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Limits to diplomacy: Learning from the Implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel in east and southern Africa

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Abstract
The WHO Global Code of Practice on the International Recruitment of Health Personnel (the Code) provides a global architecture that includes ethical norms and institutional and legal arrangements to guide international co-operation on the management of health worker migration and serves as a platform for continuing dialogue. This paper explores how the policy interests of African countries informed the development of the Code and how east and southern African (ESA) countries have used, implemented and monitored the Code. Data were collected using four approaches: literature review, policy dialogue at the 66th World Health Assembly, a regional questionnaire survey and three country studies in Kenya, Malawi and South Africa. Three years after adoption of the Code, the main concerns relating to human resources for health (HRH) in the region were internal migration and absolute shortages of health professionals, rather than external, or out-, migration. The final version of the Code was not perceived to adequately cover African policy interests on compensation and mutuality of benefits. Concern was also expressed about the voluntary nature of the Code. Dissemination and implementation of the Code was lacking in all countries in the region, and only one country had a designated authority. Beyond the shift in policy concerns, barriers to implementation included lack of champions or designated authorities, poor preparedness, weak mobilisation of stakeholders and low involvement of civil society. We recommend that negotiations on international instruments should include provisions relating to their implementation, that deliberate efforts should be made to plan for the mechanisms and resources for their implementation after their adoption, and that the involvement of civil society be promoted at all stages.

Introduction

The Sub-Saharan Africa region (SSA) faces a very high disease burden coupled with low health care expenditure and a shortage of skilled health workers. As described in the 2006 World Health Report, Africa has 25% of the global disease burden, but only spends 1% of financing for health and has only 1.3% of the global health workforce (WHO, 2006). The health worker crisis is one major reason SSA has made poor progress towards achieving selected Millennium Development Goals (MDGs) (Anand and Bärnighausen, 2004; Travis et al., 2004; Hongoro and McPake, 2004; Sheikh, 2011). This is partly attributed to under-investment in the social sector, resulting in significant falls in health worker earnings, to the point where out-migration has become increasingly appealing for health workers from the region (Kuehn, 2007). In addition to these problems, pull factors, such such as higher salaries, and better working conditions and training opportunities, in the Global North have attracted health personnel from the countries already facing shortages (Cheng, 2009; Labonte et al., 2007; Eastwood et al., 2005; Oberoi and Lin, 2006).

Several studies have highlighted the significant loss of human and financial resources from Africa due to the out-migration of health professionals (Mills et al., 2011; JLI, 2004; Kirigia et al., 2006; Mensah et al., 2009; Muula and Panulo, 2007; Muula et al., 2006; Pagett and Padarath, 2007). An estimated 300,000 highly skilled professionals (including health workers) had emigrated from Africa by the year 2000, and countries such as Zambia and Zimbabwe retained less than 30% of their trained physicians, leading to the issue becoming a matter of concern for African policy makers in the early 2000's (Liese et al., 2003). Mackintosh et al., (2006) use the term "perverse subsidy" to describe the investment that source countries forego because of the outflow of their health workers. This migration of health professionals from low-income countries eventually attracted international attention, becoming the subject of research and discourse in global diplomacy, in arenas such as the World Health Organisation (WHO), United Nations General Assembly and other high-level forums (Hagopian et al., 2004; Kirigia et al., 2006; Scheffler et al., 2008; Muula et al., 2007; Mills et al., 2011).

African countries raised the issue of health worker migration through a variety of forums, including the Southern African Development Community (SADC). SADC health ministers issued a strongly worded statement in 2001 that:

> *"The active and vigorous recruitment from developing countries … could be seen as looting from these countries and is similar to that experienced during the periods of colonisation when all resources, including minerals, were looted to developed countries" (SADC, 2001: 33).*

A protracted diplomatic process followed across a range of regional and international institutions, leading to the Commonwealth Code for recruitment of health workers (Commonwealth Secretariat, 2003) and a resolution at the World Health Assembly (WHA) in 2004 (Resolution WHA57.19) mandating the WHO Director-General to develop a voluntary Code of Practice on the issue.

The WHO Global Code of Practice on the International Recruitment of Health Workers ('the Code') was subsequently adopted in May 2010. The Code is a voluntary instrument

that lays down global principles and practices around international recruitment and migration of health personnel and wider human resources (HR) development and management issues. It also includes periodic reporting by member states to the WHO Secretariat.

By September 2012, 81 countries had appointed designated national authorities and 48 had reported to the secretariat. However, among those, only one African country had submitted a report and only 13 had designated authorities (WHO, 2013). This lack of reporting raises the question of whether African countries perceive the Code as a sufficient response to their concerns and policy interests. At the time of drafting the Code, the main policy interests of African countries in the global debate on health worker migration and the HRH crisis included a just return for their investment in health workers and support for the health systems of countries facing severe shortages of health personnel (Connell et al., 2007). This paper addresses four questions on the engagement of sub-Saharan African countries with the Code:

1. To what extent were the policy interests of African countries incorporated (or not incorporated) into the Code through African diplomacy?
2. What were the perceived factors affecting how well African policy interests were present in the final draft of the Code?
3. To what extent do countries in east and southern Africa see and use the Code as an instrument for negotiating foreign policy interests related to their HRH concerns?
4. To what extent was monitoring of the Code used to advance African policy interests on human resources for health (HRH) in foreign policy?

Codes of practice represent one instrument in foreign policy to manage cross border issues, in this case to manage the ethical issues in and costs of and health worker migration (Pagett and Padarath, 2007). As a soft law, non-binding instrument, codes represent a statement of intent and guidance and make no provisions for sanctions against those who breach them. The WHO Global Code of Practice on the International Recruitment of Health Personnel provides an example of such instruments, and a lens through which to explore their role in global health.

The work formed part of the EQUINET programme on 'Contributions of global health diplomacy to equitable health systems in east and southern Africa.' This paper presents an the perceptions of policy personnel on the development and negotiation of the Code and summarizes the state of its implementation in the ESA region. It presents enabling factors and barriers in the negotiation and implementation of the Code and discusses the conditions necessary for its use as an effective tool in addressing selected challenges to health strengthening systems in eastern and southern Africa. It also examines the foreign policy implications, given the cross border drivers and nature of health worker migration.

Methods

The contexts, content, actors and processes in the stages of negotiation and implementation of the Code in the ESA Region were explored using the policy triangle framework (Walt et al., 2008). A multi-pronged approach was used, including literature

review, policy dialogue during the 66th WHA in 2013, a questionnaire survey using a 33-item semi-structured tool sent to HRH practitioners in 16 ESA countries and three country studies. Ethics clearance for the study was obtained from the University of Limpopo (Turfloop Campus) Research Ethics Committee (TREC), while verbal permission and consent were obtained from all informants.

Literature on codes of practice and bilateral and multilateral agreements in the 16 ESA countries was reviewed. One hundred three documents from 1970 to 2013 were included in the review based on their relevance to HRH migration, including themes relating to negotiation and compensation for health worker migration, "brain drain," codes of practice on ethical and active recruitment of health workers, bilateral agreements on health worker migration, as well as those making direct reference to the Code.

The authors convened a policy dialogue at the 66th World Health Assembly in May 2013. This event took the form of a question and answer style informal interaction with 15 stakeholders from WHO Secretariat (n=2), international civil society organisations (n=3), delegates from Europe and North America (n=2) and African delegates to the WHA (n=8). Participants discussed a series of questions focussing on barriers and enabling factors in implementing the Code, inputs required for countries to benefit from the Code and pertinent HRH recruitment, migration, or retention issues not reflected in the current version of the Code. The informants were purposively selected for their familiarity with and previous engagement on the Code and gave verbal consent to answer the questions.

A questionnaire survey using a 33-item, semi-structured tool was emailed to HRH practitioners – in ministries of health, training institutions and regulatory authorities – in 16 countries in the region. The informants targeted for the questionnaire survey were identified through the ECSA Health Community HRH Expert Committee, and from the EQUINET and WHO African Region's database of HRH officials in the region. Fourteen respondents providing information for nine out of 16 countries (56% country response rate) completed the questionnaire. No responses were received from Angola, Botswana, Democratic Republic of Congo (DRC), Malawi, Mozambique, Namibia and Zambia.

Three country case studies in Kenya, Malawi and South Africa were conducted between April and October 2013 to examine the perspective of key stakeholders. The case studies were qualitative and based on key informant interviews in Kenya and South Africa, while the Malawi study included key informant interviews supplemented by a questionnaire survey to ensure maximum response by the stakeholders, some of whom were not available for face-to-face interviews. The key informant interview guide and the questionnaire covered the same thematic areas, that is the HRH situation and priority issues, familiarity with the Code, efforts towards implementation and how useful the Code was perceived to be.

Primary key informants were drawn from various categories of stakeholders, identified through a stakeholder analysis that mapped the level of involvement of different categories of stakeholders with HRH issues. Further key informants were identified

through a snowballing strategy using suggestions from primary informants. Informants included health professionals and representatives of professional associations/organizations, regulatory bodies/councils, training institutions, government departments responsible for health (ministry or provincial department) and recruitment agencies.

Interviews were conducted using a standard key informant interview guide and were captured on a voice recorder; field notes were taken to capture non-verbal cues. In some interviews, however, respondents were reluctant to be recorded so only field notes were taken. Data were analyzed using Techs' open coding method as described in Creswell (2011) and the data were organized using the research questions outlined in the introduction. The main limitations of the present study were the lack of response to the questionnaire and the observation that even those respondents indicating lack of knowledge of the Code nevertheless voiced their opinions on what was lacking in the Code. Nevertheless, our use of multiple methods and sources of evidence mitigated this shortfall.

Results

The findings present the views of informants on HRH problems in the region, the reflection of African policy interests in the Code (or lack thereof), the implementation and factors affecting implementation of the Code, and on the monitoring of the Code in the region.

HRH problems in the region

The findings show that by 2013 health worker migration was not seen by the survey and interview respondents to be a priority HRH challenge. This is a significant departure from the situation in the late 1990s and early 2000s when calls were made for countries in the North to "stop stealing health workers from the region" (Ehman and Sullivan, 2001; Johnson, 2005; Dodani and LaPorte, 2005; Dovlo, 2005). Instead, the survey results show that by 2013, the most critical HRH challenges in the countries were seen to be rural/urban disparities in the distribution of health professionals, absolute shortages of health professionals, low salaries, low morale and low productivity of health professionals. These were reported by survey and interview respondents to relate to problems of low output from training institutions, poor facilities, lack of equipment and essential supplies, poor living conditions and limited opportunities for professional development among qualified personnel. External migration was not among the top three challenges cited by the survey respondents, by key informants in the country case studies, nor at the policy dialogue during the WHA. However, most respondents also indicated that data on health worker migration were not readily available or accessible. This may have led to an underestimation of migration as an issue within the countries studied. The lack of data on health worker migration is not a uniquely African problem, and appears to also affect high- and middle-income countries (Chikanda, 2006; Connell and Buchan, 2011).

Were policy interests of African countries reflected in the Code?

The Code was, as indicated earlier, motivated by Africans due to their concerns over outmigration of health workers. Respondents who had participated in the development and negotiation of the Code, or knew what role(s) their countries had played, believed,

however, that a number of issues could have been more explicitly addresed in the final Code. These included:

- Compensation to source countries, including support for training of health professionals and support for bonding agreements that oblige health professionals to work for the government in source countries for a specific period in return for sponsorship received for training.
- Control of the number of professionals that migrate from each country.
- Migrant health workers' concerns, such as mistreatment of migrant health workers, violation of their rights and denial of license renewals.
- The strengthening of boards and councils in source countries to monitor health professionals.
- Issues of equity, transparency and accountability in recruitment and deployment.
- Sharing of information on HRH migration between countries.
- Guaranteed return of health professionals who migrate.
- Evidence on the impact of HRH migration on health systems in the region.

In relation to how useful the Code was in addressing the above issues of concern to them on health worker migration, some respondents indicated that it was "useful and may be effective", while others stated that it was "business as usual, no effect". There were equally mixed views on the extent to which these same concerns were reflected in the Code, varying from "completely covered", "partially covered", "largely not covered", to "not at all covered".

These concerns appear to have been excluded in the process of the negotiation of the Code. Taylor and Dhillon (2011) provide a comprehensive account of the development of the Code. The authors indicate that issues of compensation and language that would have had more teeth had to be watered down in the face of opposition from developed countries, in the negotiations between 2004 and 2008. In their account, when the African voice was regained during the final drafting committee process (2008-2010), it was possible to influence language to provide for monitoring and reporting mechanisms that the louder voices from the North had opposed (Taylor and Dhillon, 2011). The scepticism by our respondents on the content of the Code seems to be borne out by the developmental process during which the decision was taken to compromise on issues such as compensation.

Scrutiny of the various drafts against the final version shows that the final Code captured most, but not all of the issues raised by African countries (WHO, 2008, 2010). The specific reference to mutuality of benefits in the Code yielded, however, to less explicit language on net returns to developing countries, supporting the perception by policy respondents that the final Code did not adequately address certain policy concerns held by African countries, as shown for example in Box 1 below.

Box 1: Changing text on Mutuality of benefits in draft to final Code

First Draft (August 2008): **"Article 5: Mutuality of benefits**: 5.1 In accordance with the principle of mutuality of benefits, both source and destination countries, should derive benefits from international recruitment of health personnel."

Second draft (December 2009): **"Article 5 – Mutuality of benefits:** 5.1 In accordance with the guiding principle of mutuality of benefits, as stated in Article 3 of this code, the health systems of both source and destination countries should derive benefits from the international migration of health personnel. In developing and implementing international recruitment policies, Member States should strive to ensure that the balance of gains and losses of health personnel migration should have a net positive impact on the health systems of developing countries and countries with economies in transition."

Code final version (May 2010): **"Article 5 – Health workforce development and health systems sustainability:** 5.1 In accordance with the guiding principle as stated in Article 3 of this Code, the health systems of both source and destination countries should derive benefits from the international migration of health personnel. Destination countries are encouraged to collaborate with source countries to sustain and promote health human resource development and training as appropriate. Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers."

Source: WHO 2010: Draft Code and Final Code Versions.

Dissemination of the Code

From the survey, case studies and policy dialogue it was evident that the Code had not been widely disseminated among stakeholders. Many of the key informants conceded that they were unaware of the Code's contents, and yet they were HRH practitioners and, in some cases, members of the HRH technical working group - a multi-sectoral group of all those partners and agencies, government, bilateral/multilateral agencies and non-government players with a stake in HRH. Lack of knowledge hindered meaningful discussion with the informants on the policy implications of the Code. For instance, the options for addressing the need for compensation were not well explored given the paucity of knowledge of the Code.

Some key informants indicated Kenya (only) had attempted to discuss the Code in the HRH technical working group and to develop a document to guide the Code's implementation. Nevertheless, even in Kenya implementation has been lacking, with no efforts at further dissemination and no designated authority appointed.

The survey showed that only Zimbabwe had a designated national authority for exchange of information on health personnel migration and implementation of the Code. When asked where policy positions had been taken on the Code since its adoption, most commonly mentioned were the positions of the East Central and Southern African Health Community (ECSA HC), the East African Community (EAC), SADC and the African Union (AU). Even for Zimbabwe, it was not clear to what extent the Code had been disseminated.

Implementation and use of the Code in east and southern Africa

During the policy dialogue at the WHA, a suggestion was made that implementation of the Code should be integrated with wider health service plans to strengthen the health system, linking it to other strategies in the national HRH plan, such as those geared towards delivery of an essential health package.

While poor dissemination was generally found, a few countries had used the Code to guide engagement with partners and external funders on HRH migration and retention, to raise consciousness among HRH practitioners and other stakeholders and to mobilise internal resources for HRH development. Respondents to the survey from Swaziland and Zimbabwe indicated that implementation committees had been established, with a monitoring mechanism and an implementation strategy.

Kenya had various government-to-government agreements related to the employment of health workers with Namibia, South Sudan, Lesotho and Botswana. It appeared, however, that these were not related to the Code. The agreement with Namibia resulted from a memorandum of understanding that was signed on 12 June 2004 and renewed on 1 April 2009 (Dulo et al., 2013). It is possible that the negotiations on the Code that were underway at the time at global level influenced the later bilateral agreement, but we found no evidence in support of this.

The major challenge to implementing and reporting on the Code was the lack of dissemination, followed by the lack of a focal person to drive the process, lack of information on the magnitude of migration at country level, lack of political support and high turnover of top Ministry of Health officials and low capacity of the country to recruit graduates such as doctors. The present study also pointed to a number of barriers to Code implementation, outlined below.

The Code was perceived as a watered down document with no real teeth or force, in view of its non-binding and voluntary nature. There was little publicity about it, which may lead to an understatement of achievements in using its content in the region. For example, an informant from the South African Department of Health stated:

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

There was a lack of preparedness within the countries, with limited or no mechanisms in place for implementation. Those who had driven the negotiations for the Code reported a degree of 'burn-out'. Many felt that the negotiations for the Code had been an exhausting process, albeit successful. According to one Ministry of Health official, after adoption of the Code: "*We then went back to other things. For the Code, it was mission accomplished, and we didn't have any more energy for it."* Further overburdened HR departments in the ministries of health that found it difficult to accommodate the Code in their work.

A high turnover among key-players in ministries of health in some countries, including ministers, permanent secretaries, directors or heads of HR management, led to loss of institutional memory and champions on the Code. As stated by a ministry of health official:

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

There was poor mobilization of national-level stakeholders, including civil society, which some attributed to lack of financial support for sustained activities around the Code. Weak regional co-ordination and a decline in voice from the Africa region hampered translation of the Code into national action. Lack of strong leadership from the WHO made it difficult for member states to unpack the Code for implementation. Many respondents felt that the lack of leadership was the result of reforms at the WHO secretariat that had tended to downgrade HRH from amongst its priority areas.

Accordingly, there were no success stories from the ESA region on implementation and utilization of the Code, and therefore no enabling factors were identified. Lack of prompt action within the countries after the 63rd WHA in 2010, which adopted the Code, was seen as a missed opportunity that could have aided implementation of the Code.

Monitoring the Code

As this research showed no implementation of the Code in the region, it was not possible to gauge the extent to which countries in the ESA region were motivated, capable and prepared to monitor implementation of the Code or to use knowledge gained from monitoring to further engage on African policy interests on health workers. Constraints to reporting on the Code were similar to those for implementation, as outlined above, including the lack of dissemination and lack of a focal point or responsible authority. The findings also unmasked the weakness of monitoring systems within the region, evidenced by lack of sound, accessible or usable data on HRH migration, with consequences for the implementation of the Code.

Discussion

Overall, this paper provides insight on the negotiation process, on the perceptions about the Code in its final adopted form, on the lack of implementation and reporting on the Code and the factors responsible for that state of affairs. It also examines the extent to which policy interests of African countries were or were not brought into the Code.

Various authors have expressed reservations on the potential for success of codes of practice, including this Code (Buchan 2010; Connell 2010; Connell and Buchan 2011). The loss of perceived urgency around the underlying issue of HRH migration in the region, perception of loss of some areas of African concern in the final wording, lack of widespread knowledge of the Code and the lack of progress in domestication, implementation or reporting on the Code would tend to raise the same caution suggested by those authors. However, its voluntary and non-binding nature and the

experience of the only other WHO Code, the WHO/UNICEF International Code of Marketing of Breast-milk Substitutes, whose success took many years from its adoption, suggest that it may be too early to judge the success of the Code.

The negotiation process

At the start of the negotiations for the Code, HRH migration – "brain drain" – was a major concern among health sector policy actors in the region. However, based on the research presented in this paper, it is apparent that health worker out-migration is no longer among the most critical HRH challenges in the region. Rather, internal migration appears to be the biggest concern currently, notwithstanding the lack of data on the extent and impact of external migration. As the Code negotiation process dragged on between 2001 and 2010, countries implemented other measures to address HRH concerns. These included the Commonwealth code, the UK-South Africa agreement, the Southern Africa HRH agreement for the SADC region and the Kenya-Namibia agreement, as cited earlier.

There was some dissatisfaction with the final provisions of the Code, with the perception that the Code omitted issues of compensation and mutual benefits. As Taylor and Dhillon (2011) point out, one of the last clauses to be dropped during Code negotiations was the one on mutuality of benefits. However, by the penultimate draft of the Code, even the African region had dropped mention of compensation (WHO, 2008), which, according to Taylor and Dhillon (2011) was done in the interests of progress in the negotiations. Another issue for dissatisfaction was the voluntary and soft law nature of the Code, although from the outset the WHO Director-General was mandated to develop a voluntary code.

Countries reportedly supported a unified negotiating platform by the Africa Group at the WHA (Taylor and Dhillon, 2011). It would appear that the diplomacy around the negotiations meant that countries gave up a national voice to gain of a stronger, unified African voice. This raises the question, however, of how far that unified approach enabled or masked the preparedness of individual countries for follow through on the Code. In other words, did forming a united African voice mean that country-specific concerns were not sufficiently addressed?

Barriers to Code implementation

The lack of knowledge of the content of the Code limited discussions on the preparedness of the individual countries to implement the Code. The question arises whether this is unique to the Code or whether there is a lack of knowledge for or co-operation on implementation issues in other areas of health diplomacy.

The interaction with policy makers through the policy dialogue at the WHA confirmed that the major barriers to implementation of the Code included lack of preparedness, poor mobilization at country level, over-burdened HR departments in the ministries of health and lack of national champions to drive Code implementation and reporting. Some informants expressed the view that countries were, in fact, implementing the Code in various ways, or at least taking steps in line with the objectives of the Code, although they did not provide any specific examples.

The Code itself advocates for bilateral agreements between source and recipient countries to aid its implementation (WHO, 2010). Bilateral agreements have stronger enforceable relevance and commentators like Dhillon (2011) see them as an important means for achieving the Code's objectives. Bilateral agreements are also seen as a useful way of accessing compensation, but so far none have been concluded between countries in the region and recipient countries of African health workers outside Africa. Connell (2010) observes that recipient countries have no interest in putting in place compensatory mechanisms, often arguing that migration is freely chosen and that there is no means of knowing how long migrants will stay, despite strong ethical arguments in favour of restitution. Connell suggests that this makes financial compensation to source countries for losses of workers difficult to implement, and that compensation is inherently impossible as long as ethical arguments confront political realities (Connell, 2010). It appears that recipient countries prefer to address health worker issues through general development aid support rather than with specific bilateral agreements. The lack of bilateral agreements on compensation also suggests that African countries have not been able to use the Code as a negotiating tool in health diplomacy to pursue their own policy interest, at least not to the extent intended in the build up to its adoption.

Nevertheless, Dhillon et al., (2010) do highlight that individual European Union (EU) countries have offered support for strengthening HRH. France supports 20 countries, mostly from Africa, with about 30 projects where the development aid is either entirely dedicated to health workers, or where a wider health system project includes a component on HRH. France has signed nine bilateral agreements on migration flows with countries in Francophone Africa to date. Some of the ratified agreements (i.e. Senegal, Benin and Congo) address the issue of migration with a comprehensive approach and a particular focus on health professionals and support for HRH development (Dhillon et al., 2010).

Conversely, the South African case study suggested that inactivity in relation to the Code may be due to other factors than an inability to use it as a diplomacy tool. Informants in that country were unanimous in stating that South Africa still faced many HRH challenges, but that these did not include health worker migration. The findings there suggest that measures such as improving health worker conditions and bilateral agreements, rather than the Code, might have mitigated the effect of health professional migration and stemmed the outflows, perhaps to the extent that it is no longer a major issue in the country. In terms of advocacy and further use of the Code for health diplomacy, however, it is significant that a country such as South Africa, a major contributor during the development processes for the Code, has made little effort to disseminate or implement the Code.

Information and advocacy around the Code

The notable lack of civil society involvement at all stages weakened the role of health civil society engagement in galvanizing action for Code implementation. While acknowledging the enormity of the task ahead, civil society organizations expressed a sense of optimism. Despite the slow start in the first three years, the view was that the kind of mobilization that contributed to the adoption of the Code was needed now to get countries in the region to implement and monitor the Code.

In contrast, the WHO/UNICEF International Code of Marketing of Breast-milk Substitutes, adopted by the 34th WHA in 1981, has been supported in both its adoption and implementation by the involvement of the International Baby Food Action Network (IBFAN), which was established two years prior to its adoption. IBFAN advocated for the adoption of this code and has provided evidence for and consistent advocacy on its implementation (Allain, 1989; Hoepner et al., 2014). Unlike the "breastmilk code", no definite group or social movement has developed around the Code. Moreover, the Code is not a single issue around which simpler campaign messages can be crafted. The comparative trajectory of the two codes, and the relative role of civil society in this, is a matter for separate research. However, the experience of IBFAN and the findings of this study suggest that a strong civil society movement could build the advocacy needed for the implementation of the Code.

Among the obstacles to implementing and monitoring application of the Code is the lack of accessible HRH data. According to a government respondent, although countries may not have reported on the Code, many things were being done in line with the objectives of the Code. If this is so, and the Code or its objectives are indeed being implemented, then what are the barriers to reporting on this progress? Following a long and intense diplomatic struggle to get the Code adopted, ESA countries were found to have made limited effort to implement the Code and report on its progress.

The research also raised suggestions on what ought to be done to ensure implementation of the Code. Many policy makers realized through these interactions, that there was a lot to be done, and much that *could* be done to use the Code. This awareness may itself lead to concrete action at national level. As indicated earlier, three years after adoption may be too early to judge the fortunes of the Code, and with renewed vigour, it may be possible for countries, especially in the African region, to explore ways of utilizing the Code to their benefit.

Conclusions and Recommendations

Countries in the ESA region have made relatively little progress in implementing and monitoring the Code and have not used it to advance bilateral agreements or engage on HRH outmigration in global health platforms. The research presented here found that the Code remains largely unknown in the region. Much of the stagnation on Code implementation at the ministry of health level would appear to be due to lack of a focal person or to overwhelmed HR departments. The lack of progress in this regard suggests waning political will on issues of HRH migration within the region. Whereas the main African interests were reflected in the final wording of the Code, some elements, especially on compensation and mutuality of benefit that were not included. This appears to have led to perceptions that the Code did not meet the expectations of the African countries. The research also suggests that implementation plans, issues and capacities need to be given more attention in future global health negotiations on this or other issues, if a global instrument like the Code or other codes are to have a positive effect.

There continue to be pull factors attracting inward migration of health workers, while push factors drive their out-migration (Padarath et al., 2003). For example the

Affordable Care Act in the USA potentially raises a new demand for health workers. Countries in the region can use implementation of the Code as a mechanism through which to manage future HRH challenges. The findings from this research suggest six policy recommendations for countries to make more effective use of the Code to address the earlier stated African policy concerns on HRH migration, by specifically:

1. Appointing designated authorities to drive the processes for implementation and reporting, coupled with efforts to strengthen the HR departments within ministries of health.

2. Identifying which components of the Code they sought to emphasize and through which mechanisms to best address their specific concerns and issues, within the overall measures for health system strengthening.

3. Obtaining leadership and support from the WHO in the implementation and monitoring of the Code, with regional organizations such as ECSA HC, SADC, ECOWAS, West African Health Organization (WAHO) and the AU playing a more active role in bringing the countries together to plan for implementation.

4. Giving civil society in Africa a greater role in advocacy for implementation of the Code, supported by evidence and in collaboration with other national stakeholders.

5. Engaging academic and research institutions to provide evidence from research on the extent and impact of HRH migration to inform decision making in the region.

6. Reporting on Code implementation, including to raise issues and galvanise action on recommendations.

It is a curious finding that following a long and intense diplomatic struggle to get the Code adopted, countries in east and southern Africa appear to have taken so few steps towards implementing and reporting on the application of the Code. While this may reinforce the reservations expressed by others on the potential for successful use of codes of practice in global health, the constraints identified in the use of this Code suggest issues to note in future negotiations, and that it may be early days yet to judge the success or otherwise of this Code.

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Disclaimer of interest
The authors declare that they have no competing interests.

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