

Towards a Regional Strategy to Strengthen the Nurse Workforce of the English-speaking CARICOM

International Legal Instruments, Agreements and Obligations

Christoph Kurowski, Carmen Carpio, Marko Vujcic, Lawrence O. Gostin and
Tanya Baytor

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Health, Nutrition and Population (HNP) Discussion Paper

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Toward a Regional Strategy to Strengthen the Nurse Workforce of the English-speaking CARICOM: *International Legal Instruments, Agreements, and Obligations*

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Abstract: This paper assesses relevant international obligations of English-speaking Caribbean Community (ES CARICOM) countries and the pros and cons of different instruments that govern a regional strategy to strengthen the region's nurse workforce. The paper presents a critical review of international legal agreements governing health personnel to which ES CARICOM countries subscribe and reviews the advantages and disadvantages of international legal instruments, drawing on evidence in the literature and expert opinions.

Keywords: nurses, nursing, human resources for health, health worker migration, Caribbean, legal instruments, regional strategy

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The study design benefitted from three rounds of consultations that were a part of the dissemination of an assessment of the Nurse Labor and Education Markets in the English-speaking CARICOM. The first round of consultations took place in March 2010 in Jamaica, hosted by the ministry of health and bringing together representatives from the ministry of health, the Jamaican nursing bodies and associations, Jamaican nurse teaching institutions, the University of the West Indies, the International Labour Organization, and the World Health Organization. The second round of consultations took place in July 2010, hosted by the Regional Nursing Body (RNB) and bringing together chief nursing officers; and the final consultation was held in September 2010, hosted by the CARICOM and bringing together the Caribbean ministers of health.

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PREFACE

Health workers form the heart of every health system. They play a critical role not only in delivering health services, but also in motivating people to seek the care they need. As demand for good health care rises around the globe, a growing number of countries face shortages of doctors, nurses, midwives, and support workers. These shortages are especially acute in developing countries. Linked to this, developing countries also face challenges in how to improve training capacity, performance, and distribution of health workers.

In the Caribbean, the focus is on strengthening the nurse labor force. Nurses there constitute the largest group of health professionals and play the central role in strengthening preventive health services in the face of the demographic and epidemiological transitions that have shifted the burden of disease from infectious to chronic conditions. But with open market reforms underway both regionally and internationally, English-speaking Caribbean nurses now face unprecedented mobility in the labor market. Thanks to their high-quality education and native language, they have been increasingly inclined to migrate to Canada, the United Kingdom, and the United States for work.

To pre-empt the deeper nursing shortages in the Caribbean, collaboration is needed at the regional level. A first phase of collaboration between the ES CARICOM and the World Bank produced a comprehensive picture of the nurse education and labor market, demonstrating both a supply insufficient to meet growing demand as well as tremendous losses of human capital at multiple points in the markets. The study further highlighted the need for a regional approach to strengthen workforce monitoring, to improve and expand training capacities, and to manage migration. In this second phase of work, an evaluation of legal instruments was carried out to identify potential instruments that can be built upon to govern a regional approach and action.

Our hope is that through our continued collaboration with the ES CARICOM, the region can begin to make headway toward a regional approach to address the challenges that face the nurse labor force and produce economic and social benefits that cross country boundaries and positively affect the region.

Keith Hansen
Director
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EXECUTIVE SUMMARY

1. With growing shortages fuelled by the health needs of a rapidly aging population and tremendous losses of human capital occurring at multiple points in the markets, the supply of nurses in the English-speaking Caribbean is insufficient to meet demand. Reducing shortages requires swift policy action in three priority areas: strengthening workforce monitoring, improving and expanding training capacities, and managing migration.
2. Given broad consensus about priority areas for policy action and the need for a regional approach, countries asked the Bank to identify relevant obligations under existing international legal agreements and examine their pros and cons. This included an examination of lessons learned in the use of various legal instruments to identify the most appropriate instrument to govern a regional strategy and strengthen the region's nurse workforce.
3. In response to the governments' request and in the absence of analysis in the literature, the present study assesses relevant obligations through a critical review of international legal agreements governing health personnel to which English-speaking CARICOM (ES CARICOM) countries are signatories and reviews the pros and cons of international legal instruments, drawing on evidence in the literature and expert opinions.
4. Obligations under legally binding, international agreements, for instance, the Global Agreement on Trade in Services (GATS), the Caribbean Single Market Economy (CSME), and conventions sponsored by the International Labour Organization (ILO) do not limit the use of policy instruments to manage migration. Furthermore, they say nothing at all about the policy priority areas of nurse training and workforce monitoring. Obligations under non-legally binding agreements, namely the Commonwealth and the World Health Organization Code of Practices and the Pan American Health Organization (PAHO)-sponsored Regional Plan for Action provide a supporting framework for regional action in all of the priority policy areas. A regional legal agreement could therefore shape policies and rulings on health personnel in the context of the GATS and CSME and provide granularity to the broad principles laid out in the Code of Practices and the PAHO Regional Plan for Action.
5. In defining the scope of commitments of a regional legal agreement, ES CARICOM states would have to ascertain whether they would commit to actions to strengthen the nurse workforce or the health workforce more broadly. While the challenges of strengthening the nurse workforce have been systematically assessed, information about other groups of health professionals remains patchy. At the same time, however, the literature suggests that causes and trends are likely to be the same or similar. In defining commitments, CARICOM states would face the challenge of a weak, (albeit growing) evidence base for policy action in the priority areas. Knowledge gaps exist particularly in cross-country coordination in expanding training capacities and managing migration to the benefit of both source and destination countries. Therefore, it

is critical that the scope of commitments includes actions to monitor the workforce and evaluate policy initiatives.

6. As the evidence continues to grow, the ES CARICOM will need to identify a flexible instrument that allows it to adjust policies. This need for flexibility speaks against the adoption of a legally binding instrument such as a multilateral treaty or a framework convention, to which changes are cumbersome and costly. Furthermore, ES CARICOM stakeholders favor quick action, while negotiating legally binding instruments tends to be a lengthy process in which commitments are attenuated. For the same reasons, adopting a non-legally binding instrument seems advantageous. Learning from the experience of overly ambitious initiatives (for example, the Commonwealth Code of Practice), it could focus on a few of the most urgent priorities, and promise action negotiated quickly with commitments adjusted or expanded as needed and appropriate. These advantages of flexibility and faster pace, however, must be weighed against the cost of commitments that are not enforceable under international law. However, international experience suggests that non-legally binding instruments create expectations that constitute powerful incentives for compliance. The risks of poor compliance could be further mitigated by ensuring gains for all states, commitments to monitor the workforce, and evaluated policies and external reviews (for example, by the ILO).

7. Within the category of non-legally binding instruments, a multilateral memorandum of understanding seems the most suitable option. This is because a resolution would require a sponsoring UN agency, and because a code of practice would also govern private institutions, which play a minor though not negligible role for the training and employment of the health workforce in the ES CARICOM. A multilateral memorandum of understanding could be converted into a pact among states as more and more countries enter the agreement and joint actions produce results and greater visibility for the initiative in the region as well as globally.

8. Therefore, a multilateral memorandum of understanding with a focus on a few of the most urgent and promising actions, negotiated quickly and with commitments adjusted and expanded as needed, seems the most appropriate instrument and approach to translate high levels of political commitment into an actionable regional strategy to strengthen the ES-Caribbean nurse workforce.

PART I – INTRODUCTION

9. **In 2008, at the request of the ministers of health, the World Bank initiated a stream of work to strengthen the nurse workforce in the English-speaking Caribbean.** At that time, the ministers of health were concerned with chronic staff shortages in local health facilities and about anecdotal evidence of significant migratory outflows. They considered shortages and outflows key impediments to the provision of quality health services and the ability to attract businesses and retirees to the region, an important source of economic growth. For at least four reasons, they requested the World Bank to focus its research on the nurse workforce. Nurses constitute the largest group of health professionals and play a critical role in strengthening preventive health services in the face of demographic and epidemiological transitions. With the implementation of the CARICOM Single Market and Economy (CSME), nurses enjoy free movement in the regional labor market. Furthermore, thanks to their high-quality education and native language, they are more likely to migrate and work in Canada, the United Kingdom, and the United States.

10. **A first phase of work provided a comprehensive picture of the nurse education and labor markets of the ES CARICOM, demonstrating both a supply insufficient to meet a growing demand as well as tremendous losses of human capital at multiple points in the markets** (World Bank 2009). The study estimated the stock of nurses in the ES CARICOM at approximately 7,800 in 2007 with shortages under existing policies at 3,400 nurses increasing to 10,700 in 2025 due to the health needs of a rapidly aging population. On the supply side, the analysis uncovered tremendous loss of human capital at multiple points in the nurse education and labor markets. For every 100 qualified nursing applicants, only 34 were accepted into programs. Of the 34 that were accepted, only 20 graduated. Within 20 years, only 5 out of the 20 graduates would remain working in the ES CARICOM.

11. **The first phase of work highlighted three priorities for policy action: strengthening workforce monitoring, improving and expanding training capacities, and managing migration.** Strengthening the monitoring of the workforce is critical, as information remains scarce and impedes evidence-based policy making. Improving the quality of training seems the best entry point to bolster the nurse workforce in the short term. While dropouts represent a significant loss, the literature is abundant with evidence to inform policy making, and some schools have achieved substantially higher-than-average completion rates. Expanding training capacities presents the most viable option for meeting medium- and long-term demand. Box 1 below provides a summary of the policy recommendations that surfaced during the first phase of work for each priority policy area. Unlike other regions in the world, there are no binding constraints to scaling up training slots except that creative strategies are needed to address the insufficient number of nurse tutors. Managing migration is crucial for stabilizing the nurse labor market. With the vast majority of nurses expressing an intention to migrate, immigration policies of destination countries are the main drivers of outflows. In extensive consultations, regional stakeholders carefully reviewed the findings of the study and endorsed the extensive consultations.

Box 1. Policy Recommendations from Phase 1 Study, “The Nurse Labor and Education Market in the English-speaking CARICOM: Issues and Options for Reform”, World Bank, June 2009 (Report No. 48988-LAC)

Recommendations to Strengthen Workforce monitoring

ES CARICOM should identify the information requirements to monitor nurse education and migration flows within the region. This would require a thorough review of existing data and the identification of information needs. Countries would then need to develop, maintain, and use information for policy making.

Recommendations for Improving and Expanding Training Capacities

ES CARICOM countries should consider promoting policies, many of them endorsed under GATS, such as (i) training nurse tutors outside the region; (ii) using in-service programs offered online; (iii) allowing for the temporary recruitment of nurse tutors from Canada, the United Kingdom, and the United States; and (iv) drawing on the diaspora to meet the need for tutors with specific clinical skills and areas of expertise. Any policy strategy to expand nurse-training capacity requires an exploration of alternative arrangements for financing nurse education. To meet financial requirements to boost nurse-training capacity, a tripartite financing model with contributions from local and destination-country governments and students is a viable alternative to the current model.

Recommendations for Managing Nurse Migration

ES CARICOM countries should consider promoting the following policies: (i) creating barriers to migration such as the adoption of bonding schemes already successfully adopted by some countries in the region; (ii) easing push factors by offering, for example, further in-service training opportunities; (iii) leveraging expatriates as volunteers to support training systems; (iv) turning brain drain into brain circulation by providing the nurses who return home with opportunities to work; (v) lowering barriers to entry for health professionals from inside and outside the CSME, in particular, for nurse tutors; (vi) establishing mutual recognition agreements to facilitate the mobility of nurses, which is already in place with the United Kingdom and could be expanded to countries that may be potential sources of migrants to the ES CARICOM; (vii) establishing agreements on recruitment to facilitate the international flow of nurses; (viii) exploring agreements on twinning, staff exchange, and educational support to support the structured temporary movement of staff based on needs and career development; and (ix) exploring a code of practice that could help minimize the negative impact of migration by disallowing active recruitment from designated countries. In addition to policies to retain nurses in the ES CARICOM, therefore, a strategy to manage migration requires reaching out to destination countries to establish and agree on annual flows, cost-sharing arrangements for necessary investment in nurse-training capacity, and technical support.^{1,2}

12. **In addition, the first phase of work emphasized the need for extensive collaboration among ES CARICOM.** Workforce losses due to migration are effectively recorded at the point of entry into a foreign country, that is, not in the source country but in the destination country. In the ES CARICOM, only a limited number of countries have institutions that offer studies in higher degrees, including the training of critically needed nurse tutors. More generally, secondary and tertiary health service–delivery capacities and thus opportunities to expand training capacities are concentrated in a few countries in

1. C. Kurowski, Global Responsibilities, in *Human Resources for Health: Overcoming the Crisis* (Boston: Joint Learning Initiative, 2004).

2. J. Buchan, “Global Nursing Shortages Are Often a Symptom of Wider Health System or Societal Ailments,” *BMJ* 324, no. 7340 (2002): 751.

the region. Within the increasingly deregulated labor market of the Caribbean Single Market Economy, managing migration requires a harmonized approach with the recruitment of nurses. Given the differences in the workforce size of the ES CARICOM countries relative to prime destination countries such as Canada, the United Kingdom and the United States, it also requires reaching out jointly to these countries to raise and sustain their interest in reaching mutually beneficial agreements.

13. **In a series of consultations and discussions, stakeholders endorsed the proposed priority areas and committed to regional action; moreover, ministers of health requested the Bank to assess relevant international obligations of ES CARICOM countries and the pros and cons of different instruments to govern a regional strategy to strengthen the region's nurse workforce.** This report summarizes the findings of this second phase of work. It is important to note that these findings are often not specific to nurses, as agreements tend to govern health professionals or workers on the whole. The report is structured as follows: after this introduction, section B provides a description of international legal instruments and assesses the advantages and disadvantages of legally binding versus non-legally binding mechanisms. Section C examines international legal agreements governing policies for health professionals in the ES CARICOM, including a review of international obligations. Section D suggests recommendations to guide the way forward.

PART II – INTERNATIONAL LEGAL INSTRUMENTS

14. **There are two types of international legal instruments: (1) legally binding instruments or treaties; and (2) non-legally binding instruments.** Legally binding instruments or treaties create obligations and corresponding duties of compliance between parties or the signatory states under international law. Non-legally binding instruments represent a political commitment or agreement between states that is not legally enforceable but may still create expectations of compliance (for a list of definitions, see annex 1).

Legally Binding International Instruments

15. **A legally binding international instrument or treaty creates legal obligations, under international law, between the state parties to the treaty, and establishes corresponding duties of compliance.**³ Legally binding instruments or treaties can be bilateral, multilateral, or a framework convention. The Vienna Convention on the Law of Treaties 1969 (VCLT) specifically defines a treaty as, “an international agreement concluded between states in written form and governed by international law, whether embodied by a single instrument or in two or more instruments and whatever its particular designation.”⁴ This characterization highlights that a treaty must be governed by international law. Scholars concur that an agreement may be deemed a treaty if its language demonstrates that the intent of the parties was to create a legally binding instrument, to be governed by international law, regardless of whether or not such intentions are expressly stated. For example, words such as “shall” and “enter into force” signal the parties’ intent to create a legally binding instrument.⁵ Moreover, this suggests that the exact label given to a treaty is irrelevant. Many treaties are referred to as conventions, agreements, or charters. However, these names do not indicate any difference in the substance of a treaty. As long as the document signals the intention of the parties to create a legally binding instrument governed by international law, it is considered a treaty regardless of its label.⁶

16. **The Vienna Convention on the Law of Treaties 1969 (VCLT) is an international agreement that outlines the particular rules that govern the formation, interpretation, and dissolution of treaties.** The VCLT defines an international treaty and specifies the steps involved in creating and dissolving a treaty. Part II of the VCLT outlines the crucial steps in developing and concluding a treaty. Sean D. Murphy separates these components into the following eight steps:⁷

3. B. Carter, P. Trimble, and A. Weiner, *International Law*, 5th ed. (New York: Wolters Kluwer Law & Business, 2007).

4. See *The Vienna Convention on the Law of Treaties*, May 23 1969.

5. S. Murphy, *Principles of International Law* (St. Paul: Thomson West, 2006).

6. *Ibid.*

7. Murphy, *Principles*.

Step 1. Representation. A treaty may only be concluded by two (bilateral) or more (multilateral) state parties and international organizations that have treaty-making powers. In treaty negotiations, each of these entities must be represented by a person authorized to represent either the states' or the international organization's position. A head of government such as the minister of foreign affairs, the head of a diplomatic mission, or a state representative to an international organization are considered such "authorized persons" and enjoy by virtue of the offices they hold "full powers."⁸ Alternatively, states can provide designated individuals with documentation referred to as "full powers," which allows them to act on behalf of states during treaty negotiations.⁹

Step 2. Negotiations. In bilateral treaty negotiations, the two states' representatives will meet in several sessions to create the text of the treaty. Once the text is agreed upon by both parties, each representative will initial the document to indicate the conclusion of negotiations. Multilateral treaty negotiations are more complicated. The negotiations between multiple states and organizations often last much longer. Simply, creating a consensus on text of a treaty takes much longer when there are more than two parties to an agreement. However, once there is general agreement on the terms and text of the agreement, a vote is taken. A two-thirds majority is enough to consider the treaty "adopted."¹⁰

Step 3. Signature. Once a treaty has been adopted, the parties must indicate their consent to be bound by its terms. This is typically done by having the states' representative sign the agreement. However, occasionally states will perform a symbolic "exchange of documents" to signify their endorsement.¹¹ In a bilateral treaty this process is straightforward. The parties will simply sign the agreement at an agreed upon time after the text has been initialled. However, the procedure for a multilateral treaty is different. After adoption, the treaty will be opened for signature for a specified period of time. States may only sign the treaty during this period. However, many treaties provide terms that allow states to "accede" to the treaty after the signing period has ended.¹²

Step 4. Ratification. Most treaties require a second step after the signature to signal the states' intent to be bound by international law. Ratification is the phase in which states are meant to follow their national procedures to indicate domestic acceptance of the treaty.¹³ In a bilateral treaty, a copy of the instruments of ratification will be exchanged by the two parties. In multilateral treaties, states will submit the signed treaty into a chosen depository or location.

8. See *The Vienna Convention*, art. 7, May 23 1969.

9. See *The Vienna Convention*, art. 6, May 23 1969.

10. Murphy, *Principles*.

11. See *The Vienna Convention*, art. 12 and 13, May 23 1969.

12. Murphy, *Principles*.

13. See *The Vienna Convention*, art. 15, May 23 1969.

Step 5. Entry into force. A treaty enters into force on a date stipulated within the text of the treaty. In bilateral treaties this is usually after both parties ratify the treaty. However, in multilateral treaties, a date is typically set for a time after a specified number of states have ratified the treaty.

Step 6. Reservations. In multilateral treaties it is possible for states to file a reservation or indicate they do not wish to be bound by one or more of the treaty's terms. The VCLT allows for this unless the treaty prohibits or limits the type of reservations or the reservation is fundamentally incompatible with the purpose of the treaty.¹⁴

Step 7. Ratification, termination, and withdrawal. Each treaty usually provides specific terms that allow for the automatic dissolution and/or automatic renewal of the treaty after a specified period of time. If such terms are not included in the text of the treaty, the treaty will remain in operation indefinitely unless a party to the treaty is legally able to provide a notice of termination.¹⁵ If states wish to end their involvement in a treaty before the automatic termination period, they may withdraw, suspend, or terminate the treaty in specific instances. For example, if the treaty does not provide any rules for its own termination, then according to the VCLT, it is not possible to terminate it unless it is shown that the parties to the treaty never intended to prevent its termination. If the states are able to show this, they may then terminate the treaty after providing 12 months notice.¹⁶ As well, a treaty can be terminated or suspended if one of its parties has breached the terms of the treaty, there has been a fundamental change in circumstances, or performing the terms of the treaty has been rendered impossible. In the first situation, states may suspend a treaty only if they have been specifically affected by other states' breach of the treaty terms or if the breach affects all of the parties to a multilateral treaty. In the second circumstance, a state may suspend a treaty if new and unforeseen circumstances arise that change the conditions that were essential to states consenting to sign the treaty.¹⁷ Finally, a treaty may be terminated if an object crucial to the execution of the treaty is destroyed, preventing states from carrying out their obligations.¹⁸ For example, this would occur if the treaty imposed rights or responsibilities on states in regards to a landmark, which later was destroyed by a natural disaster.

Step 8. Dispute settlement and enforcement mechanisms. To assist states in interpreting treaties, many treaties include provisions for creating a judicial or arbitral institution that governs dispute resolution. Such an institution will assist in interpreting the treaty's provisions, resolve states' disputes regarding the

14. See *The Vienna Convention*, art. 19–23, May 23 1969.

15. Murphy, *Principles*.

16. *Ibid.*

17. *Ibid.*

18. *Ibid.*

treaty's terms, and provide remedies for breaching the treaty.¹⁹ For example, the treaty that created the European Union provided that a new institution, the European Court of Justice (ECJ), would preside over all disputes related to the EU.²⁰ To date, the ECJ has clarified many of the treaty's terms and punished many EU countries that have been in breach of EU rules. These countries have either been fined or ordered to carry out the activity that caused them to breach their obligations in the first place. Notably, very few treaties actually set up judicial or arbitral tribunals. The lack of such a body is hypothesized to weaken the effect of a treaty significantly.²¹

17. **There are three types of legally binding international instruments: bilateral treaties, multilateral treaties, and framework conventions** (table 1). Each instrument is described below in greater detail.

Table 1. Types of Legally Binding International Agreements

Type of arrangement	Purpose	How they are created	Are they legally binding?
Bilateral treaties	To create legally binding obligations between the two parties	Through bilateral negotiations. After signature, most treaties require that the treaty be ratified to signal the states' intent to be bound by international law. Treaties can only be agreed to by states.	Yes, a breach of the treaty is a violation of international law.
Multilateral treaties	To create legally binding obligations between more than two parties	Through multilateral negotiations. After signature, most treaties require that the treaty be ratified to signal the states' intent to be bound by international law. Treaties can only be agreed to by states.	Yes, a breach of the treaty is a violation of international law.

Source: Summary of Legally Binding International Instruments section of this study

Bilateral Treaties

18. **Bilateral treaties are legally binding agreements concluded between two states or one state and an international organization that govern a wide range of substantive issues.** These treaties may be short or lengthy. They may be of limited or unlimited duration, and often, though not always, carry important provisions regarding dispute settlement and suspension or termination of the treaty.²² The two parties negotiating the treaty will ultimately determine such specifications, and it will be

19. K. W. Abbott and D. Snidal, "Hard and Soft Law in International Governance," *International Organization* 54 (2000): 421–53.

20. Ibid.

21. K. Raustiala, "Form and Substance in International Agreements," *The American Journal of International Law* 99, no. 3 (2005): 581–614.

22. Murphy, *Principles*.

considered legally binding under international law as long as the procedures outlined in the VCLT and described above are followed.

19. **The two principal drawbacks to a bilateral treaty are that its terms can become watered down if parties differ on the extent to which they wish to be bound by international law, and its complex dissolution terms could cause parties to seek a more flexible instrument.** Even if two states agree on the subject and purpose of the treaty, if one wishes to be bound under international law to a lesser or greater degree than the other, the obligations or terms of the treaty may be watered down.²³ Secondly, the rules on treaty dissolution as outlined in the VCLT are fairly complex. As a result, if there is a degree of uncertainty surrounding the subject of an agreement, states are much more likely to agree to a memorandum of understanding (discussed in more detail in the non-legally binding instrument section) instead of a bilateral treaty. Memorandums of understanding offer states greater flexibility in changing the terms of the agreement or dissolving it altogether as they do not have to follow the specific VCLT procedures and its requisite timeline.²⁴

Multilateral Treaties

20. **A multilateral treaty differs from a bilateral treaty in that there are more than two parties to the agreement, a characteristic that also leads to its unique disadvantages.** A multilateral treaty is not substantively different from a bilateral treaty except there is more than one state or international organization party to the agreement. Thus, the advantages of a multilateral treaty are identical to bilateral ones. However, the greater number of states involved in multilateral treaties can lead to certain disadvantages that are unique to this type of agreement. In particular, it is difficult to convince more than two states to agree on meaningful substantive treaty terms and detailed text and wording. This can result in three problems: (i) If the states cannot come to a consensus, the text may be so watered down that the states' obligations to each other do not change the status quo significantly;(ii) If states do not agree to the final text of the treaty, there may not be enough countries to ratify the agreement, and it may never come into effect. (iii) Alternatively, there may be so many reservations by different countries to the terms of the treaty that international law will govern only very few countries in a small number of provisions. This may deprive the treaty of meaningful international effect.

Framework Convention Protocol Approach

21. **An option to bypass resistance to a traditional treaty approach is to utilize a framework convention-protocol approach.** “A convention-protocol approach does not try to address all substantive issues in a single document; rather, it divides the negotiation of specific issues under separate agreements.”²⁵ In particular, it calls for international

23. A. Taylor and R. Roemer, *International Strategy for Tobacco Control*, WHO Programme on Substance Abuse (Geneva: WHO, 1996), WHO/PSA96.6.

24. Abbott and Snidal, “Hard and Soft Law,” 421–53.

25. Taylor and Roemer, *International Strategy*.

cooperation in achieving broad goals in a particular area, with an eye to establishing more detailed and legally binding protocols in the future. For example, in the Vienna Convention on the Ozone Layer (1985), states agreed on general principles for protecting the ozone layer. However, specific legally binding policies for reducing the chlorofluorocarbons were not agreed upon until the Montreal Protocol on Substances that Deplete the Ozone Layer (1989).²⁶

22. **Framework conventions are very effective when a subject is controversial; however, they do require constant lobbying and consensus building.** While the original document may not have strong substance or structure, over time, when greater political consensus is reached or more evidence for a particular position comes to light, stronger legally binding protocols or amendments can be added.²⁷ This usually makes it a more politically acceptable option than a treaty. Moreover, the “framework” or the broad goals can provide a forum for continuing cooperation and negotiation of goals.²⁸ However, if state consensus is never built, a weak framework will never be strengthened by protocols or amendments. The framework-protocol approach requires constant lobbying and consensus building in pursuit of its goals. Conventions can be even more time consuming to implement than regular treaties; on average, full negotiation and implementation is six to ten years.

Non–Legally Binding International Instruments

23. **Non–legally binding instruments represent political commitments among states that are not subject to international law, and their exact form is often determined by the needs of the parties to the agreement.** These instruments are more difficult to characterize than legally binding ones since there is no equivalent VCLT that governs the formation of non–binding legal instruments. Consequently, while different categories of non–legally binding instruments have developed over time, each is subject to its own permutations and combinations depending on the goals of the parties that negotiated the agreement.²⁹ These instruments include resolutions by international organizations, pacts between states, codes of practice, and memorandums of understanding (MoUs).

24. **Even though non–legally binding instruments are not legally enforceable, they can play an important role leading to international law.** Often the terms of non–legally binding agreements are developed as precursors or prototypes for treaties that are concluded later in time.³⁰ If the principles contained in a non–legally binding agreement

26. Raustiala, “Form and Substance,” 581–614.

27. L. O. Gostin, “Meeting the Basic Survival Needs of the World’s Least Health People: A Scholarly Examination of the Most Pressing Health Hazards,” *The Georgetown Law Journal* 96, no. 2 (2008): 331–93.

28. L. O. Gostin, “A Proposal for a Framework Convention on Global Health,” *Journal of International Economic Law* 10, no. 4 (2007): 989–1008.

29. Carter, Trimble, and Weiner, *International Law*.

30. C. M. Chinkin, “The Challenge of Soft Law: Development and International Change,” *International Law Quarterly* 38 (1989).

have been uniformly and consistently followed by states over time, the agreement may become a source of unwritten law called customary international law. This is what is meant when non-legally binding agreements are referred to as having become “legal norms.”

25. **There are three types of non-legally binding international instruments: resolutions of international organizations and declarations and pacts by states, codes of practice, and MoUs** (table 2). Each instrument is described below in greater detail.

Table 2. Types of Non-legally Binding International Agreements

Type of arrangement	Purpose	How they are created	Are they legally binding?
Resolution, declaration, pact	Non-legally binding statements of policy produced by specialized UN agencies that express the viewpoint of member states on a particular issue. Outlines broad policy statements or detailed rules and procedures to achieve a policy goal.	A resolution is either the product of an international organization or a pact by individual states. Often presented as a list of recommendations to member states.	No. (However, this ultimately depends on the intent of the parties.)
Code of practice	Sets forth general rules and practices to be followed in achieving a policy goal. Developed to guide the behavior of governments, organizations, and public and private entities.	Through bilateral or multilateral negotiations, but can be a unilateral national policy decision. There is no standard format: a code can be broad and aspirational or more detailed.	No.
Memorandum of understanding	To establish agreement on terms or issues between two or more states. The content can vary from general statements of support to specific commitments to be fulfilled by all parties.	Through bilateral or multilateral negotiations. Unlike treaties, MoUs may be negotiated on behalf of a nonstate entity such as a government body (e.g., the ministry of health).	No. (However, this ultimately depends on the intent of the parties.)

Source: Summary of Non-Legally Binding International Instruments section of this study

Resolutions of International Organizations and Declarations and Pacts by States

26. **Intergovernmental resolutions and pacts by states are identical as both offer agreed upon policy statements and differ only in the former being brokered by a UN agency.** Intergovernmental resolutions also referred to as declarations, principles, and guidelines are non-legally binding statements of policy produced by specialized UN agencies that express the viewpoint of member states on a particular issue.³¹ Most often, resolutions are presented as a list of recommendations to member states; however, they may also be presented as general policy statements or a set of principles. Notably, the content of a resolution can range from precise, restrictive commitments to broad policy statements.³² A pact between two or more states is almost identical to an

31. J. Klabbbers, *An Introduction to International Institutional Law* (Cambridge: Cambridge University Press, 2000).

32. K. M. Gorove, A. Taylor, and R. Roemer, "Feasibility of a Regional Convention on Tobacco" (Unpublished discussion paper for PAHO, May 1999).

intergovernmental resolution. The only difference between the two is that a pact is not brokered by a UN agency. Instead, it is a non-legally binding statement of policy agreed upon between two or more states.

27. **Even though resolutions are not legally binding, they can still have a significant impact on states' behavior.** If the UN agency sponsoring the resolution has a recognized competence in a particular field and all of the member states actively participate in the work of the organization, they can have a powerful impact upon international law.³³ The unanimously adopted resolutions of the UN Security Council provide such an example.³⁴ Most member states have unanimously agreed to and followed (qualifying the behavior as states' practice) the nonbinding provisions in UN resolutions on the use of force. This has allowed the International Criminal Court to determine that there is in fact a legal norm creating an international prohibition against the use of force under customary international law.³⁵ Moreover, many environmental treaties have been preceded by nonbinding resolutions by international organizations.³⁶ For example, the United Nations Environmental Protection Agency (UNEP) developed a resolution called the Cairo Guidelines for Principles of the Environmentally Sound Management of Hazardous Wastes (1987), which two years later was formalized into the Basel Convention on the Control of Trans-boundary Movements of Hazardous Wastes and their Disposal Treaty (1989).³⁷

28. **Pacts by states can also significantly influence states' behavior.** For example, the Helsinki Final Act (1975) shaped the development of human rights standards at both national and international levels.³⁸ This particular pact was agreed upon between 33 "eastern" and "western" European States during the Cold War. It involved detailed provisions on economics, security, and human rights. Essentially, the western states agreed to recognize the Communist regimes of Eastern Europe in exchange for the eastern states' political commitments toward supporting human rights.³⁹ While the Helsinki Final Act was not universally followed, most states did pursue its extensive provisions. Moreover, for those states that did not comply with the terms of the resolution, it provided a point of public criticism and provoked charges of wrongdoing.⁴⁰ It became very difficult for eastern states to claim that human rights were matters of domestic jurisdictions.

29. **Although intergovernmental resolutions and political pacts by states have the same two functions, they may be more likely to create an influential resolution than**

33. Murphy, *Principles*.

34. *Ibid.*

35. C. M. Chinkin, "The Challenge of Soft Law."

36. Taylor and Roemer, *International Strategy*.

37. *Ibid.*

38. *Ibid.*

39. *Ibid.*

40. Abbott and Snidal, "Hard and Soft Law," 421–56.

a pact. The two functions shared by both intergovernmental resolutions and pacts by states are the following: (a) they may focus on setting multilateral goals for national conduct that, although informal, are intended to have authoritative status; or (b) they may reflect a dynamic methodology of moving slowly toward the formalization of obligations under customary international law or as a precursor to a treaty.⁴¹ The advantage of a resolution is that an international organization provides both the leadership and technical expertise on a particular topic, as well as a neutral platform for consensus building. In contrast, pacts are more likely to be beleaguered by past disagreements between states, differences over leadership, and sometimes even the purpose of the process.⁴² Though, as seen in the Helsinki agreement, this can be overcome if there is enough political impetus to reach an agreement.

Codes of Practice

30. **Codes of practice (“codes”) are nonbinding instruments developed to guide the behavior of organizations, public and private entities, and governments.**⁴³ Codes typically comprise a set of voluntary principles, standards, or guidelines. Importantly, there is no standard format: they can be broad and aspirational or more detailed and operational depending on the context and objectives they are intended to meet.⁴⁴ Codes negotiated between states (“intergovernmental codes”) may request that governments implement their terms through either general state practice or adopt them into national legislation. Similarly, codes agreed upon by organizations and public and private entities may be espoused as part of their internal governance or regulatory procedures.⁴⁵ Though, as a non-legally binding instrument, states, organizations, and public and private entities are under no legal obligation to follow the agreed terms of a code, and they will suffer no legal consequences for failing to do so.

31. **There are numerous examples of codes that have successfully regulated the behavior of organizations, public and private entities, and governments.** The voluntary nature of codes should not automatically discount their effectiveness in shaping behavior.⁴⁶ Many influential intergovernmental codes negotiated through international organizations have significantly influenced states’ behavior. The Codex Alimentarius, a set of harmonized food and safety standards, administered by the World Health Organization (WHO) and the Food and Agriculture Organization of the United Nations (FAO), is one example. Many states choose to adopt the Codex standards, not because they are legally bound to, but because it is in their best interest. If they refuse to implement the standards, their food exports will likely suffer as other states may require

41. Ibid.

42. Ibid.

43. W. Cragg, “Multinational Corporations, Globalization, and the Challenge of Self-Regulation,” in *Hard Choices, Soft Law*, ed. J. Kirton and M. Trebilock (Aldershot, U.K.: Ashgate, 2004).

44. Murphy, *Principles*.

45. Ibid.

46. Abbott and Snidal, “Hard and Soft Law,” 421–56.

compliance with the standard.⁴⁷ Another illustration is provided by the Organisation for Economic Co-operation and Development's (OECD's) Guidelines for Multinational Enterprises.⁴⁸ While the guidelines do not represent a mandatory legal commitment, many OECD members have gone as far as to give them domestic legal effect. They are represented in some OECD members' national legislation and referred to by their judiciaries.⁴⁹ Finally, the FAO and UNEP regime, which requires prior informed consent on the international transfer of hazardous chemicals and pesticides, provides a particularly salient example. Several years after its implementation, member states agreed to ratify its terms into a legally binding treaty.⁵⁰

32. Codes have also been effective in improving working conditions in corporate settings and in having corporations take responsibility for their actions. A plethora of corporate codes have been developed to influence the behavior of international corporations, predominately in the areas of social conditions and the environment. These codes range from unilateral codes adopted by private entities or transnational companies and trade associations to multiple stakeholder codes that are the result of negotiations between several groups including industry representatives, organized labor, civil society, and even governments.⁵¹ To date, there is evidence that many corporate codes have been effective in improving working conditions in developed countries as well as having corporations take responsibility for the actions of their suppliers and subsidiaries. For example, the International Code of Ethics for Canadian Businesses, which all Canadian businesses can join on a voluntary basis, has significantly improved the labor standards for employees of Canadian businesses in developing countries. In particular, the code has improved the record of Canadian companies engaging in child labor exploitation, improved health and safety standards, allowed for freedom of association, and encouraged nondiscrimination with respect to gender, race, and religion.⁵² It is hypothesized that corporate codes derive their effect by subjecting corporations to government and public criticism for failure to implement the terms of their code. Ultimately, the code can provide a point of leverage on corporate behavior.⁵³

33. Codes can have significant influence over the various actors that utilize them; however, they should not be allowed to become symbolic policy statements. At their most effective, they can be implemented into national law, act as precursors to a legally binding instrument (similar to resolutions and pacts described above), and even

47. Murphy, *Principles*.

48. Cragg, "Multinational Corporations."

49. Abbott and Snidal, "Hard and Soft Law," 421–56.

50. *Ibid.*

51. R. Jenkins, "Corporate Codes of Conduct: Self-regulation in the Global Economy," *Technology, Business and Society* programme paper no. 2 (Geneva: United National Research Institute for Social Development, 2002).

52. Cragg, "Multinational Corporations."

53. Jenkins, "Corporate Codes."

become customary international law.⁵⁴ Alternatively, governments and civil society can develop public expectations that a code will be complied with by all of its parties. Consequently, if the terms of a code are violated, they can invoke the code's provisions in public debate to marshal both public and political support against the contravening party.⁵⁵ However, as will be illustrated below, if codes are not developed through a consensus-building process, the terms are too narrow, or they contain no monitoring mechanisms, they will often be no more than symbolic statements of policy.

Memorandums of Understanding (MoUs)

34. **MoUs are nonbinding agreements negotiated between states or between nonstate entities that are attractive for their flexibility in adjusting to changing contexts and in who can negotiate them.** The content of MoUs can vary from general statements of support to specific commitments intended to be fulfilled by both parties. However, unlike a treaty, MoUs may be negotiated on behalf of a nonstate entity such as a government body (for example, the ministry of health or the ministry of the environment). Consequently, MoUs are seen as more flexible than treaties as they allow government actors (treaties can only be agreed to by states) with specialized knowledge of the field to define the terms of the agreement according to the specific needs of each country. Furthermore, given the difficulty in dissolving treaties described above, MoUs are the preferred international instrument in uncertain or volatile situations. If a situation changes dramatically, the terms can be easily altered or dissolved. That said, since establishing the guiding principles, procedures, and practices of MoUs are typically the result of protracted negotiations, the terms and conditions of the agreement are usually taken seriously by the signing parties, and their dissolution usually only takes place under very serious circumstances.⁵⁶

35. **When MoUs govern labor markets, compliance of their terms is often monitored by the International Labour Organization (ILO).** Based on its experience in monitoring MoUs governing the foreign recruitment of migrants, the ILO has identified 24 best practice elements (table 3). While this does not guarantee that best practices are followed, it does provide for some accountability.⁵⁷

54. C. Chinkin, "Normative Development in the International Legal System," in *Commitment and Compliance: The Role of Non-Binding Norms in the International Legal System*, ed. D. Shelton (Oxford University Press, 2004).

55. Carter, Trimble, and Weiner, *International Law*.

56. Abbott and Snidal, "Hard and Soft Law," 421–56.

57. Khalid Koser, "Study of Employment and Residence Permits for Migrant Workers in Major Countries of Destination" (Geneva: International Labour Office, 2009).

Table 3. ILO Best Practice Elements of Prototypical Bilateral Labor Agreements for the Recruitment of Migrants

1. Identifies the competent government authority	14. Stipulates employment conditions
2. Provides appropriate exchange of information	15. Provides a conflict resolution mechanism
3. Addresses the needs of migrants in an irregular situation	16. Allows for the role of trade unions and collective bargaining rights
4. Provides notification of job opportunities	17. Provides social security
5. Draws a list of potential candidates in home country	18. Provides information on remittances
6. Preselects candidates in home country	19. Provides housing
7. Allows final selection of candidates in home country	20. Assists and encourages family reunification
8. Allows nomination of candidates by employer in home country	21. Provides appropriate social and religious organizations
9. Provides for medical examination	22. Establishes a joint commitment between two states or government bodies
10. Provides for entry documents	23. Provides for validity and renewal of agreement
11. Provides for residence and work permits	24. Defines the applicable jurisdiction
12. Provides for transportation	
13. Provides for employment contract	

*Source: ILO*⁵⁸

Pros and Cons and Implementation Challenges of Binding versus Nonbinding International Legal Instruments

36. **The major advantage to a legally binding instrument or treaty is that it is governed by international law; accordingly, parties to the treaty are under an obligation not to breach the terms they have agreed to.** Typically, a treaty will outline specific provisions to be followed if the terms are breached. For example, it may provide a remedy such as financial compensation for the injured party or for retaliatory measures such as sanctions.⁵⁹ Alternatively, an independent arbitral or judicial institution may be given the power to make judgments against the party in breach of the treaty's terms. Regardless of whether or not the treaty itself stipulates provisions for its breach, the VCLT does provide that, in the event of breach, the affected party may unilaterally terminate the treaty or suspend the performance of its own obligations under the treaty.⁶⁰

37. **Because treaties create legally binding obligations, developing the terms and obligations can be a slow and arduous process resulting in watered down substance with meaningless international effect.** Treaties are most difficult to negotiate when the topic they are meant to govern is controversial. Furthermore, states are in general reluctant to enter into agreements that place nondomestic actors in charge of formerly national decisions. They are reluctant to agree to terms and obligations that may

58. Ibid.

59. Carter, Trimble, and Weiner, *International Law*.

60. Ibid.

disadvantage them in the future; therefore, they tend to dodge obligations with outcomes that are difficult to anticipate because the issues are new, complex, and not fully understood. Therefore, the substance of treaties is often narrow and watered down.⁶¹ If states cannot agree on the text, even in a watered-down form, in the case of multilateral treaties, the treaty may be signed by only a few states and therefore not have a meaningful international effect.⁶² Furthermore, in the case of multilateral treaties, once a treaty is signed, the ratification process, which requires a minimum number of parties to ratify the treaty before it enters force, can take years.⁶³ For example, it took eleven years (1969 to 1980) for the VCLT to take force. Consequently, treaties are typically only negotiated for controversial topics when there is an overwhelming political will or pressure to act in a comprehensive and meaningful way.⁶⁴

38. Non-legally binding instruments can become a source of unwritten law, offer flexibility in who can define the terms of the agreement, and be easily altered in response to the needs of a changing environment. Non-legally binding agreements can lay the foundation for future treaties and may become a source of unwritten law if the principles of those agreements are followed uniformly and consistently by states over time. These instruments also offer flexibility in that they allow government actors (treaties can only be agreed to by the states) with specialized knowledge of the field to define the terms of the agreement according to the specific needs of each country. They are also preferred in uncertain or volatile situations because the terms of non-legally binding instruments can be easily altered or dissolved.

39. The challenge with non-legally binding instruments lies in their enforceability and in the risk of becoming symbolic statements of policy. Even though non-legally binding agreements create expectations of compliance among the various members to the agreement, they are not actually enforceable under international law. These types of agreements also need to ensure they are developed through a consensus-building process and contain monitoring mechanisms, and that their terms are technically appropriate and not too narrow, otherwise they risk becoming symbolic statements of policy.

International Legal Agreements and Obligations Governing Policies for Health Professionals in the ES CARICOM

40. This section reviews current international legal agreements and their obligations governing policies for health professionals in the ES CARICOM.

61. W. Reinicke and J. Witte, "Interdependence, Globalization, and Sovereignty: The Role of Non-Binding International Accords," in *Commitment and Compliance: The Role of Non-Binding Norms in the International Legal System*, ed. D. Shelton (Oxford University Press, 2000).

62. Taylor and Roemer, *International Strategy*.

63. Ibid.

64. Ibid.

Legally Binding Instruments Governing Policies for Health Personnel

41. **Although there are no treaties with specific provisions for health personnel concluded to date, three multilateral treaties governing policies of health personnel have been concluded among a significant number of nations.** These three multilateral treaties, discussed below, are the General Agreement on Trade in Services (GATS), the ILO Migration Conventions, and the CARICOM Single Market and Economy (CSME).

The General Agreement on Trade in Services (GATS)

42. **The GATS is a multilateral treaty, governing all World Trade Organization (WTO) members in the cross-border trade of services, including health personnel, which balances trade expansion with national policy.** The preamble of the GATS treaty states that the cross-border trade in services (including health personnel) is intended to “contribute to trade expansion under conditions of transparency and progressive liberalization and as a means of promoting economic growth of all trading partners and the development of developing countries.”⁶⁵ To achieve this goal, the GATS treaty operates with two main principles, referred to as the “main pillars.” The pillars are: (1) GATS ensures increasing transparency and predictability of rules and regulations; and (2) GATS promotes the progressive liberalization of trade through successive negotiations.⁶⁶ These pillars are significant as they indicate that GATS is not simply meant to serve the purpose of trade expansion in and of itself. Additionally, the second pillar specifically acknowledges the right of governments to regulate trade to meet their national policy objectives.

43. **The GATS definitions for trade in services and service provision identify areas of service that are applicable to health personnel in WTO member countries.** There are twelve ES CARICOM member states: Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, and Trinidad and Tobago. Ten of these are members of the WTO; Bahamas became an observer in 2010—meaning that it must start accession negotiations within five years of becoming an observer—and Dominica is not a member. This underlines the influential role of GATS in the region; all countries, with the exception of one, are members of the GATS. The GATS specifically identifies twelve areas of service, which apply to WTO members, (see table 4). Within these twelve areas, business, educational, financial, and hospital services encompass most of the trade-related services relevant to health personnel. In particular, these areas include services provided by medical and dental personnel, midwives, nurses, physiotherapists, and paramedics and educators.

65. The World Trade Organization, *The General Agreement on Trade in Services: Preamble* (Washington: WTO, 2006).

66. WTO, *The General Agreement on Trade in Services: An Introduction*.

Table 4. GATS – Definition of Services

1. Business services	7. Financial services
2. Communication services	8. Health-related and social services
3. Construction and related engineering services	9. Tourism and travel-related services
4. Distribution services	10. Recreational, cultural, and sporting services
5. Educational services	11. Transport services
6. Environmental services	12. Others
Source: GATS website, 2011	

44. **Under the GATS’ four modes of service supply, mode 4 defines the supply of a health service by health personnel from one WTO member in the country of another.** According to GATS, service provision refers to four modes of service supply. These are mode 1: cross-border trade; mode 2: consumption abroad; mode 3: commercial presence; and mode 4: the movement of natural persons, (see table 5). For the purpose of this discussion, mode 4: the movement of natural persons via temporary migration is the relevant area of service provision. Simply put, health personnel providing medical, dental, midwifery, nursing, physiotherapy, paramedic and educational services involves “the supply of a health service by one WTO member, through presence of natural persons of another WTO member.”⁶⁷

Table 5. GATS – Definition of Service Provision through the Four Modes of Supply

<p>Mode 1. Cross-border trade: Trade that moves from the territory of one member into the territory of another. <i>For example, telemedicine, e-learning initiatives</i></p> <p>Mode 2. Consumption abroad: Trade in the territory of one member to a service consumer of any other member. <i>For example, health care tourism</i></p> <p>Mode 3. Commercial presence: Trade by a service supplier of one member, through commercial presence, in the territory of another. <i>For example, foreign direct investment</i></p> <p>Mode 4. Movement of natural persons via temporary migration: Trade by a service supplier of one member, through presence of natural persons of any other member. <i>For example, foreign nurses providing services in a country</i></p> <p>Source: GATS website, 2011</p>

45. **WTO members have unconditional and conditional obligations under GATS mode 4, most importantly, in the context of health personnel, those members may not apply most favored nation (MFN) status to discriminate in the hiring of health workers on the basis of nationality.** Unconditional obligations must be undertaken by

67. Ibid.

all WTO members, although member states can vary the degree of the conditional obligations they undertake. The unconditional obligations require that WTO members not apply MFN status or that a state may not discriminate between WTO member services or service providers. In the context of health personnel shortage, this has significant implications. It means that WTO members may not discriminate in the hiring of health workers on the basis of nationality if the future employee is from a country with WTO membership. For example, since both Canada and Jamaica are WTO members, Canada may not favor Canadian over Jamaican health workers in their hiring processes.⁶⁸

46. **GATS only allows for two exceptions to the MFN treatment, a pre-existing regional trade agreement and a reservation made to MFN treatment when acceding to the WTO.** If there is a pre-existing regional trade agreement, a WTO member can show preference for hiring a health worker from a country with which it has a regional trade agreement over a WTO member with whom it does not have an agreement. The second exception to this unconditional obligation occurs if a reservation was made to MFN treatment at the time a country acceded to the WTO. To date, very few countries have made such reservations.⁶⁹

47. **For conditional obligations such as market access and national treatment, WTO members can choose the level of service liberalization they wish to engage in with other WTO members.** These obligations only apply if a state has agreed to liberalize individual sectors and modes via a bilateral negotiation. The first conditional obligation is market access (MA). Under MA a state may not restrict access to its services market by limiting (i) the number of service suppliers; (ii) the value of transaction or assets; (iii) the number of operations or quantity or output; (iv) the number of natural persons supplying the service; (v) the type of legal entity or joint venture; and (vi) the participation of foreign capital. The second is national treatment (NT), which means that WTO members cannot engage in any discriminatory measures detrimental to other WTO foreign services or suppliers.

48. **The level to which a WTO member has agreed to the unconditional obligations will be denoted in the GATS trade liberalization schedule as either none, unbound, or partial commitment.** None means that a WTO member has fully liberalized trade in a particular service sector and mode and that it may not restrict the conditional obligations. Unbound means that a member has not agreed to liberalize any sector or mode, while partial commitment indicates that a state has made only some restrictions to MA and NT. Significantly, all partial commitments are subject to an obligation to increase service liberalization incrementally over time.⁷⁰

49. **Regardless of the level of commitment a WTO member has made under the unconditional obligations, two further exceptions to the conditional obligations**

68. P. Van den Bossche, *The Law and Policy of the World Trade Organization: Text Cases and Materials*, 2nd ed. (Cambridge: Cambridge University Press, 2008).

69. Ibid.

70. WTO, *The General Agreement on Trade in Services: An Introduction*.

relate to service supplied under government authority and public policy decisions. Any service supplied in the exercise of governmental authority, neither on a commercial basis nor in competition with one or more service suppliers, is exempted from GATS obligations. For example, this excludes nursing services provided under a national health care system. The second exemption refers to certain public policy decisions. The GATS will allow violation of the conditional obligations MA and NT for the purposes of national policies such as (i) job creation in disadvantaged regions; (ii) equitable access to services; and (iii) consumer protection.⁷¹ That said, it is important to note that this second exemption has not been tested in the dispute resolution system of the WTO. Consequently, it is not known exactly which policies would qualify for the exemption in a satisfactory manner. Thus, any country considering agreeing to MA or NT should not assume that public programs created to meet the above aims will not fall under WTO scrutiny. It would therefore be wise to wait for further clarification.⁷²

50. **While GATS ensures needed experts can enter developing countries without restriction, it also means developing country experts can leave for developed countries much more easily, and their return is not guaranteed.** Even though mode 4 uses language of temporary migration, this is somewhat misleading. Nothing prevents a destination country from offering full citizenship to health personnel hired under the auspices of GATS. Moreover, under a full MA and NT schedule, GATS could preclude a developing country from making a MoU or other agreement with a developed country, which limits the number of expert migrants entering the developed country.

51. **Jamaica is the only CARICOM nation that has committed to unconditional obligations that cover health personnel services under GATS. However, it has limited its conditional obligations and is exempt from GATS obligations since health care is mainly supplied through the public sector on a noncommercial basis.** Under the GATS unconditional obligations, Jamaica has committed to a policy of nondiscrimination in the hiring of health workers on the basis of nationality. On the other hand, it has limited its conditional obligations under MA and NT, meaning that it has not fully liberalized restrictions to its services market, nor fully applied nondiscriminatory measures for all WTO foreign service or suppliers. Furthermore, two additional exceptions to the conditional obligations, which relate to service supplied under governmental authority and public policy decisions, exempt Jamaica's nurse labor market from GATS. This is because Jamaica's nurse education and health care are supplied mainly through the exercise of governmental authority and not on a commercial basis. Under current GATS arrangements, Jamaicans may only hire foreign health personnel if the Work Permit Review Board is satisfied that the skills are unavailable locally. Also, work permits and visas are typically required for all health personnel, although managers or executives are exempted from 30-day permits, and experts from-14-day ones.⁷³

The CARICOM Single Market and Economy (CSME)

71. Ibid.

72. Van den Bossche, *The Law and Policy*.

73. General Agreement on Trade and Services: Schedule of Agreements.

52. **As a regional instrument that aims to remove all obstacles to the free movement of services and labor in the ES CARICOM, the CSME can influence health personnel policy.** The CSME is a multifaceted plan to integrate the economies of the ES CARICOM States, as set out in various provisions of the *Revised Treaty of Chaguaramas Establishing the Caribbean Community Including the CARICOM Single Market and Economy* (Revised Treaty or Treaty).⁷⁴ All twelve ES CARICOM states are members of the CSME. The CSME provides for a free trade area, a customs union with common external tariffs, and harmonization of laws and policy.⁷⁵ As necessary concomitants to the free movement of services, labor, and intercommunity travel, the Revised Treaty calls on member states to establish common standards for accreditation and equivalency of qualifications, and to harmonize social services such as education and health.⁷⁶ The goal of removing restrictions in the area of services is unequivocal. To facilitate the movement of skilled service sector workers, the treaty establishes common standards for mutual recognition of diplomas, certificates, and other evidence of qualifications.⁷⁷ Moreover, the treaty forbids member states from introducing any law that restricts the hiring of service providers from other member states and mandates the removal of laws preventing such hiring.⁷⁸

53. **The CSME uses the same requirements as other multilateral treaties; however, it provides for the trade in services to begin gradually.** CSME uses the same requirements as GATS, MFN, MA, and NT to determine if ES CARICOM members are complying with their obligation to liberalize trade in services. However, in the Revised Treaty, MFN, MA, and NT are unconditional. Understanding that this may initially provide a shock to the ES CARICOM economy, the treaty provides that the trade in services begins gradually. Initially, member states are only required to grant the following community nationals the right to seek employment in other countries: (i) university graduates (including nurses and health professionals); (ii) media; (iii) sports persons; (iv) artists; and (v) musicians. With respect to these groups, member states are obliged to implement this measure by establishing the necessary legislative, administrative, and procedural arrangements to (i) provide for movement of community nationals into and within their jurisdictions without harassment or the imposition of impediments, (ii) eliminate the requirement for passports for community nationals traveling to their jurisdictions, (iii) eliminate the requirement for work permits for community nationals seeking approved employment in their jurisdictions, and (iv) establish mechanisms for certifying and establishing equivalency of degrees and for

74. Revised Treaty of Chaguaramas Establishing the Caribbean Community, Including the CARICOM Single Market and Economy, 2001, http://www.caricom.org/jsp/secretariat/legal_instruments/revised_treaty.pdf.

75. The Revised Treaty provides that member states are to harmonize company and intellectual property laws among others. *The CARICOM Single Market and Economy*, 2009, http://www.caricom.org/jsp/single_market/single_market_index.jsp?menu=csme. The Revised Treaty also calls for harmonization of economic, monetary, and fiscal policy.

76. Ibid.

77. Ibid. art. 35, para. 1.

78. Ibid. art. 37, para. 1.

accrediting institutions; as well as for harmonization and transferability of social security benefits.

54. **The CSME includes provisions for less developed countries and for situations of economic hardship caused by its impact on health personnel movement in the region.** The assumption is that countries with lower paid health personnel will see their immediate move to higher paid positions since restrictions to movement are removed. However, the exceptions to the removal of restrictions are numerous and broad.⁷⁹ For example, services and activities involving the exercise of “government authority” are excluded. It is possible to interpret this as including health services provided by national health services or authorities. As well, special provisions may be provided for less developed countries not able to maintain their professional workforce in the new climate. Finally, if the new rights create serious difficulties in any sector of the economy or economic hardship in a particular community or region, some of the CSME rights may be restricted and a waiver of the obligation to grant rights may be given for a limited time period. However,, the treaty does demand a repeal of the waiver once the particular hardship has subsided.⁸⁰

55. **Until the CSME is in effect and rulings are made, it will be difficult to determine the exact effect it has on the health personnel climate in the ES CARICOM.** At first glance, it appears that there are enough exemptions in the CSME to prevent the free trade in services (allowing health personnel to move freely to seek positions in the more developed Caribbean nations) from causing further hardship to the least developed countries in the ES CARICOM. However, it must be cautioned that the scope of these exemptions has not yet been defined either broadly or narrowly.

The ILO Migration Conventions

56. **The ILO Migration for Employment Convention, which provides the means for protecting the ethical recruitment of health workers, has been ratified in several ES CARICOM countries.** There are two ILO conventions relating to professional or labor migration, one of which is Convention No. 97, “Convention Concerning Migration for Employment.” This Convention has been ratified by 49 countries including nine ES CARICOM members: Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Saint Lucia, and Trinidad and Tobago.⁸¹ Among the nonratifying CARICOM members are three ES CARICOM members: Antigua and Barbuda, St. Kitts and Nevis, and St. Vincent and the Grenadines.⁸² The convention requires that states accord migrants and nationals the same treatment, irrespective of race, religion, sex, or nationality.⁸³ This

79. Ibid.

80. Ibid. art. 47, para. 7.

81. ILO Convention 97, available at <http://www.ilo.org/ilolex/cgi-lex/convde.pl?C097>. For ratifications, see <http://www.ilo.org/ilolex/cgi-lex/ratifce.pl?C097>.

82. <http://www.ilo.org/ilolex/cgi-lex/ratifce.pl?C097>.

83. ILO Convention 97, art. 6.

nondiscrimination principle applies to both remuneration and collective bargaining.⁸⁴ The ratifying states also agree to ensure that migrants receive adequate medical attention “at the time of departure, during the journey, and on arrival in the territory of destination.”⁸⁵ Although this convention does provide protections for the “ethical recruitment” of health workers, whether these protections will apply to health worker migrants in recruiting countries depends on whether or not they have signed Convention No. 97.

57. The ILO convention for ensuring equality between migrant and health workers has not been ratified by any ES CARICOM country, and therefore cannot be extended to health workers in the region or in destination countries (the United States, the United Kingdom, Australia, and Canada). The second ILO convention relating to professional or labor migration is Convention No. 143, entitled, “Convention Concerning Migrations in Abusive Conditions and the Promotion of Equality of Opportunity and Treatment of Migrant Workers.”⁸⁶ This convention focuses on equality between migrants and nationals in security of employment, work relief, and retraining.⁸⁷ Part 1 of the convention also includes a clause that explicitly extends remunerative rights to undocumented or illegal migrants, though this is qualified.⁸⁸ Not only have ES CARICOM countries not ratified Convention No. 143, in general it is very poorly subscribed to.⁸⁹

Non-Legally Binding Instruments Governing Policies for Health Personnel

58. The flexibility of non-legally binding instruments has made it an attractive option for addressing health personnel issues bilaterally and multilaterally. The non-legally binding instruments discussed below are the Regional Plan for Action for Human Resources for Health (2007–15), the Commonwealth Code for the International Recruitment of Health Workers (2003), and the Global Code of Practice (2010).

The Regional Plan for Action for Human Resources for Health (2007–15)

59. Several international organizations have attempted to address the urgent and pressing international health personnel challenges through intergovernmental resolutions. Most relevant to the ES CARICOM nations is the resolution developed under the auspices of the Pan American Health Organization (PAHO), outlining a

84. Ibid.

85. ILO Convention 97, art. 5.

86. ILO Convention 143, available at <http://www.ilo.org/ilolex/cgi-lex/convde.pl?C143>. For ratifications, see <http://www.ilo.org/ilolex/cgi-lex/ratifce.pl?C143>.

87. ILO Convention 143, part 1, art. 8.

88. See ILO Convention 143, part 1, art. 9 (“Without prejudice to measures designed to control movements of migrants for employment by ensuring that migrant workers enter national territory and are admitted to employment in conformity with the relevant laws and regulations, the migrant worker shall, in cases in which these laws and regulations have not been respected and in which his position cannot be regularized, enjoy equality of treatment for himself and his family in respect of rights arising out of past employment as regards remuneration, social security and other benefits.”).

89. <http://www.ilo.org/ilolex/cgi-lex/ratifce.pl?C143>.

Regional Plan for Action for Human Resources for Health (2007–15).⁹⁰ Presently, all twelve members of the ES CARICOM are members of PAHO. The declaration is comprehensive and broad in scope. It requests that member states develop a sophisticated national plan, with specialized competencies within the ministry of health to deal with health personnel policies at the national and local levels. In particular, it focuses on meeting specific strategic goals as part of a ten-year human resources plan adapted to each country's specific situation (see table 6). It also requests that the director of PAHO promote and facilitate the technical and financial cooperation between the countries and support the plans of action.⁹¹ To date, this resolution has not had much visible impact in the ES CARICOM. It is likely that the majority of the intended effects have not yet been seen because the plan is meant to be implemented over a ten-year period, and it is currently only in its third year of operation. Moreover, there is little available literature evaluating the early influence of the resolution. It appears that more time will be needed to determine the success of this initiative.

90. Pan American Health Organization, "Regional Plan of Action for Human Resources for Health," Resolution CE140. R13, 140th Session of the Executive Committee, June 25–29, 2007, CSP27/10.

91. *Ibid.*

Table 6. PAHO Resolution on Regional Goals for Human Resources for Health – Objectives

- Make long-range plans and policies so the workforce can adapt to changes in the health systems, and to better develop institutional capacities to define these policies.
- Deploy appropriate personnel in the right positions and to the most suitable areas of countries to achieve an equitable distribution of quantity and skill set of workers.
- Promote national and international initiatives for developing countries to retain their health workers and avoid personnel deficits.
- Implement general labor initiatives between the workers and health organizations that promote healthy work environments and foster commitment to guaranteeing health services for all the population.
- Develop mechanisms of cooperation between training institutions and health services institutions to adapt the education of health workers to a universal and equitable model of providing quality care and meeting the health needs of the entire population.
- Develop a national plan of action for human resources for health intended to strengthen integrated primary health care and public health capacities and ensure access to underserved areas.

Source: Regional Goals for Human Resources for Health, PAHO 2007.⁹²

The Commonwealth Code of Practice for the International Recruitment of Health Workers (2003)

60. **Many regional codes of practice have been implemented to manage health worker migration by regulating their recruitment in developing countries.** The most prominent of these are the *Commonwealth Code of Practice for the International Recruitment of Health Workers* (2003) (Commonwealth Code) and the *Pacific Code of Practice for the Recruitment of Health Workers in the Pacific Region and Regional Strategy on Human Resources for Health* (2006) (Pacific Code). This section will focus solely on the Commonwealth Code because it has jurisdiction and applies to many of the ES CARICOM members. Further, the Pacific Code largely reiterates the terms of the Commonwealth Code.

61. **The Commonwealth Code provides a regional framework for international recruitment, that takes into account the effects on developing countries.** The Commonwealth Code was intended for all 53 Commonwealth nations with the hope that non-Commonwealth countries would sign on. Presently, there are only 22 signatories; most are developing nations, including the twelve ES CARICOM member states on the Commonwealth's list of developing countries that should be exempt from recruitment. The purpose of the code is to provide members of the Commonwealth with a framework for international recruitment with special consideration of the effects of international health worker recruitment on developing countries.⁹³ It recommends that this should be

92. Ibid.

93. Commonwealth Code of Practice for the International Recruitment of Health Workers, Commonwealth Secretariat, 2003.

done both by preventing targeted recruitment of health workers from countries that are experiencing health worker shortages and by encouraging ethical recruitment that safeguards the rights of recruits (see table 7).⁹⁴

62. **The Commonwealth Code differs dramatically from the national codes in its scope of influence in that it applies to the private sector as well as to the public sector.** Firstly, it recommends that all employment agencies, public and private, be bound by the code. This would be achieved through national regulatory systems to monitor recruitment agencies and through the implementation of mechanisms to detect noncompliance.”⁹⁵ Secondly, the code suggests that international recruitment should only be done on the basis of bilateral agreements, “in which both countries would have responsibility for ensuring compliance with the code.”⁹⁶ Thirdly, it recommends the mutuality of benefits or that recruiting countries reciprocate the benefits they have received from the recruitment of foreign health workers in the form of technology transfer, technical and financial assistance, training programs, and arrangements for facilitating nurse return. Finally, it recommends that all countries ensure they have strategies and the capacity to train and retain health personnel.⁹⁷

Table 7. The Commonwealth Code of Practice for the International Recruitment of Health Workers: Guiding Principles

- The targeted recruitment of health workers from countries experiencing health worker shortages should be discouraged.
- The rights of recruits and the conditions relating to their profession in recruiting countries should be safeguarded.
- Recruiters should not seek to recruit health care workers who have an outstanding obligation to their own country.
- Recruiters should provide international recruits with accurate information and ensure that they are protected by the same employment regulations and rights as equivalent grades of domestic staff.
- Recruiting countries should offer technical assistance to the countries they are recruiting from.
- Recruiting countries should consider reciprocating the advantages that they have gained through recruitment by offering programs that transfer technology and financial assistance, through training programs, and by facilitating the return of recruits.
- Recruiting countries are responsible for ensuring that the relevant regulatory bodies are responsible for the behavior of recruitment agencies via appropriate licensing and registration procedures.
- All countries should pursue national-level strategies and capacity building for retaining trained personnel.

Source: Commonwealth Secretariat 2003.⁹⁸

94. Ibid.

95. Ronald LaBonte et al., “The Brain Drain of Health Professionals from Sub-Saharan Africa to Canada” (Capetown: Southern African Migration Project, 2006).

96. Companion Document to the Commonwealth Code of Practice for the International Recruitment of Healthcare Workers, Commonwealth Secretariat, 2003.

97. Ibid.

98. LaBonte et al., “The Brain Drain.”

63. **The Commonwealth Code has had very little impact to date, reflecting the importance of the need to build consensus in the development of the instrument.** While the Commonwealth Code is broader than the national codes of conduct discussed above, in that it applies to the private sector as well as to the public sector, it has likely gone too far. The prominent Commonwealth health worker recruiting countries—the United Kingdom, Australia, and Canada—refused to sign the code due to its broad focus. In particular, they felt that provisions for the mutuality of benefits were too onerous, and the regulation of public and private agencies infringed excessively on their national sovereignty.⁹⁹ The end result is that the code does not apply to the major recruiting countries, thus nullifying its effect on the ES CARICOM region altogether. This situation highlights the importance of developing political consensus as part of the process of creating a comprehensive international health personnel instrument. While the strongest possible instrument is always desired, it must always be the product of compromise.

The Global Code of Practice on the International Recruitment of Health Personnel (May 2010)

64. **In, 2010, the first international code of practice for health personnel was passed; the code solves some of the problems that have plagued both national and regional codes.** In May 2004, the WHO member states adopted a resolution mandating the WHO director-general, in consultation with member states and all relevant stakeholders, to develop a code of practice on the international recruitment of health personnel that draws on the best practices of many existing national and regional codes of practice and bilateral agreements.¹⁰⁰ The code, also known as the WHO Code of Practice, became a reality when it was passed by the World Health Assembly on May 21, 2010 (all twelve ES CARICOM states are voting members). The WHO Code of Practice has successfully overcome some of the problems faced by other codes; for example, it does not create terms that are considered too onerous by destination countries, such as requiring the mutuality of benefits through technical assistance and compensation and specifically detailing how countries should regulate public and private recruitment.

65. **The substance of the WHO Code of Practice is similar to the Commonwealth Code; however, it limits onerous obligations and encourages agreements tailored to individual country needs.** The primary objectives, scope, and guiding principles of the WHO Code (table 8), outlined in articles 1-3, focus on increasing the consistency of national policies and discouraging unethical practices while promoting an equitable

99. Manuel Dayrit, Allyn Taylor, Jean Yan., Jean-Marc Braichet, Pascal Zurn, Esther Shainblum, “WHO code of practice on the international recruitment of health personnel”, *Bulletin of the World Health Organization*, 86 (10) 2008, PP 737-816.

100. World Health Organization Secretariat, *Global Code of Practice on the International Recruitment of Health Personnel* (124th session of the executive board, provisional agenda item 4.10, Dec. 4, 2008), accessed October 30, 2009, http://apps.who.int/gb/ebwha/pdf_files/EB124/B124_13-en.pdf.

balance of interests among health workers, source countries, and destination countries.¹⁰¹ The principles in article 4 emphasize the importance of ethical international recruitment practices, specifically highlighting those that seek to promote the equality of rights and opportunities for internationally recruited health workers and promote transparency and fairness in the recruitment process of migrant health workers. Article 5 also encourages the mutuality of benefits to ensure that the balance of losses and gains of health personnel has a net positive impact on the health systems of developing countries. Notably, it does not make specific reference to technical or financial reparations. It does, however, encourage bilateral agreements in the area of technical assistance, support for health personnel retention, and the twinning of health facilities and capacity training on the premise that these agreements can give effect to policy measures that are tailored to the needs of individual countries.¹⁰²

66. Articles 5 to 10 of the WHO Code expand upon the Commonwealth Code to promote the sustainability of the health workforce. Article 5 of the WHO Code outlines provisions for promoting sustainability in the national health workforce by taking measures built upon an evidence-based plan to educate, retain, and sustain a health workforce that is appropriate for the specific conditions of each country, including the areas of greatest need.¹⁰³ It is distinct from the Commonwealth Code in that article 5 emphasizes that all nations must strengthen their health worker educational and vocational training capacities, consider the social and economic status of their health worker personnel and their career opportunities, and adopt measures to deal with health worker maldistribution in underserved areas.

67. Articles 6 and 7 of the WHO Code are new and innovative approaches to developing a solid evidence base for formulating health worker migration policies. These policies effectively address the drivers, trends, and impacts of health worker migration. To date, the evidence on health worker migration trends is weak and fragmented. The WHO Code seeks to address this problem by strengthening health information systems and establishing common definitions and conventions on data gathering. Moreover, it recommends facilitating the exchange of health worker information by maintaining an updated database of laws and regulations regarding health worker migration, progressively establishing national data-gathering programs, and providing data to the WHO Secretariat every three years after the adoption of the code.¹⁰⁴

68. The final articles (8, 9, and 10) of the WHO Code focus on implementation and monitoring of the terms of the code. In particular, these provisions are intended to encourage signatories to give effect to the code in their national legal and administrative

101. Manuel et al., *International Recruitment of Health Personnel: A Global Code of Practice*, *World Health Organization Bulletin* 86, (10), accessed October 30, 2009, <http://www.who.int/bulletin/volumes/86/10/08-058578/en/print.html>.

102. World Health Organization, *Global Code of Practice on the International Recruitment of Health Personnel* (126th session of the executive board, December 3, 2009), EB1236/8.

103. Ibid.

104. Ibid.

systems and to take an active role in reviewing their current policies. Importantly, article 9 gives the WHO an oversight role in monitoring how states implement the terms of the code. Requiring states to report to WHO on the status of national implementation of the code is expected to increase compliance with the terms of the code.¹⁰⁵

105. Ibid.

Table 8. The Global Code of Practice on the International Recruitment of Health Personnel – Article 3 – Guiding Principles

- The health of all people is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states. Governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures. Member states should take the code into account when developing their national health policies and cooperating with each other, as appropriate.
- Addressing present and expected shortages in the health workforce is crucial to protecting global health. International migration of health personnel can make a sound contribution to the development and strengthening of a national health workforce. However, the setting of voluntary international standards and coordination of national policies in international health personnel recruitment are desirable to advance frameworks that equitably strengthen health systems worldwide to mitigate the negative effects of health worker migration on the health systems of developing countries and safeguard the rights of health personnel.
- The specific needs and special circumstances of countries, especially those developing countries and countries with economies in transition that are particularly vulnerable to health workforce shortages or have limited capacity to implement the recommendations of this code, should be considered. Developed countries should, to the extent possible, provide technical and financial assistance to developing countries with economies in transition aimed at strengthening health systems, including health personnel and development.
- Member states should take into account the right to the highest attainable standard of health of the populations of source countries and individual rights of health personnel to leave any country in accordance with applicable laws. They should strive to mitigate the negative effects and maximize the positive effects of migration on the health systems of the source countries. However, nothing in this code should be interpreted as limiting the freedom of health personnel, in accordance with applicable laws, to migrate to countries that wish to admit and employ them.
- International recruitment of health personnel should be conducted in accordance with the principles of transparency, fairness, and promotion of sustainability of health systems in developing countries. Member states, in conformity with national legislation and applicable international legal instruments to which they are a party, should promote and respect fair labor practices for all health personnel. All aspects of the employment and treatment of migrant health personnel should be without unlawful distinction of any kind.
- Member states should strive, to the extent possible, to create a sustainable health workforce and work toward establishing effective health workforce planning, education, and training and retention strategies, which will reduce their need to recruit migrant health personnel. Policies and measures to strengthen the health workforce should be appropriate for the specific conditions of each country and should be integrated within national development programs.
- Effective gathering of national and international data, research, and information sharing on the international recruitment of health personnel is needed to achieve the objectives of this code.
- Member states should facilitate circular migration of health personnel so that skills and knowledge can benefit both source and destination countries.

*Source: WHO Global Code of Practice on the International Recruitment of Health Personnel.*¹⁰⁶

69. **The effectiveness of the WHO Code will rest in how the instrument addresses the scope of the health personnel problem.** The problem of scope was central to the decreased effectiveness of the UK’s National Health Service (NHS) Code of Practice and the South African policy. These codes limited their sphere of operation to the public

106. Ibid.

sector and neglected the international recruitment of health workers in the private sector. Like the Commonwealth Code, the WHO Code addresses both private and public sector recruitment. The Commonwealth Code, however, comes across as overly broad and onerous. The tone it uses in the provisions on the mutuality of benefits implies that destination countries “owe” source countries reparation. Additionally, the recommendations that states ensure that international recruiters follow fair practices are very specific and have no regard for national preferences for regulatory procedures. The WHO Code’s language on mutuality of benefits, is softer and more conceptual; it does not explicitly use controversial language such as “reparation,” “restitution,” and “direct regulation.” This is far more acceptable to member states who agree to follow the code. This language does not place destination countries in a situation where they are signing what may seem like an admission of wrongdoing. Secondly, it allows states to determine the manner in which they will choose to regulate recruitment. Overall, the WHO ensured that the language of the code was palatable to all member states by creating a win-win situation for all.

70. **In the absence of legal norms, the provisions for monitoring and implementation under the WHO Code can be key for shaping state behavior.** Much of the success of the NHS Code and the South African policy was due to the tightly centralized control the respective departments of health had over hiring processes. As an international organization, the WHO clearly cannot interfere with sovereign law-making processes. However, monitoring and implementation programs outlined in the code do have a positive history of shaping state behavior in the absence of legal norms.¹⁰⁷ As a result, it is anticipated that the broad and comprehensive scope of the terms of the WHO Code, the WHO’s platform for developing political consensus, and the provisions in monitoring have the potential to make the WHO Code a successful health personnel instrument. In further support of this, the WHO has launched a web-based public hearing to take place over the March–April 2011 period on the draft guidelines for monitoring the implementation of the WHO Code. This will strengthen the level of commitment among the code’s members in that not only are they a part of the code, but they are also allowed to help shape it.

Obligations of ES CARICOM Countries under International Legal Agreements

71. **Obligations under legally binding international agreements, that is, GATS, CSME, and ILO conventions do not limit approaches to managing migration and do not address the policy priority areas of nurse training and workforce monitoring** (table 9). The GATS prohibits discrimination in the hiring of health personnel on the basis of nationality; however, a WTO member can show preference for hiring health personnel from a country with which it has a regional trade agreement. Furthermore, the GATS requires removing restrictions on the free movement of labor; however, it does exempt services provided on a noncommercial basis. The CSME also requires removing restrictions on the free movement of labor and services; additionally, it requires the mutual recognition of diplomas, certificates, and other evidence of qualifications. But like

107. Abbott and Snidal, “Hard and Soft Law,” 421–56.

the GATS, it allows for exemptions of activities exercised under government authority, especially when provisions create economic hardship. Obligations under the ILO Convention No. 97 are limited to showing migrants the same treatment as nationals. Neither the GATS and CSME nor the ILO Convention deal with issues pertaining to the training of health personnel or the monitoring of the health workforce.

72. **Obligations under non-legally binding agreements provide a supporting framework for regional action in the priority policy areas** (table 9). The WHO Code of Practice and the Commonwealth Code of Practice call for recruitment that upholds principles of fairness and mutual benefits. The latter calls for developed countries not to target developing countries, and destination countries to reciprocate benefits to source countries in the form of technology transfer and technical and financial assistance. The WHO Code of Practice, the Commonwealth Code of Practice, and the PAHO Regional Plan for Action call for plans and policies to strengthen health workforces and develop institutional capacities. Only the Regional Plan for Action provides an explicit reference to training, that is, the effective coordination between health personnel demand and supply. The WHO Code of Practice requires signatories to monitor the health personnel workforce and evaluate policies. It is important to note, however, that key destination countries of ES CARICOM migratory outflows such as Canada and the United Kingdom are not signatories to the Commonwealth Code of Practice.

Box 2. Benefits of a Regional Approach to Manage Nurse Migration

Preempting further deterioration of nursing shortages in the Caribbean requires swift, comprehensive, and collaborative policy action at the regional level. A regional approach will provide economic and social benefits that will spill over country boundaries and have a positive impact at a regional level. This seems warranted for at least three reasons. First, given the size of some of the countries (less than 150,000 population), a regional CARICOM approach to manage nurse migration is the only way to mitigate significant unintended impact and promote scale economies. Second, without proper coordination, the implementation of a regional approach is expected to swell currently nascent migratory flows of nurses within the ES CARICOM to the detriment of stocks in poorer countries. Finally, more recent experiences of attempts to manage migration suggest that small initiatives do not sustain the interest of destination countries.^{108,109,110}

Promoting scale economies. A regional approach would harness the comparative advantages of different countries. The local expertise can be fully exploited; pooling these skills and knowledge would allow for critical mass to be reached. This, in turn, would allow countries to take advantage of other countries' experience, strengths, and resources. Country initiatives would be collated into a single, regional strategy that would be coordinated to address the scarcity of tutors, the intraregional distribution of clinical training capacities, and the limited number of institutions offering higher degrees.

Promoting coordination to manage migration. Proper coordination through a regional approach can provide a platform for a high level of policy harmonization among the CARICOM countries. With the implementation of the CARICOM Single Market Economy (CSME) and the associated increases in intraregional migration, a coordinated approach to govern intraregional migration is required. Such an approach can help galvanize support around the

108. M. Robinson and P. Clark, "Forging Solutions to Health Worker Migration," *Lancet* 371 (2008): 691–93, doi:0.1016/S0140-6736(08)60310-4.

109. L. Dawson, *A Managed Temporary Movement Program for Nurses from the Caribbean to Canada: The Short (but Interesting) Life of a Policy Advocacy Proposal* (Ottawa: Carleton University, Center for Trade Policy and Law, 2006).

110. M. H. Cheng, "The Philippines' Health Worker Exodus," *Lancet* 373 (2009): 111–12, doi: 10.1016/S0140-6736(09)60022-2.

need to manage migration as a priority among CARICOM leaders. Coordination at the regional level would allow monitoring of cross-country flows to include not only entry data, which is currently monitored at a country level, but also, information on exit flows.

Sustaining interest of destination countries. A regional approach would counter the small size of the ES CARICOM countries and strengthen the ability of the region to reach out to migration destination countries such as Canada, the United Kingdom, and the United States. Given the discrepancies between the sizes of workforces and considering recent experiences of attempts to manage migration suggesting that small-scale initiatives do not sustain the interest of destination countries, the ES CARICOM countries should pursue a regional initiative rather than a small-scale one. Given the size and the linkages of local nurse labor markets in the ES CARICOM, no country in the region is in a position to efficiently tackle the challenges ahead on its own. Therefore, countries ideally join forces and adopt a regional approach to strengthen the evidence base, increase training capacity, and manage migration, and, if possible, they will do this with technical and financial support from countries where a large part of their nurse workforce will tend to migrate — Canada, the United Kingdom, and the United States.

Source: Authors, 2011

73. **In turn, a regional legal agreement could shape policies and rulings on health personnel migration in the context of the GATS and CSME and provide granularity to obligations of the PAHO Regional Plan for Action and the Commonwealth and the Global Code of Practice.** As the GATS and CSME include provisions to exempt health personnel from the general obligations requiring free movement of labor, a regional legal agreement could fill this vacuum and shape national policies and rulings in ES CARICOM countries. Moreover, a regional legal agreement could convert the broad principles set forth in the Regional Plan for Action and the Codes of Practice into specific commitments to shape national policies, rules, practices and actions. Specifically, a regional strategy could support the implementation of a common monitoring framework, in line with the WHO Code of Practice, to strengthen information systems to monitor the nurse workforce across the region.

Table 9. Obligations under Key International Agreements Affecting Health Personnel

Agreement	Obligations	Comments
<i>Legally binding international agreements</i>		
GATS (General Agreement on Trade in Services) Signatories: Antigua & Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, and Trinidad and Tobago	<ul style="list-style-type: none"> ▪ Not to discriminate in hiring of health workers on basis of nationality without pre-existing regional trade agreement ▪ Remove restrictions on the free movement of labor ▪ Conditional obligations on market access and national treatment 	WTO system provides strong incentives for compliance. Exempts services provided on a noncommercial or noncompetitive basis (e.g., nursing service provided in a national health care system) and for public policy that addresses: <ul style="list-style-type: none"> ▪ Job creation in disadvantaged regions; ▪ Equitable access to services or consumer protection.
CSME (CARICOM Single Market and Economy) Signatories: Antigua & Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, St. Kitts and	<ul style="list-style-type: none"> ▪ Free movement of services and labor ▪ Mutual recognition of diplomas, certificates, and other evidence of 	Excludes activities exercised under government authority. Provides for exemptions when the rights granted would create serious economic hardship.

Nevis, St. Lucia, St. Vincent and the Grenadines, and Trinidad and Tobago	qualifications	
ILO (International Labor Organization) Convention No. 97 Signatories: Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, St. Lucia, and Trinidad and Tobago	<ul style="list-style-type: none"> ▪ Provide migrants with treatment no less favorable than given to nationals 	
<i>Non-legally binding international agreements</i>		
WHO Global Code of Practice on the International Recruitment of Health Personnel Signatories: Antigua & Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, and Trinidad and Tobago	<ul style="list-style-type: none"> ▪ Recruit in accordance with principles of transparency and fairness, and promote sustainable health systems in developing countries ▪ Report to WHO on status of national implementation of code ▪ Strive to implement policies and measures to strengthen health personnel ▪ Monitoring and evaluation 	Voluntary agreement. Development of guidelines is encouraged.
PAHO (Pan American Health Organization) Signatories: Antigua & Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, and Trinidad and Tobago	<ul style="list-style-type: none"> ▪ Develop national plan of action for human resources for health ▪ Deploy appropriate personnel ▪ Make long-range plans and policies so that the workforce can adapt and develop institutional capacities ▪ Develop mechanisms of cooperation ▪ Implement general labor initiatives between workers and health organizations 	Comprehensive and broad in scope. National plans are meant to be implemented over a ten-year period. Limited literature available to evaluate early influence.
Source: GATS, CSME ILO, WHO, PAHO websites, 2011		

PART II – CONCLUSIONS

74. **The joint request by ES CARICOM stakeholders for the present study is testimony to their broad consensus to collaboratively and urgently address the forces that threaten the sustainability of the region’s nurse workforce.** Moreover, consultations with these stakeholders have demonstrated an equally broad consensus about policy priorities, including strengthened monitoring of the nurse workforce, enhanced training capacities, and managed migration. Looking forward, the challenge is to transform these broad agreements into formal commitments of joint and lasting action. The objective of this study is to guide this critical step.

75. **The current consensus about policy priorities and the scope of possible substantive commitments significantly increases the chance of successful negotiation of a legal agreement governing joint action.** Success seems even more attainable due to commitments in the policy priority areas as demonstrated in this assessment, which would complement but not conflict with any current international, legally binding commitments of any of the ES CARICOM countries under treaties such as the GATS, the CSME, and ILO conventions. To the contrary, a regional, legal agreement governing the priority action areas could shape future rulings under the GATS and CSME. Moreover, if action oriented, such an agreement could provide granularity to broad principles endorsed by ES CARICOM states under the PAHO Regional Plan for Action and the Commonwealth and WHO Codes of Practice.

76. **In defining the scope of commitments of a regional legal agreement, ES CARICOM states would have to deal with both a critical question and a critical challenge. The primary question is whether states would commit to actions to strengthen the nurse workforce or the health personnel workforce more broadly.** While the challenges of strengthening the nurse workforce have been systematically assessed, information about other groups of health personnel remains patchy. However, the literature suggests that causes and trends are likely to be the same or similar. The main challenge, therefore, is that the evidence base for policy action in the priority areas remains weak, though it is growing. Knowledge gaps exist in particular in cross-country coordination in expanding training capacities and managing migration to the benefit of both source and destination countries. As for cross-country coordination in expanding training capacities, ES CARICOM countries themselves launched several bilateral initiatives, and a rapid assessment could quickly generate important lessons learned. More generally, it is critical that the scope of commitments includes actions to monitor the workforce and evaluate policy initiatives and that a legal instrument allow for the easy adjustment of commitments to incorporate lessons learned.

77. **This need for flexibility speaks against the adoption of a legally binding instrument such as a multilateral treaty or a framework convention and its protocols, to which changes are cumbersome and costly.** Furthermore, ES CARICOM stakeholders favor quick action, but negotiating legally binding instruments tends to be a lengthy process in which commitments are watered down. For these very reasons, adopting a non-legally binding instrument seems advantageous. Learning from past

experiences with overly ambitious initiatives (for example, the Commonwealth Code of Practice), the instrument could rather focus on a few of the most urgent and promise actions negotiated quickly with commitments adjusted and expanded as needed and appropriate. These advantages of flexibility and a faster process, however, must be weighed against the cost of commitments that are not enforceable under international law. However, international experience suggests that non-legally binding instruments create expectations that constitute powerful incentives for compliance. The risks of poor compliance could be further mitigated by ensuring gains for all states, commitments to monitor the workforce, evaluating policies, and conducting external reviews (for example, by the ILO).

78. Within the category of non-legally binding instruments, a multilateral memorandum of understanding seems the most suitable option. This is because a resolution would require a sponsoring UN agency, and because a code of practice would also govern private institutions, which play a minor though not negligible role in the training and employment of the health workforce in the ES CARICOM. A multilateral memorandum of understanding could be converted into a pact among states as more and more countries enter the agreement and joint actions produce results and greater visibility for the initiative in the region as well as globally.

ANNEX 1. DEFINITIONS

International Legal Definitions

1. *Sources of International Law*¹¹¹

- a) **Customary international law.** Customary international law exists when there is uniform and consistent state practice regarding a particular matter and when there is a belief among states that such practice is legally compelled.¹¹²
- b) **Treaties.** A treaty refers to a written international agreement concluded between states and governed by international law, whether embodied in a single instrument or in two or more related instruments, and whatever its particular designation.¹¹³
- c) **General principles of international law.** These principles have been used in the following way:
 - i. Principles that exist in the national laws of states worldwide.¹¹⁴
 - ii. General principles of law derived from the specific nature of the international community. That is, those principles that arise from the rudimentary character of the society of sovereign states such as *pacta sunt servanda* or the principle of good faith among nations and the principle of nonintervention by one state in the affairs of another.¹¹⁵
 - iii. Principles intrinsic to the idea of law. For example, *res judicata* or *lex posterior derogat priori*.¹¹⁶
 - iv. Principles of law that appear to arise from notions of natural law or natural justice, such as principles barring discrimination on the basis of race or favoring equity and reciprocity.¹¹⁷
- d) **Subsidiary sources.** *Courts and Scholars:* These subsidiary sources include judicial decisions of courts and the writings of scholars that identify the content of international law.¹¹⁸

111. Murphy, *Principles*.

112. *Ibid.*

113. *The Vienna Convention*, art. 2, May 23, 1969.

114. Murphy, *Principles*, 86.

115. *Ibid.*

116. *Ibid.*, 87.

117. *Ibid.*

118. *Ibid.*, 88; see *Statute of the International Court of Justice*, art. 38(1) (d), June 26, 1945

- e) **Law making by international organizations.** This source comprises law generated by organs of an international organization that is regarded as binding on the member states of that organization.¹¹⁹

2. *Legally Binding Instruments*

- a) **Bilateral treaties.** Agreements between two states that meet the requirements to be considered "treaties" under the Vienna Convention on the Law of Treaties.¹²⁰
- b) **Multilateral treaties.** Agreements between more than two states that meet the requirements to be considered "treaties" under the Vienna Convention on the Law of Treaties.¹²¹
- c) **Termination or suspension.** The Vienna Convention on the Law of Treaties allows state parties to terminate or suspend treaties in whole or in part if certain criteria are met:
- i. **Breach.** If the reason for terminating or suspending a treaty is a breach, the breach must be material.¹²² In the case of a bilateral treaty, a material breach entitles the nondefaulting party to terminate the treaty or suspend its operation in whole or in part.¹²³ In the case of a multilateral treaty, upon breach, all parties may agree unanimously to suspend a treaty in whole or in part between themselves and the defaulting state or between all the parties.¹²⁴ Additionally, a specially affected party may suspend a treaty's operation in whole or in part in its relations with a defaulting state.¹²⁵
 - ii. **Other justifications for termination.** State parties may terminate treaties based on supervening impossibility of performance¹²⁶ or a fundamental change in circumstances.¹²⁷

119 . Murphy, *Principles*, 89.

120. Carter, Trimble, and Weiner, *International Law*, 93.

121. Ibid.

122 *Vienna Convention*, art. 60.

123 Ibid.

124 Ibid.

125. Ibid.

126. Ibid., art. 61.

127. Ibid., art. 62.

3. *Treaty Terms*

- a) “Ratification,” “Acceptance,” and “Approval” signify, in each case, a step beyond the signing of a treaty, often mandated by states’ constitutional requirements and necessary for a treaty to become binding on a signatory state.¹²⁸
- b) “Full powers” means a document emanating from the competent authority of a state designating a person or persons to represent the state for negotiating, adopting, or authenticating the text of a treaty; for expressing the consent of the state to be bound by a treaty; or for accomplishing any other act with respect to a treaty.
- c) “Reservation” means a unilateral statement, however phrased or named, made by a state when signing, ratifying, accepting, approving, or acceding to a treaty; whereby it purports to exclude or to modify the legal effect of certain provisions of the treaty in their application to that state.¹²⁹
- d) “Negotiating state” signifies a state that took part in the drawing up and adoption of the text of the treaty.
- e) “Contracting state” means a state that has consented to be bound by the treaty, whether or not the treaty has entered into force.
- f) “Party” means a state that has consented to be bound by the treaty and for which the treaty is in force.
- g) “Third state” means a state that is not a party to the treaty.

4. *Non—legally Binding Instruments*

- a) **Memorandums of understanding (MoUs).** Nonbinding writings that detail the preliminary understanding among parties who plan to enter a political agreement.¹³⁰
- b) **Codes of practice.** A set of general rules and practices to be followed in achieving a policy goal or political agreement.
- c) **Pacts by states.** These refer to nontreaty agreements by states through which they set forth certain aspirations that are not legally binding or subject to a

128. Murphy, *Principles*, 69.

129. *The Vienna Convention*, art. 2(1) (d).

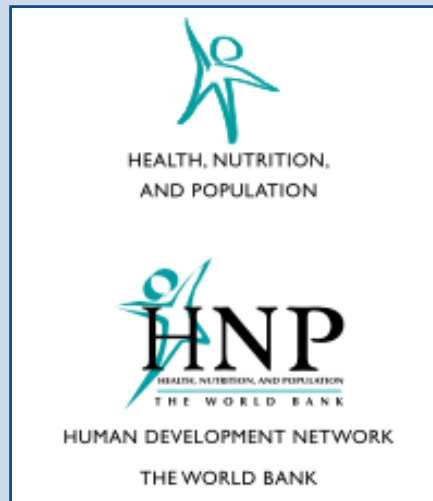
130. See “Letter of Intent,” in *Black's Law Dictionary* (St. Paul: Thomson West, 2008).

process of ratification. Pacts are, however, a means by which the international community can pursue consensus on values.¹³¹

- d) Recommended resolutions of international organizations.** Recommended resolutions are nonbinding resolutions that can powerfully influence the development of international law if the international organization promulgating them has recognized competence, there is near-universal participation of states in the work of the organization, the recommendations are adopted with little or no dissent, and adoption occurs in a manner that speaks to the existence of an international legal norm.¹³²

131. Murphy, *Principles*, 98.

132. *Ibid*, 99.



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