Relevance and effectiveness of the Code from a civil society advocacy perspective

1. WHA 2010-2013: From engagement to indifference, from optimism to frustration: Was the making of the Code already its main achievement?

2. State of civil society advocacy on Code implementation after 2010

3. Relevance and effective of the Code in view of achieving change:
   - What needs to change?
   - How useful is the Code to support our demands?

4. Options for the Future of the Code

I am glad to share with you some very first thoughts at the beginning of both the review process and the political dialogue on the future of the Code. It is the perspective of a civil society advocate on the relevance and effectiveness of the Code for promoting and achieving change in the field of human resources.

1. Let me first look back to the World Health Assemblies in 2010 and 2013

The Code negotiations and its adoption at the 63rd WHA can be considered as a major achievement of global health diplomacy in the last years. The Code is one of only few regulatory instruments developed and adopted by WHO – and if you want to know more about the difficult negotiation process, you might read the paper of Taylor/Dhillon (2013) or ask one of the colleagues in this room who participated in that famous night session ending at 4.30 in the morning.

The adoption of the Code was a great relief. We remember the applause and the enthusiastic statements. It was done, yes. But there was a second, more implicit message behind this relief: “This is how far we could go together, do not expect anything more from us.” The adoption of the Code was also the end of a process, with an uncertain future.

At a WHA side event organized by the Medicus Mundi International Network together with many other partners we had our question marks regarding the Code itself and its implementation, but at that moment we first needed to push for its adoption. So our event was rather seen as a successful “pep rally” for the Code.

But I remember what Annelies Allain from the International Baby Food Action Network said to us: Enormous civil society mobilization and advocacy
efforts were undertaken (and in fact needed!) to ensure impact of the International Code of Marketing of Breast-Milk Substitutes, that non-binding instrument developed by the WHO thirty years before that has in fact been truly transformative and saved the lives of countless infants around the world.

So the question and challenge was: could the success story of the Baby Milk Code be repeated?

Three years later, at the WHA in 2013, a first answer was “no”.

The figures on Code implementation presented by the Secretariat in its report to the Assembly were frustrating; the discussion of the agenda item in Committee B was all in all a disappointing “non-debate”. It looked as if most of the WHO member states already disengaged from the process, although there were some desperate calls for renewed leadership and revitalizing Code implementation. We will hear them soon again, after the next round of reporting.

At the same World Health Assembly, all debates and side events focusing on Universal Health Coverage were crowded and vibrant.

At our civil society side event, WHO ADG Marie-Paule Kieny confirmed that the implementation of the Code had been “painfully slow”. The side event itself did not give clear perspectives on how to “stoke up the fire for Code implementation”. Our conclusion at that moment: The Code was “lost in translation”.

MMI statements at the 2013 WHA focused on two issues:

First on transparency and accountability: We expected the disclosure of country information gathered through the National Reporting Instrument – and were very disappointed that these data were not accessible to us.

Secondly on capacities: We highlighted the lack of sufficient dedicated staff capacities and financial resources within WHO Secretariat and at Regional Offices and Member States level for properly following up the process.

We warned WHO member states that the success or failure of Code implementation would be seen as a case study for the capacity of WHO – and its members – in the field of global standard setting and regulation.

I think that this is still valid. But today this cannot mean that we want to “save” the Code at all means. We need to have an in-depth look at its relevance and effectiveness first, and then discuss what to do with it. This is what the Medicus Mundi International Network and myself expect from the Code review process.
2. What can be told about civil society advocacy for Code implementation after 2010?

When I talk about “civil society advocacy for Code implementation”, let me begin with a simple question that some of you might even call naïve: Why (the hell) do the WHO member states need to be “advocated” by civil society for implementing the Code???

The Code was unanimously adopted by the WHO member states. Together with the WHO secretariat, they are the main responsible for its implementation.

So why do they need to be pushed, Why is there a need for a kind of “intermediary” civil society pressure/advocacy needed to make countries stick to their commitments?

And, looking at all those political declarations and WHA or UN resolutions and their long preambles quoting previous declarations and resolutions, I add a second stupid question:

How many “intermediary” commitments (Codes, resolutions, declarations…) do the political responsible need to make before moving from analysing a problem to political and practical action?

There are obvious governance issues. To say it simply:

Commitments without strong accountability mechanisms are worthless.

And, obviously, there is still little coherence of policies at country and international level. Economic interests and power are dominating over public health within a country, within an administration. There is a long way to achieve health in all policies.

Looking now a bit closer at civil society advocacy for the Code implementation.

Obviously we have not reached at all the benchmark set by the “Baby Milk activists”. Far from that.

Civil society advocacy has been scattered, not systematic. There have been some efforts in some regions and countries, some successes, too, but there has been no “movement” nor global advocacy consortium for the implementation of the Code.

I refer to reports of colleagues from Equinet Africa and from the European project “Health Workers for all and all for Health workers” and to my experience as a coordinator of the “migration” working group of the civil society Health Workforce Advocacy Initiative. I admit that I do not know much about activities in all the regions.

Civil society advocacy on migration punctually used the Code as a key reference.
This happened, for example, in the case of the migration of nurses from Spain or the Philippines to Germany, the advocacy for the rights of migrant health workers in different European countries, or, most recently, the struggle against the export of Ugandan health workers to Trinidad and Tobago. I hope to get a better overview in the current review. So advocacy case stories would be most welcome contributions.

There are some limiting factors for civil society advocacy for Code implementation

The MMI Network, rooted in international cooperation and focusing on health systems, got involved in the migration issue only in 2009, when, at a meeting on best practices in the field of HRH, a colleague from the Uganda Catholic Medical Bureau stated: „Retention is difficult for both public and privat not-for-profit sector: The UK are stealing our doctors and nurses!“. We then had Jean-Marc Braichet from the WHO secretariat with us, and he attracted our attention to the development of the Code of Practice. He asked us to “help WHO to get it adopted” – and this is what we did.

But since 2010, Migration of health personnel has been replaced by other “hotter” advocacy issues such as

- Universal Health Coverage and, after Ebola, the “resilience” of health systems
- Production of health workers
- Health in the post-2015 process
- Health governance and the WHO reform
- etc.

Another factor is the difficult political discourse on health workers migration.

In the field of mobility and migration, there is no easy “enemy” (“Nestle kills”, “Patents kill”) to be used for political campaigning, but there are complex, multifaceted issues which are difficult to address, “not least because of the different policy domains under which global health and global migration have evolved, differences in health policy and financing in high-, medium- and low income countries, and unequal economic and social development. Articulating what the ‘right to health’ and the ‘right to migrate’ mean in this context is equally complex.” (here I quoted a recent paper by Yeates and Pillinger)

Part of this complexity is that, also in civil society, there are different “tribes” to be united for successful advocacy. Professional associations, trade unions, NGOs working in the field of development cooperation and global health policy, migrants’ organizations etc. It is not easy to bring them and their different realities, approaches and languages together. When it was achieved such as in campaigns in Germany or Switzerland, this lead to strong messages and considerable success.
On the other side, the Code itself and its implementation mechanisms proved to be a rather difficult reference for advocacy. I mean

- its non-binding status, with no clear road to national legislation or regional and bilateral agreements;
- the blocked access to national reports on Code implementation;
- the missing implementation of proper “stakeholder mechanisms” in most of the countries.
- In some countries is was not even possible to identify the Designated Authority orto get into a proper dialogue with it.

But there are also some content elements

- First the Title: Amani Siyam rightly states that “it’s all in the Code”. The Code covers so many relevant fields, but its title only highlights international recruitment, and not even migration/mobility.
- The call for self-sufficiency is difficult to explain. It is often misunderstood as directed against the right to migrate and brings advocates in a situation to defend themselves as not xenophobe.
- As a result of the negotiations, some of the Code language is too weak. The most obvious example is that the Code does not provide any proper reference for calls for compensation for the loss of investment into the training of health workers.

For evidence based advocacy, one issue which is itself addressed by the Code, but not at all resolved, has proved to be a major obstacle: the lack of knowledge, both as statistic data and research:

- on migration patterns of health personnel;
- on the nature and range of global policy actors, policy responses and initiatives in HRH migration;
- on the real costs or damage of emigration to national health systems of source countries;
- on difficult concepts such as “active recruitment” or circular migration;
- etc.

3. Relevance and effective of the Code in view of achieving change: What needs to change?

- How useful is the Code to support our demands?

What is needed to properly address international migration and recruitment of health personnel?

Provisions on migration and ethical recruitment of health personnel are the core elements of the Code. Many important issues are addressed in the Code – so yes, it is still relevant. And for some of them, such as the protection of the rights of migrant health workers, the Code could also be effectively used for civil society advocacy promoting change.

For other issues such as the mutuality of benefits, the Code is not sharp enough for supporting our demands.
If we have a look at the extended content of the Code and the question of what is needed to overcome the global health systems / HRH crisis, the picture is different.

“It’s all in the Code” – or almost... The Code in fact covers relevant fields such as the need for investments in the national health systems and health workforce or the need to act coherently at national, regional and global level.

But with its non-binding character and its focus on migration, the Code is not the first, most obvious reference and instrument for civil society advocacy for health workforce and health systems strengthening.

And for addressing the economic, social and political determinants of the health systems crisis, the Code is of no real help at all.
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<thead>
<tr>
<th>Option</th>
<th>Experience</th>
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<tbody>
<tr>
<td>Invest in the national health system and health workforce. Protect cost-effective public health services from budget cuts. Increase the fiscal space for health and social protection and implement mechanisms for health impact assessments of fiscal policies</td>
<td>yes</td>
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<tr>
<td>Think and act coherently at national, regional and global level. Address intersections between migration, health, development cooperation, fiscal and employment policies in a consistent manner</td>
<td>yes</td>
</tr>
<tr>
<td>Improve global health governance</td>
<td>yes</td>
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<tr>
<td>Address economic, social and political determinants</td>
<td>no</td>
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### Options for the Future of the Code

If I dare to speak about options for the future of the Code, I need to repeat what I said in the very beginning: it is initial thoughts at the beginning of both the review process and the political dialogue on the future of the Code. I very much look forward to both of it.

A colleague stated that “at these times, nobody is willing to open up things”, referring to the Code, its negotiations process, the factual balance of power between the source and destination countries of health workers migration.

**So in the given situation I see two “pragmatic” options:**

We can try once more to revitalize Code implementation in order to maintain its relevance. This might include some minor modifications of the Code itself and its implementation mechanisms built on “safe ground” which needs to be explored.

From a civil society perspective, such modifications should include stronger accountability mechanisms, with improved transparency, and stronger recommendations on national legislation and bilateral/regional agreements.

Achieving rapid progress in data collection and undertaking considerable investments in research would certainly be catalysts for a more dynamic Code implementation, the same as the promotion of good practices.

But this cannot be done without investments: WHO members should agree on the need for strengthening the capacities at WHO global and regional level to provide leadership and technical advice. And they need to invest themselves, at a national level.
Another pragmatic option is to accept the Code’s limitations at a global level and to focus a next effort on developing strong regional mechanisms.

I quote again Yeates / Pillinger: “It is evident that there has been a lack of progress in strengthening the global institutional framework. This is seen as a reflection of the unwillingness of destination country governments to engage in binding measures, for example, as seen in the growth of multilateral non-binding initiatives and consultative forums, and in the increasing liberalization of global labour markets.”

But, on the other hand, there are some dynamic and encouraging developments regarding coordination and regulation at a regional level in the policy domains addressed by the Code. And we have to admit that there are strong differences in the realities and institutional settings in different regions.

So, at a global level, WHO might leave the Code and its accountability mechanism as they are, but focus its efforts on fostering and supporting related regulation and action at a regional level.

But there are more ambitious options

Would it not be time for developing an overarching global governance framework on health workers migration and mobility?

From a civil society perspective, such a framework

- should be consequently rooted in a “3R” (rights-regulation-redistribution) approach.
- should focus on rights of migrant health workers.
- should include stronger guidance for national legislation and the development of bilateral/regional instruments
- should address (the other side of the currently existing) redistribution: the compensation or return of investment for sending countries

Such an effort would require a broader institutional ownership/platform, including ILO, IOM, OECD, ECOSOC and other multilateral and regional organizations and actors, and integrating their current policy initiatives spanning health, migration and development.

Again, I refer to Yeates / Pillinger for inspiration.

Or would it be the time to integrate the Code into a broader instrument (a non-binding code or binding convention) on international obligations for strengthening national health systems?

The recent hypes on UHC and Ebola, described before as “distracting” attention from migration as advocacy issue, can also be considered as an opportunity: the need to strengthen national health systems is finally back at the top level of health policy.

This is at least a good starting point.