codes of practice, position statements and guidelines call for monitoring and evaluation systems to be put in place. However, few give details on how to implement such a system. McIntosh et al (2007) provide a detailed overview of the Codes call for monitoring systems. They observe that

although the Melbourne Manifesto called for "evaluation and monitoring of international immigration to inform this code"' it offered no mode of implementation. In contrast, the Commonwealth Code Companion Document suggests monitoring compliance of recruitment agencies through an auditing system. It also suggests that countries develop effective data collection on the movements of health providers inside and outside of their borders. However, currently, there are no systems in place that are associated with any of the Codes to monitor the impact of targeted recruitment in developing countries (Willets et al, 2004). Nor are there systems in place that reflect the Codes of Practice in the developed world to monitor who is being recruited, where are they being recruited from and how are they being recruited (McIntosh et al, 2007). Developing such systems is necessary if codes of practice are to become a meaningful part of the international architecture addressing health worker migration.

5. CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

The review suggests that, despite a renewed policy and international interest in the ethics of recruitment of HRH from poor countries, current frameworks and codes have clearly been unable to stem the tide of workers flowing to the North (with the exception of the UK). Key constraints include the weak or non-existent framework for implementation of the Codes, the voluntary nature of the instruments, a lack of advocacy for subscription to the Codes and a lack of adequate and effective data collection and monitoring systems. Further, codes have no legal status and sanctions for non-compliance are therefore ineffective and unenforceable. There are no formally constituted bodies to provide an oversight and watchdog role for countries that have subscribed to the instruments.

Meanwhile, codes and frameworks may be able to have only limited impact if the push factors driving migration, as well as health worker shortages in the North, are not simultaneously addressed.

To ensure the evolution of effective instruments for the ethical recruitment of health workers, countries and international organisations must implement strategies to mitigate the factors pushing health workers out of their country; implement codes of practice that address country or region-specific needs; and build north-south collaborations to move the agenda for ethical recruitment ahead together.

5.2 Recommendations

To develop better migration instruments, countries and international organisations should do the following:

- Develop monitoring and evaluation systems.
- Address strategies to mitigate the factors pushing health workers out of their country.
- Implement codes of practice that address country or region-specific needs.
- Build North-South collaborations to move the agenda for ethical recruitment ahead together.
- Implement enforcement mechanisms that promote compliance.

Further, follow-up investigation is needed to explore the practical experences of the instruments to help guide policymakers in determining what works, what doesn't and what needs to happen in health worker migration policy development.

REFERENCES

1. Africa Working Group, Joint Learning Initiative (2004), The Health Workforce in Africa: Challenges and Prospects, WHO, World Bank, Rockefeller Foundation, and Global Health Trust, Table 3, page 89.

2. Australian Bureau of Statistics "data available upon request" (2001) Census of Population and Housing (received October 31, 2005). Copyright in ABS data vests with the Commonwealth of Australia. Used with permission.

3. Bach (2003) "International migration of health workers: Labour and social issues" Sectoral Activities Programme International Labour Office/ Geneva, 2003 http://www.ilo.org/public/english/dialogue/sector/papers/health/wp209.pdf [accessed January 8, 2007]

4. BMA (2005) 'The Healthcare Skills Drain-A Call to Action. London http://bma.org.uk/ap.nsf/Content/skillsdrain?OpenDocument&Highlight=2,skills,drain [accessed December 5, 2006]

5. Buchan (2007) As per email communication with Jim Buchan – still awaiting release of a 2007 DFID paper on the NHS Code of Practice and migration data. Please reference this paper when released for more specific information and data. [September 28, 2007]

6. Buchan J, Parkin T, Sochalski J (2003) 'International nurse mobility: Trends and policy implications, Geneva: World Health Organisation.

7. Buchan J, Dovlo D (2004) 'Internationals Recruitment of Health Workers to the UK: A Report for DFID' DFID February 2004

8. Cadastre des Professionels de Santé (2005) Service Publique Fédéral de Santé Publique, Sécurité de la Chaîne Alimentaire et Environnement: Administration de l'Expertise Médicale MEDEX (received December 14, 2005).

9. Chetty K, Maslin A (2006) 'A Memorandum of Understanding Between the Governments of South Africa and the United Kingdom & Northern Ireland on the Reciprocal Educational Exchange of Healthcare Concepts and Personnel' Commonwealth Ministers Meeting. Geneva.

10. Clemens M and Pettersson G (2006), "Medical Leave: A new database of health professional emigration from Africa", CGD Note (Washington, DC: Center for Global Development).

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

12. Commonwealth (2003b) Companion document to the Commonwealth Code of Practice for the International Recruitment of Health Workers.

13. Couper I (2003a) 'The Melbourne Manifesto: a code of practice for the international recruitment of health care professionals' Workshop Presentation: Santiago, Chile.

14. Couper I (2003b) 'The Melbourne Manifesto: Progess Report' Workshop Presentation: Santiago, Chile.

15. DOH (2004) Code of Practice for the International Recruitment of Healthcare Professionals, Department of Health, London. http://www.dh.gov.uk/assetRoot/04/09/77/34/04097734.pdf [accessed December 15, 2006]

16. DOH (2006) 'Policy on Recruitment and Employment of Foreign Health Professionals in the Republic of South Africa' April 1, 2006. National Department of Health: Pretoria.

17. Dovlo D, Martineau T (2004) 'A review of the migration of Africa's health professionals.' JLI Working Paper 4-4. Joint Learning Initiative, Global Health Trust.

18. Enquête Socio-Économique (2001) Service Publique Fédéral d'Économie, PME, Classes Moyennes et Énergie: Direction Générale de la Statistique et de l'Information Économique (received May 5, 2006).

19. EQUINET (2007) As stated during plenary by Dr. David M. Ndetei at the EQUINET/ HST/ ESCA regional policy and research meeting on health worker migration and retention in east and southern Africa, held from March 17-19, 2007 in Arusha, Tanzania.

20. ESCA (2001) East, Central and Southern African Health Community: Resolutions of the 34th Regional Health Ministers Conference, 22-26 October 2001, Dar es Salaam, Tanzania.

21. ESCA (2003) East, Central and Southern African Health Community: Resolutions of the 38th Regional Health Ministers Conference, 17-21 October 2003, Livingstone, Zambia.

22. ESCA (2004) East, Central and Southern African Health Community: Resolutions of the 40th Regional Health Ministers Conference, 1-5 November 2004, Victoria Falls, Zimbabwe.

• Federal Republic of Nigeria (1996) Social Statistics in Nigeria 1995-1996, Federal Office of Statistics, Abuja: Table 4.1, 'Health Manpower in Nigeria 1993-1996'.

23. Friends of the Earth (2002). 'Undemocratic, ineffective and inherently weak- the voluntary approach.' London: Friends of the Earth http://www.foe.co.uk/resource/briefings/voluntary_approach.pdf [accessed February 02, 2007]

24. Gilson L, Erasmus E (2005) 'Supporting the Retention of HRH: SADC Policy Context' EQUINET/ HST: Centre for Health Policy, School of Public Health, University of Witwatersrand

25. Go S (2003) 'Recent trends in migration movements and policies: The movement of Filipino professionals and managers' OCED: *Migration and the labour market in Asia*. Paris

26. Hansard (2004) HC Deb 24 Feb 2004 vol.418 c254w, United Kingdom Parliament. http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040223/index/40223-x.htm [accessed Feb.21, 2007]

27. ICN (2002) 'International Council of Nurses: Position statement on ethical nurse recruitment' International Council of Nurses.

28. Institut National de la Statistique et des Études (1999) Économiques Recensement de la Population Française (received November 3, 2005).

29. Instituto Nacional de Estatística–Portugal (2001) Recenseamento Geral da População 2001, custom tabulation 15384 (received November 7, 2005).

30. Instituto Nacional de Estadística de España (2001) Censo de Población y Viviendas 2001, Resultados Detallados Definitivos (updated February 17, 2004), http://www.ine.es/inebase

31. JLI (2004) 'Global Responsibilities' Chapter four in *Human Resources for Health: Overcoming the Crisis*, JLI Strategy Report. Global Equity Initiative: Harvard University.

32. Labonte R, Packer C, Klassen N (2006) 'Managing health professional migration from sub- Saharan Africa to Canada: a stakeholder inquiry into policy options' Human Resources for Health 4 (22) Canada http://www.human-resources-health.com/content/4/1/22 [accessed December 5, 2006]

33. Labonte, R., Packer, C., Klassen, N. et al (2007) 'The Brain Drain of Health Professionals from Sub-Saharan Africa to Canada: Some Findings and Policy Options' Queens University: South African Migration Project. 2007.

34. McIntosh T, Torgerson R, Klassen N (2007) 'The Ethical Recruitment of Internationally Educated Health Professionals: Lessons from Abroad and Options for Canada' Canadian Policy Research Networks, Research Report H11: Health Network.

35. Menshah, K. Mackintosh, M. Henry L. (2005) 'The skills drain of health professionals from developing world: A framework for policy formulation', Medact: London .

36. MOH (2005) 'Africa unites against brain-drain in health'. Press release issued by South Africa Ministry of Health.

37. MOU (2004) Memorandum of Understanding between the Ministry of Health and Social Services of the Government of the Republic of Namibia and The Ministry of Health of the Government of the Republic of Kenya on Technical Cooperation in Health. 2004.

38. NEPAD (2003) The New Partnership for Africa's Development (NEPAD) Health Strategy.

39. Nielson J (2006) ' Ten Steps to Consider Before Making Commitments in Health Services Under the GATS' Chapter 4 Blouin C, Drager N, Smith R 'International Trade in Health Services and the GATS: Current Issues and Debates' http://www.myilibrary.com/Browse/open.asp?ID=28062&loc=108 [accessed July 26, 2007]

40. Nullis-Kapp (2005) 'Efforts underway to stem 'brain drain' of doctors and nurses' Bulletin of the World Health Organisation 83(2): p.84-87.

41. OCED (2004) 'The International Mobility if Health Professionals: An Evaluation and Analysis based on the Case of South Africa' Chapter 3, Trends in Migration.

42. Packer C, Labonte R, Spitzer D (2006) 'Globalization and the Health Worker Migration Crisis' Draft Paper, University of Ottawa.

43. Padarath A, Chamberlain C, McCoy D, Ntuli A, Rowson M (ed), Loewenson R (ed) 'Health Personnel in Southern Africa: Confronting maldistribution and brain drain' Discussion Paper 4 EQUINET: Harare.

44. PHR (2004) 'An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa' Physicians for Human Rights. Accessed on: http://physicians-forhumanrights.org/library/documents/reports/report-2004-july.pdf [accessed Feb. 20, 2002]

45. Rudasa (2002) 'Summary Report by the South African Delegates: Report of the 5th World Rural Health Conference in Melbourne, Australia' Rural Doctors Association of Southern Africa. http://www.rudasa.org.za/download/5wrhc_report.doc [accessed Feb. 20, 2002]

46. SADC (2001) Statement by SADC Health Ministers on the Recruitment of Health Personnel by Developed Countries. http://www.doh.gov.za/department/sadc/docs/pr/pr0609-01.html [accessed April 10, 2007]

47. Sanders and Lloyd (2005) "Human Resources: International Context" Chapter 6. Gray A, Govender M, Gengiah T, Singh J. Health Legislation. In: Ijumba P, Barron P. editors. South African Health Review 2005. Durban: Health Systems Trust.

48. Statistics Canada (2001) "Labour Force 15 Years and Over by Occupation National Occupational Classification for Statistics) (3) and Place of Birth of Respondent (57)", adapted from Statistics Canada, 2001 Census, Custom Table CO-0878 (received November 16, 2005), copyright permission 2005309. Copyright retained by Statistics Canada

49. Statistics South Africa (2001) 2001 census database (received November 11, 2005).

50. UK Census office (2001) UK Census Commissioned Table CO435 (received October 28, 2005). Crown copyright 2005. Crown copyright material is reproduced with the permission of the Controller of HMSO, license number C02W0007736

51. US Census Bureau, Census (2000) Special Tabulation, STP 266 (received November 10, 2005).

52. U.S. Dept. of Commerce, Bureau of the Census (2000) Census of Population and Housing, 2000 (United States): Public-Use Microdata Sample: 5-percent sample (computer file), ICPSR release, Washington, DC: U.S. Dept. of Commerce, Bureau of the Census [producer], 2003, Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2003.

53. WHO (2005) Global Atlas of Infectious Disease, http://www.who.int/GlobalAtlas, accessed July 19, 2005

54. WHA (2004) "WHA57.19 International migration of health personnel: a challenge for health systems in developing countries." Resolutions and Decisions. 57th World Health Assembly, 2004

55. WHA (2006) 'WHA59.23 Rapid scaling up of health workforce production' Resolutions and Decisions. 59th World Health Assembly. 2006. http://www.who.int/gb/ebwha/pdf_files/WHA59/A59_1Rev1-en.pdf [accessed April 10, 2007]

56. WHO (2003) 'International Migration, Health and Human Rights' Health and Human Rights Publication Series Issue 4, December, 2003 WHO http://www.who.int/hhr/activities/en/intl_migration_hhr.pdf [accessed August 1, 2007]

57. WHO (2006a) 'The World Health Report 2006 – Working Together for Health' Geneva http://www.who.int/whr/2006/en/index.html [accessed January 8, 2007]

58. WHO (2006b) 'International migration of health personnel: a challenge for health systems in developing countries' Fifty-Ninth World Health Assembly, WHO Secretariat.

59. WHO (2007) 'New initiative seeks practical solutions to tackle health worker migration' WHO Media Centre Press Release 15 May 2007, Geneva http://www.who.int/mediacentre/news/notes/2007/np23/en/index.html [accessed July 27, 2007]

60. WHO-AFRO (2002a) 'Acceleration Human Resources Development for Health in the African Region' Press Release WHO 52nd Regional Committee for Africa (8-12 October 2002).

61. WHO-AFRO (2002b) 'WHO Regional Committee for Africa ends in Harare' Press Release WHO 52nd Regional Committee for Africa (8-12 October 2002).

62. Willets and Martineau (2004) 'Ethical international recruitment of health professionals: Will codes of practice protect developing country health systems?' Liverpool School of Tropical Medicine: UK. [http://www.liv.ac.uk/lstm/research/documents/codesofpracticereport.pdf] accessed 08/02/07

63. WMA (2003) 'The World Medical Association Statement on Ethical Guidelines for the International Recruitment of Physicians' World Medical Association 2003.

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 the region:
- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET: R Loewenson, R Pointer, F Machingura TARSC; M Chopra, M Tomlinson MRC South Africa, M Masaiganah, Peoples Health Movement, Tanzania; I Rusike, CWGH, Zimbabwe; G Woelk, University of Zimbabwe; TJ Ngulube, CHESSORE, Zambia; L Gilson, Centre for Health Policy, South Africa; M Kachima SATUCC, D McIntyre, Health Economics Unit, Cape Town, South Africa; G Mwaluko, Tanzania; Martha Kwataine MHEN Malawi; A Ntuli, Health Systems Trust; S lipinge, University of Namibia; L London, UCT; N Mbombo, UWC Cape Town, South Africa; P Makombe SEATINI, Zimbabwe; I Makwiza, REACH Trust Malawi, S Mbuyita, Ifakara Tanzania