Health Worker Migration Initiative

GLOBAL POLICY ADVISORY COUNCIL

RECOMMENDATIONS REPORT

Recommendations on WHO's Draft Code of Practice on the International Recruitment of Health Personnel

Prepared by Realizing Rights: The Ethical Globalization Initiative, Secretariat for the Global Policy Advisory Council

OCTOBER 2008

THESE RECOMMENDATIONS REFLECT THE PREVAILING VIEWS OF INDIVIDUAL HWM GLOBAL POLICY ADVISORY COUNCIL MEMBERS AROUND AN ISSUE OF COMMON CONCERN. THEY DO NOT NECESSARILY REFLECT THE VIEWS OF PARTICIPATING GOVERNMENTS OR ORGANIZATIONS OR OF EACH INDIVIDUAL MEMBER ON EACH POINT.

The Health Worker Migration Initiative (HWMI) is a partnership between the World Health Organization, the Global Health Workforce Alliance, and Realizing Rights that aims to develop and promote innovative policy solutions to address the growing global problem of inequitable healthcare access due to the migration of health workers. The HWMI was formally launched May 15, 2007 in Geneva during the World Health Assembly.

The HWMI's Global Policy Advisory Council is chaired by the Honourable Mary Robinson and Dr. Francis Omaswa, and is composed of Ministers of Health and Development from both source and destination countries, as well as leading health, labour, and migration experts. Realizing Rights serves as the secretariat for the Global Policy Advisory Council.

We would like to thank the Ford Foundation, the Global Health Workforce Alliance, and the John D. and Catherine T. MacArthur Foundation for their generous support of the Global Policy Advisory Council's work. We are also grateful to the Commonwealth Secretariat for hosting the Council's most recent meeting in London.

FOREWARD

By Hon. Mary Robinson and Dr. Francis Omaswa

Co-chairs of the Global Policy Advisory Council

The challenges associated with the migration of health workers, in the context of international recruitment, are real and have been well identified. The work that WHO is now undertaking in order to develop a global Code of Practice on the International Recruitment of Health Personnel is thus of utmost importance. We congratulate WHO on preparing a Draft Code of Practice, a significant achievement in this complex and sensitive area.

In this report we provide a summary of and recommendations from our recent Health Worker Migration Global Policy Advisory Council meeting in London, where we discussed WHO's Draft Code of Practice on the International Recruitment of Health Personnel. We are especially encouraged by the energy and enthusiasm that the Global Policy Advisory Council Members brought to this important issue, meeting over two days to review the Draft Code of Practice and also providing detailed written comments. There is much that we have learnt as a Council over the last year and a half, as was apparent in the rich discussion surrounding the utility and content of the WHO Draft Code of Practice. With this report, we hope to share some of the learning and discussion that took place in our most recent Council meeting and to support potential policy solutions to the challenge of health worker migration.

The inherent complexity in addressing the migration of health workers reminds us of our interconnectedness and the reality that no one country can adequately address this challenge alone. As Dr. Marc Danzon, the Regional Director for WHO Europe, powerfully pointed out at our Council meeting, this issue touches not only on the principle of global solidarity but strikes also at the heart of global security, as one single failing health system has global consequences. While there are some matters that we might disagree on, even amongst our Council Members as you will see

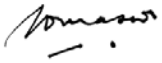
reflected in this report, there is much that we do agree upon. In particular, we believe that we can all share in a vision of a world abundant in opportunities to work and train abroad, rich in the exchange of ideas and expertise in the pursuit to further global health, and where every country also has a safe minimum number of trained health workers.

It is within the context of this vision that we present our recommendations on the WHO Draft Code of Practice on the International Recruitment of Health Personnel. Once again, we heartily reiterate our support and applaud WHO's efforts to develop and negotiate with Member States a global Code of Practice on the International Recruitment of Health Personnel.

Hon. Mary Robinson

Co-Chair Global Policy Advisory Council
President, Realizing Rights

Dr. Francis Omaswa



Co-Chair Global Policy Advisory Council
Executive Director, Africa Centre for Global Health and Social Transformation (ACHEST)

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PRINCIPAL RECOMMENDATIONS

Global Policy Advisory Council members reviewed and responded to the WHO Draft Code of Practice on the International Recruitment of Health Personnel, both collectively, at the September 18th and 19th Council meeting in London, and individually, through written comment to the Global Policy Advisory Council Secretariat. Following are the principal recommendations of the Council:

- The WHO Draft Code of Practice needs to reflect back upon why such an instrument was called for by the World Health Assembly, through World Health Assembly Resolutions 57.19 and 58.17, and to more strongly focus on mitigating the adverse effects of health personnel migration and its negative impact on health systems in developing countries. The WHO Draft Code of Practice in its current form places significantly greater attention on protecting the rights of migrant health workers than on addressing the challenges faced by health systems in developing countries.

- The Global Policy Advisory Council believes strongly that a preamble is needed to appropriately inform the rationale, context, and vision underlying the accompanying articles. The Global Policy Advisory Council, during its two-day working meeting in London, drafted proposed preamble language (Section II of the report contains text of such language).

- The WHO Draft Code of Practice needs to specify relevant stakeholders and to precisely elaborate all their roles with respect to the content and objectives of the proposed code. While there is strong attention to the role of Member States generally, the specific roles of source and destination countries, of health workers, of recruiters/employers, and of other relevant stakeholders require further elaboration.

- Wide, though not unanimous, agreement exists amongst the Global Policy Advisory Council that the principle of shared responsibility, one where if a state is indeed a global employer then shared responsibility to support the local source country health workforce should be encouraged, be present within the text of the WHO Draft Code of Practice.

- Clear guidance on precisely how Member States might implement the WHO Code of Practice is needed. Specificity in the manner and type of information to be collected for example, along with provision for technical and capacity related assistance to developing countries, would reduce the administrative and financial burden to implement the code.

INTRODUCTION

The **Health Worker Migration Global Policy Advisory Council** is a high level advisory body established in May 2007 by the Global Health Workforce Alliance, the World Health Organization, and Realizing Rights as part of the Health Worker Migration Initiative. The Global Policy Advisory Council is composed of Ministers of Health and Development from both developed and developing countries, as well as leading health, labour, and migration experts[1]. The mission of the Global Policy Advisory Council is to review and promote innovative global, regional, and national policy solutions to the challenges posed by the migration of health workers, respecting the right of health workers to migrate in search for a better life while also considering the impact on the populations left behind. The Global Policy Advisory Council is chaired by Honorable Mary Robinson, President of Realizing Rights and Dr. Francis Omaswa, Executive Director of the African Centre for Global Health and Social Transformation, and meets twice a year.

The Global Policy Advisory Council met on September 18th and 19th, 2008 at the Commonwealth Secretariat in London. The purpose of the meeting was to support WHO's effort to develop a Global Code of Practice and to provide useful recommendations that would strengthen the code's ability to achieve its stated objectives, in line with World Health Assembly Resolutions 57.19 and 58.17 calling for the development of and providing the mandate for a code of practice. Numerous Council members submitted written comments in anticipation of the Council meeting. The two-day working meeting itself resulted in both thoughtful and detailed recommendations on the WHO Draft Code of Practice on the International Recruitment of Health Personnel ("Draft COP"). Appendix II provides a list of the Council members who attended the London meeting and/or provided written comments on the Draft COP. The Draft COP itself can be found in Appendix III.

A formal web-based submission on the Council's comments to the draft code was submitted on September 30, 2008. The Council Recommendations Report, provided here, is an expanded discussion of the web-based submission, describing in fuller detail the conversation that took place amongst Council members with respect to WHO's Draft Code of Practice.

FORMAT OF THE COUNCIL RECOMMENDATIONS REPORT

The Recommendations Report is structured in a manner where the specific suggested change recommended to WHO through the online submission process is followed by more detailed discussion on the rationale underlying the specific suggestion. Section I of this report provides the recurring themes that emerged amongst the Council, with associated discussion. Section II contains the proposed language for a preamble, as strongly recommended and drafted by the Council. Section III contains specific recommended changes to the draft text by article, as well as detailed comments and related discussion.

[1] Appendix I provides a list of Global Policy Advisory Council Members

Council Recommendations

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I

RECURRING THEMES

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The following six themes emerged repeatedly and from a wide array of Council members as the Council both individually and collectively reviewed the text of WHO's Draft Code of Practice on the International Recruitment of Health Personnel. Most of the themes are reflected on in more detail in Section III, Specific Comments. The proposed preamble language, as mentioned above, is provided in Section II.

I Need to more strongly focus the WHO Draft COP on mitigating the damage to health systems in developing countries.

- Reflect back to the reason why the WHA Resolutions 57.19 and 58.17 called for a WHO Code of Practice in the first place.
- Targeted assistance to support health workforce development in source countries is needed.

Discussion: A central concern of many amongst the Council is that the Draft COP in its current form does not adequately respond to the World Health Assembly Resolutions which call for a WHO Code of Practice in the first place. The World Health Assembly Resolutions 57.19 and 58.17 are meaningfully titled "International migration of health personnel: a challenge for health systems in developing countries". Moreover, the four recommendations to member states contained within WHA Resolution 57.19 are focused on developing strategies to mitigate the adverse effects of migration of health personnel on health systems, on strengthening human resources for health, on using bilateral agreements to manage migration, and for receiving countries to support the strengthening of health systems in countries of origin.

Many amongst the Council feel that the Draft COP does not give appropriate weight to the objectives called for within the WHA Resolutions, with the balance of the code skewed more towards protecting the rights of migrant health workers than towards addressing the challenges faced by health systems in developing countries due to the emigration of health workers and the associated role of international recruitment. Moreover, the concept of shared responsibility and targeted assistance is widely recommended by the Council. It is recommended that if a state is indeed a global employer of health workers, which many out of necessity have to be, then shared responsibility to support the local source country health workforce, in any of a number of different ways, should be encouraged by the WHO COP. It is important to note however that a minority view amongst the Council feels strongly that it is not appropriate to identify such a responsibility in a non-binding document. Another minority opinion would like more focus on the role of source countries with regard to "push factors", distinguishing active

versus passive recruitment, and allowance for cases where governments might recruit through government to government agreements from nations where health professions workforce surpluses exist.

II While there is strong attention to the roles of Member States generally, the specific roles of source and destination countries, of health workers, of recruiters/employers, and of other relevant stakeholder's could use further elaboration.

Discussion: There is wide agreement amongst the Council that further elaboration of the specific roles of the various stakeholders would benefit the clarity of the instrument, its usability, as well as its future implementation. The scope of the instrument as framed is especially broad, including virtually everybody concerned with the international recruitment of health personnel as stakeholders. Possibly including for example even civil servants in health departments, which may not be desirable or practicable. As the document currently stands, it targets significant recommendations at Member States, as would be expected. It is recommended that roles for all other relevant stakeholders be further clarified, including in particular the specific roles of source and destination countries.

III The WHO Code of Practice must recognize and support existing codes and other codes that will be developed in the future.

Discussion: The Council feels that the text of the Draft COP should expressly recognize and support previous efforts related to the migration of health workers, including broader migration and development related efforts, as well as inform bilateral and multilateral instruments that will be developed in the future. Previous non-binding efforts related to the topic include, amongst others, the Commonwealth Code of Practice, the DH England Code of Practice, the EPSU-HOSPEEM Code of Conduct, and the ILO Multilateral Framework on Labour Migration. Additionally, many amongst the Council feel strongly that the implementation of the Code of Practice should be conducted in harmony with the principles of the Paris Declaration on Aid Effectiveness and the Accra High Level Forum on Aid Effectiveness.

IV A preamble, text that opens and travels with the code, is needed to inform the rationale, context, and vision behind the accompanying articles.

Discussion: The need for a preamble to inform the content of the Draft COP emerged after significant discussion amongst the Council in London. As mentioned earlier, the prevailing view amongst the Council is one that feels that the Draft COP, and the general principles in particular, do not properly situate and articulate the complexity and urgency of reason why a Code of Practice is called for in the first place. The Council feels strongly that a preamble, which opens the Code of Practice and forms an integral part of the text, is needed to inform the content and future interpretation of the substantive and procedural articles to follow. Over the course of the two day meeting, the Council drafted preamble language which can be found in Section II, Proposed Preamble Language. The Council feels strongly that this language not only provides the rationale behind the development of the Code of Practice but also provides appropriate and much needed definition to the text of the specific articles.

V A definitions section is needed, defining in particular the specific stakeholders (recruiters, employers, health workers, source nations, destination nations, etc.), distinguishing active vs. passive recruitment (article 4 as an example applies to both, while most others are associated simply with active recruitment), distinguishing documented vs. undocumented health workers, and further elaborating on the principles of fairness, transparency, and mutuality of benefits.

- Consistency in language throughout the document (e.g. to either use the term health personnel or health worker) and with other codes/key documents, though understandably challenging, is also important (e.g. WHA Resolutions, ILO Multilateral Framework, Commonwealth COP).

Discussion: It is widely agreed upon by the Council that a detailed definitions section would be useful and is needed to more clearly articulate the specific roles and responsibilities identified within the body of the Draft COP. The relevant stakeholders all need clear definition, including for example, further definition of those identified as recruiters. Distinguishing the key concept of active versus passive international recruitment should be included in the definitions section and appropriately referenced in the body of the instrument. The principles of fairness, transparency, and mutuality of benefits, critical to the Draft COP, also demand clear description in both the definitions section and through specific articulation of these principles within the body of the text. The three principles are defined and used in previous Codes of Practice, such as in the Commonwealth Code of Practice, thus their definition is all the more important to avoid confusion and to maintain consistency with previously used language. It is to be noted that some members felt that separate definitions were not needed, if these principles were specifically articulated in the body of the text. Finally, the Council widely believes that consistency in language should be maintained throughout the document, defining and using for example either the term health worker or health personnel.

VI It would be helpful if the code spelled out clearly how it was envisaged that Member States would in practice implement it, e.g. by spelling out that they were encouraged to develop/implement national policies and practices which reflected the principles of the code.

Discussion: Much discussion took place amongst the Council on the practical consideration related to implementation of the Draft COP. WHO is viewed as having the primary responsibility of leading and guiding implementation related efforts. In particular, WHO is considered by the Council as having the responsibility to define within the body of the Draft COP precise guidelines related to the implementation and monitoring of the Draft COP. A major concern raised by many amongst the Council focused on the administrative and financial burden related to the implementation and monitoring the Draft Code of Practice, especially with regard to developing countries. The articulation of clear guidelines on the information to be collected, as well as specific roles related to implementation, is viewed by the Council as a critical means to reduce this burden.

II

PROPOSED PREAMBLE LANGUAGE

II

PROPOSED PREAMBLE LANGUAGE

Recalling United Nations General Assembly Resolution 2417 (XXIII) (1968) titled "Outflow of trained professional and technical personnel at all levels from the developing to the developed countries, its causes, its consequences and the practical remedies for the problems resulting from it";

Responding to WHA Resolutions 57.19 (2004) and 58.17 (2005) titled "International migration of health personnel: a challenge for health systems in developing countries";

Considering the World Health Report 2006, "Working together for health";

Considering the progress reports of the Director General, 2006 and 2008, titled "International migration of health personnel: a challenge for health systems in developing countries";

Noting also the Kampala Declaration and Agenda for Global Action, 2008;

Affirming the right of each individual to the highest attainable standard of health and the corresponding duty of each Member State to respect, protect, and fulfill this right;

Recognizing that an adequate and accessible health workforce is fundamental to an integrated health system and for the provision of essential health services;

Conscious of the global health worker shortage;

Noting with concern that the severe shortage of health workers in many developing countries undermines their health systems and impairs their ability to achieve the Millennium Development Goals ("MDG"), especially as related to MDG 4 "Reducing Child Mortality", MDG 5 "Improving Maternal Health", and MDG 6 "Combat HIV/AIDS, Malaria, and Other Diseases";

Noting also, that as a result of our interconnectedness, a compromised health system has health and security implications for the global community;

Mindful of the historic and continued relevance of the role of international exchange in ideas, values, and people to human well being;

Affirming the right of health workers to leave their own country;

Recognizing the urgent need to develop policy instruments at the national and international levels that maximize the benefits and mitigate the negative effects ensuing from the migration of health workers, with special attention to the emigration of health workers from countries which already have depleted health systems;

Aware also of the growing evidence related to the poor treatment of some migrant health workers;

Recognizing that improving the social and economic status of health workers, their living and working conditions, their opportunities for employment and their career prospects is an important step in overcoming existing shortages and improving retention of a skilled health workforce;

Recognizing that the complexity of the challenge demands a comprehensive response and a multi-sectoral approach, encompassing all sectors associated with both migration and the determinants of health[2];

Drawing on existing initiatives and mechanisms[3] and to strengthen a global approach;

Recognizing that to foster strong health systems, governments should undertake a variety of measures to promote an adequate, accessible, and sustainable health workforce, addressing both push and pull factors, and that this code is able to address only some elements of this;

Sharing in the vision of a world abundant in opportunities to work and train abroad, rich in the exchange of ideas and expertise in the pursuit to further global health, and where every country also has a safe minimum number of trained health workers;

Believing that, in the light of the foregoing considerations, and in view of the vulnerability of health systems as exacerbated by some current practices associated with the migration of health workers, an ethical approach to the recruitment and management of health workers, among other factors, is necessary;

THEREFORE

The Member States hereby recommend the principles set out in the following articles as a basis for action by Member States, and the other parties mentioned therein.

[2] Including amongst others, the sectors of labor, education, immigration, finance, trade, and development.

[3] Including the Commonwealth Code of Practice, the Pacific Code of Practice, the DH England Code of Practice, the Scotland Code of Practice, EPSU-HOSPEEM Code of Conduct, and the ILO Multilateral Framework on Labour Migration.

III

SPECIFIC COMMENTS BY ARTICLE

III

SPECIFIC COMMENTS BY ARTICLE

Article 1

ARTICLE 1(a): remove "voluntary" after the word "promote" and include "ethical" before the word "international".

Discussion: There is a strong view among the Council that the term 'voluntary', particularly as used in the first sentence of the Draft COP, is redundant and weakens the persuasive power of the clearly non-binding code of practice. As it is, article 2.1 of the Draft COP clearly states that "The code is voluntary". Numerous Council members raised concern that the overemphasis of the term 'voluntary' within the document would detrimentally impact its effectiveness, particularly in its efforts to call for ownership and leadership by relevant stakeholders with regard to proposed principles and recommendations. Additionally, a representative from the recruiting industry stated that he would be much less likely to take the document and the principles it espoused seriously if the term 'voluntary' was emphasized. It is to important to note here that there is a minority viewpoint that feels strongly that the voluntary nature of the code should be mentioned here and clarified throughout the document, including in the title itself.

ARTICLE 1(b), (d): include "ethical" before the word "international".

Discussion: There is strong sentiment amongst the Council that the term 'ethical' though inherently ambiguous also has strong moral power and should thus be included. It helps distinguish the objectives from being generally focused on international recruitment, including perhaps simply on the business of recruitment, to focusing more specifically on principles linked to moral and social justice concerns, the reason behind the development of the COP. Moreover, the phrase "ethical international recruitment practices" is utilized in article 4.1, thus for consistency it should also be incorporated within the objectives. It is to be noted however that a small minority view exists amongst the Council, which proposes that the term 'ethical' should not be so incorporated. This viewpoint is based on the ambiguity of the term as well as its lack of use within the WHA Resolutions.

Article 2

ARTICLE 2.1: Start the sentence with "While" and join the two sentences with a comma.

Discussion: Change suggested in order to deemphasize the term 'voluntary'. See discussion related to article 1 (a).

ARTICLE 2.2: Concern that scope might be too broad (including health department civil servants as an example), particularly in consideration of the roles

and responsibilities later identified. The definitions section would help make it more specific.

Discussion: There is concern amongst many Council members that the scope of the code might be too broad, especially as the roles and responsibilities of a number of the stakeholders identified are not explicitly referred to within the code. If the scope overreaches and includes every potential person, without corresponding roles and responsibilities identified, this might make it more susceptible to not being accepted or observed. The code for example currently applies and is directed to all those whose primary intent is to enhance health (see also article 2.3). This would presumably include health department civil servants, as well as non-medical staff of non governmental organizations. A definitions section, defining health workers, migrants, recruiters, etc., would be useful in limiting the scope of the Draft COP. The identification of corresponding roles, as mentioned earlier, is also important. Finally, while article 2.2 is broad, article 2.4 is not similarly so and does not balance the interests of many stakeholders.

ARTICLE 2.3 Replace "to all" with "in relation to all".

Discussion: Change suggested to appropriately reflect the scope of the document.

ARTICLE 2.4: Add "ethical" before the word "principles" and add ", and that strengthens health systems" at the end of the sentence.

Discussion: With regard to the addition of the term 'ethical', see discussion related to article 1(b). Additionally, there is a dominant view amongst the Council that the WHO Code of Practice should be focused on mitigating damage to health systems, reflecting the WHA Resolutions which called for such a Code of Practice in the first place. In its current form, this focus is found lacking by the Council. It is important that such a concept be integrated throughout the document, thus it is recommended that "strengthens health systems" should be included to the nature and scope of the code. This addition protects not only the interests of health worker but also calls for the strengthening of health systems in order to achieve better outcomes for the populations left behind.

Article 3

GENERAL: All related points should be brought together sequentially or by amalgamation (e.g. all points related to the treatment of workers should appear sequentially).

Discussion: It is stressed that the content and order of the general principles should reflect the content and order in the subsequent articles. For example, the general principles in their current form contain nothing about article 5—mutuality of benefits. In contrast there are a number of general principles that speak about the treatment of health workers, these should either be amalgamated or at least brought into sequential order.

ARTICLE 3.1: Add "in certain circumstances" at the end of the second sentence. In the third sentence add "and their reflection in national policies and any bilateral/multilateral agreements" after the words "standards". Additionally, in the third sentence, replace "countries" with "health systems, particularly in developing countries".

Discussion: There is sentiment amongst many in the Council that the second sentence as currently drafted is too strong an endorsement of the positive impact of international recruitment. While it is important to recognize that international recruitment can make a positive contribution to the development of a national health workforce, its importance should not be overstated. Thus it is recommended that "in certain circumstances" be added in order to moderate the sentence. The changes to the third sentence are proposed as the Code of Practice is not really focused on coordinating national policies, or on bilateral agreements only. It would be more helpful to encourage countries to reflect the principles of the Code of Practice within their national policies as well as bilateral/multilateral agreements that are entered into. Finally, "health systems" was added here in order to integrate the concept throughout the document. See discussion related to Article 2.4.

ARTICLE 3.2: Replace with the following language: "Individuals have the right to the highest attainable standard of health and Member States have the corresponding duty to respect, protect, and fulfill this right".

Discussion: The article as drafted speaks to rights of nations as opposed to the responsibilities of nation states, which the Council feels needed emphasis and that international human rights law makes clear. The language as drafted allows for countries to assert their right to strengthen their own health systems at the expense of others. The recommended textual change is meant to express that it is the individual who is the holder of the right, with the responsibility of nation states to work towards achieving its realization. Moreover, there is a sentiment amongst many members of the Council that the responsibility of nation states extends to not undermining other countries' capacity to realize the right to the highest attainable standard of health. This is reflected in the second part of the recommended sentence. It is to be noted that a minority viewpoint feels strongly that such language is not appropriate and that member states are only obligated to provide a health system to the benefit of their own citizens. Another view believes that there is no need for this article in the general principles section, if such language is already present in the preamble (as it is in the proposed preamble language).

ARTICLE 3.3: Add "subject to national law and their previous obligations, such as national service and education repayment obligations".

Discussion: There was considerable debate upon this point. Support for such a change was focused upon the idea that the Code of Practice should not without qualification endorse the right of migrants to leave their country. In particular, it was felt that mention should be made of potential migrants' responsibility to respect national laws, as well as their national service and education repayment obligations. A strong contrary view however was focused on leaving the right to leave one's country unqualified, as national laws and other obligations might in certain circumstances be without adequate justification (e.g. if only health workers were restricted in this way) and that it would be unethical to expect potential migrants to respect them. In the end, the support from the Council weighed in favor of including qualifications, as present in the

language above. Moreover, the Council secretariat feels such a change is appropriate as this section aims to establish general principles associated with ethical international recruitment, and the change suggested balances the right of migrants to leave their own nation with their responsibility to fulfill prior obligations.

ARTICLE 3.4: The three principles need greater definition. In particular the principles of transparency, not explicitly referred to again, and that of mutuality of benefits need to be both clarified and elaborated upon.

Discussion: The principles of transparency, fairness, and mutuality of benefits are given great weight by the Draft COP, with all stakeholders urged to conduct all international recruitment in accordance with these principles. The Council widely agrees and feels strongly that definition of what exactly these principles entail needs greater clarification. Many Council members feel that a definition section can be used to clarify these concepts. Others believe that the clarification can be done through more specific elaboration of the corresponding recommendations. Some believe that both these approaches would be useful and are needed to give substance to these critical principles, while others caution that this approach might lead to discrepancies between the two.

ARTICLE 3.6: Add the words "and production" after the word "planning" in the first sentence. Additionally, at the end of the first sentence add "and strive to create a self-sustaining health workforce".

Discussion: The first change suggested is simply to make clear that effective health workforce production, in addition to health workforce planning is needed. The second point is one that was comprehensively discussed amongst the Council. Some Council members spoke of the need of countries to become self-sufficient with regards to their health workforce as opposed to simply sustainable, the later concept continuing to rely on foreign health workers. Others however pointed to the fact that for many countries becoming self-sufficient is not a realistic choice, with even the United Kingdom while self-sufficient currently might not be so in the future. A strong position emerged amongst the council that if a state is indeed a global employer then shared responsibility to support the local source country health workforce should be encouraged. Language in WHA Resolution 57.19 supports such a concept[4]. It is in this context that the term 'self-sustaining health workforce' is used[5]. The prevailing view amongst the Council is that this idea should be integrated throughout the document, and particularly in the general principles, and thus it has been incorporated here. It is to be noted that a minority of the Council prefer the use of the term 'sustainable'. See also discussion related to Article 6. Another minority opinion is to keep the present draft language, as it could encourage more countries to accept the Code.

ARTICLE 3.7: Remove "should be considered" as it is vague. Add "need to be prioritized by all stakeholders, both out of a spirit of solidarity and to ensure global security". A subarticle following this should state that

[4] See WHA Resolution 57.19, 1(4).

[5] Need to develop definition of a self-sustaining health workforce, as distinct from one that is self-sufficient.

"Member States that are global employers should share in the responsibility to support the local health workforce from which they recruit". Follow up in substantive sections on the variety of methods that might be utilized, reflecting on promising practices and lessons learned.

Discussion: The article as drafted is thought to be too weak, particularly as it does not clarify who should consider the needs of developing nations and to what end. It is important to recall that the WHA Resolutions calling for a COP are focused on addressing the challenges to the health systems of developing countries resulting from the migration of health workers. It is for this purpose that the Council feels that the specific needs of those countries particularly vulnerable to health workforce shortages should not simply be considered but rather need to be prioritized. Some Council Members also think that it would be useful to explain why the needs of those particularly vulnerable to health workforce shortages are important for the global community to prioritize. The two concepts that are raised are that of global solidarity and of global security. Global solidarity is a principle present in various schools of religious thought, rooted at the heart of universal human rights, and provides the underlying motivation for much of development assistance. Global security on the other hand gets to the point that a single failed health system raises security concerns for the entire global community. The global threat of avian influenza is provided as one of many potential examples. Finally, with regard to the inclusion of the comment about shared responsibility of a global employer, see discussion above related to article 3.6. There is a minority viewpoint amongst the Council which opposes addition of such language based upon the concerns that the language implies that discrimination based upon national origin would be acceptable, that the language does not specify that it only applies to active recruitment, or exclude recruitment activities that states may not be able to control, e.g. in the private sector. It was suggested that wording taken directly from the resolutions seems more likely to be generally acceptable.

ARTICLE 3.9: Include "disability", "sexuality", and "the country where they trained" in the illustrative list. Amalgamate with 3.5.

Discussion: In the illustrative list it is recommended that disability and sexuality be included to ensure that these populations are also specifically protected. Additionally, at the London Council meeting information was provided, with particular respect to the Gulf States, on a system that is emerging where health worker migrants identified as being "western trained" are offered greater compensation, better employment opportunities, and generally better treatment than similarly qualified health workers deemed "not western trained". For this reason, a number of Council members feel that the non-discrimination clause should include the "the country where they trained". Moreover, due to similarity in content article 3.9 is well suited to be amalgamated with article 3.5.

Article 4

GENERAL: Amalgamate a number of articles, such as 4.3, 4.9; and 4.5, 4.6, 4.7. In relation to the other substantive sections of the code, this section has many more sub-articles.

Discussion: The main concern raised by the Council with regard to this article in particular and to the Draft COP in general was that while there is a strong focus on protecting the rights of migrant health workers, a similarly strong focus on mitigating the challenges to health systems in developing countries is not present. In particular, the number of sub-articles focused on the protection of migrant workers make striking contrast with the limited number of sub-articles focused on mitigating the aforementioned challenges to health systems. As such the Council recommends that number of sub-articles present in this, the first substantive, article could be amalgamated or at least organized better to fit with the general principles outlined earlier. For example, articles 4.3 and 4.9 both speak of the information and programs to be offered to migrant health workers. These could be amalgamated or at least placed in sequential order.

TITLE: Change title to Recruitment Practices and Treatment of Health Workers or expand to include a list of Ethical Recruitment Practices.

Discussion: Article four is currently titled "Recruitment Practices". However, the nine sub-articles are solely focused on the treatment of and opportunities for migrant health workers. The text of the WHA Resolutions informs us that recruitment practices are not linked simply to the treatment of migrant health workers but also, and perhaps more critically, to the challenges that current recruitment practices pose to source country health systems. The Council feels strongly that this section should include further guidance on the manner in which ethical international recruitment should take place, for example on how and where active recruitment should take place. Alternatively, it is suggested that the title might be changed in order to reflect that this recruitment practices section is focused solely on the treatment of migrant health workers.

ARTICLES 4.1, 4.3, 4.4: Develop a list, e.g. drawing on that in the Commonwealth COP, of the minimum which should be provided to recruits.

Discussion: These three articles in the Draft COP point to the need for Member states to make certain that migrant health workers are provided **relevant and accurate disclosure** about potential positions, that recruiters and employers observe **fair contractual practices**, and that migrant health workers are **not subjected to improper or fraudulent conduct**. The Draft COP does not however clarify the information that is to be deemed relevant and should be disclosed, what fair contractual practices entail, or the conduct that might be deemed as improper or fraudulent on the part of a recruiter or employer. The Commonwealth Code of Practice is useful as it goes into significant depth in attempting to lay out the features of the above principles. For example the Commonwealth Code of Practice clarifies that the full and accurate disclosure of information includes information on the nature and requirements of the job, on the conditions in countries to which the migrant health workers are recruited, the administrative and contractual requirements, as well as on the various rights of the recruit. Similarly, the Voluntary Code of Ethical Conduct

for the Recruitment of Foreign-Educated Nurses to the US goes into significant depth in exploring what fair contractual practices should in practice entail. Although not all countries were happy with every detail of these existing codes, the Draft COP could be strengthened and made more useful if these three articles are further developed, taking into consideration previous efforts.

ARTICLES 4.3, 4.4: Hard for countries to "ensure" this: the responsibility should be placed not just on member states but also on recruiters and employers.

Discussion: This point goes back to one of the main concerns raised with regard to the Draft COP. The Council strongly feels that while the role and responsibility of Member States are generally well outlined, this is not the case for the rest of the key stakeholders. For the instrument to be of maximum utility it is felt that the roles and responsibility of key stakeholders should be thoroughly examined and incorporated throughout the document.

ARTICLE 4.5: Provision needs to be made, here and in the following sub-articles, to allow countries to take account of skills necessary to safe practice/patient safety, e.g. language skills.

Discussion: This addition was suggested in order to make the sub-article more appropriate for country conditions and patient safety, with the concern that inadequate language skills or familiarity with a countries procedures etc. might put patients at risk.

ARTICLE 4.8: Delete the phrase "to ensure .....are rendered free of charge to health workers" replacing it with "to ensure adherence with the code".

Discussion: The sub-article as drafted provided that the regulation and monitoring of recruiters and employers is to be recommended to Member States solely for the purpose of ensuring that services are provided free of charge to the migrant health workers. The purpose for regulating and monitoring recruiters, reflecting on the both the context underlying and content of the Draft COP, needs to be much broader and to include all the substantive principles recommended within the Draft COP.

ARTICLE 4.9: Add after the term "should", "on appointment/commencement of employment". At the end of the sentence add "if they need this".

Discussion: The recommended changes have been suggested in order to clarify that the services, along with associated financial and human resources, are not wasted on those who do not need them.

Add sub-article stating that "the place where training and qualification is obtained should not act as a discriminating factor in remuneration, promotion, or opportunities for and level of work, once the health worker is considered eligible for the specific academic and professional position".

Discussion: See discussion related to article 3.9.

Add sub-article on the responsibilies of health workers, including among others to "comply with contracts and bondings to which they are signatories with their country authorities".

Discussion: See generally discussion related to articles 4.3, 4.4. The responsibility of health workers to comply with existing contracts and governmental bondings was in particular viewed by the Council as a central responsibility for this group of key stakeholders. There is, however, sentiment amongst some in the Council that the right of migrant health workers to migrate should not be qualified, see discussion related to article 3.3.

Add sub-article on the right of health workers to return to source countries, including the role of both source and destination countries to facilitate this return.

Discussion: See generally discussion related to articles 4.3, 4.4. The Council feels it is important to stress that both source and destination countries have roles to play here. The source country in particular can make certain that administrative and legal burdens associated with returning migrant health worker's ability to practice are reduced. There is concern amongst some that inclusion of destination countries places too great a burden on countries of employment to facilitate return.

Add sub-article, focused on member states and recruiters/employers, limiting the manner in which active recruitment is taking place in vulnerable countries.

Discussion: If this article is to focus on more than simply the treatment of and opportunities for migrant health workers, then an article such as this is recommended. See discussion related to title of Article 4. There is concern amongst some that active recruitment is not appropriately defined and that it would be difficult for Member States to control this, especially if it takes place in the private sector.

Add sub-article stating that "Member States should strive to utilize only those recruiting agencies that abide by provisions in the code".

Discussion: This recommendation is suggested to further bolster this section related to recruitment practices, with the relationship between Member States and recruiting institutions of central importance. A small minority view feels that this recommendation would not apply to member states that do not have nationalized health care systems.

Article 5

GENERAL: Needs greater development and specificity. Specific content on mutuality of benefits is minimal, with only bilateral agreements and exchanges being mentioned. Look back to WHA Resolution 57.19 to enhance this section and also to suggested modification in 3.7 above.

Discussion: The Council feels strongly that this pivotal section needs both greater clarity and specificity. The content on mutuality of benefits is itself limited to bilateral agreement and exchanges. Additionally, the relative scarcity of substantive sub-articles in this and the following section in relation to the article focused on the treatment of and opportunities for migrant health workers is noted by the Council. The relative scarcity of guidance is especially striking, taking into the consideration the underlying reasons that the

WHA Resolutions called for a Code of Practice in the first place. It is strongly felt that the term mutuality of benefits can be better defined through detailed substantive sub-articles. See also comments related to Article 3.7. A minority view amongst the Council feel that the title "Mitigating Adverse Effects" (as in resolution WHA 57.19) might be more appropriate.

ARTICLE 5.2: Divide into different sections and go into greater depth. Add to illustrative list in the third sentence, "support training in source countries that is appropriate for the disease profile of such countries", "twinning of health facilities", "increased funding to support new education and training for increased production of health workers", "capacity building on appropriate regulatory frameworks", etc.

Discussion: This sub-article is focused on bilateral/multi-lateral agreements and their role in maximizing the benefits and mitigating the negative impacts related to the migration of health workers. It is recommended that this sub-article be broken into smaller sections so that the manner and content of the bilateral/multilateral agreements can be expanded. In particular, the illustrative list in the third sentence needs to be added to in order to better reflect the variety of measures that may be incorporated within bilateral/multilateral agreements. It is important to note that a minority of Council members did not feel that bilateral agreements should be endorsed so strongly, as countries cannot be expected to enter bilateral agreements with all those that they interact with, that there is little evidence of the effectiveness of bilateral agreements in the health worker migration context, and that much aid and exchange can take place outside of such agreements.

ARTICLE 5.3: Provide specifics on how to do this, such as for source countries to engage with diasporas and to ease legal and administrative barriers to returning health workers.

Discussion: Again, the Council feels that greater specificity is needed on how to operationalize this sub-article. The recommendation is one example of how specific content might strengthen this article.

Add sub-article emphasizing the role of regional and international organizations in "facilitating the development and implementation of bilateral agreements, in response to the request of state parties involved and with a specific focus on those areas within their mandate and expertise".

Discussion: There remains a capacity related gap in the ability of many countries to enter into bilateral/multilateral agreements giving effect to the principles enshrined within the Draft COP. The Council feels that regional and international organizations have a role to play, where their mandate and expertise so dictates, in supporting the development and implementation of bilateral agreements.

Article 6

GENERAL: A "sustainable health workforce" is not the same as a "self-sufficient health workforce", as one can continue to rely on foreign trained workers to maintain a "sustainable health workforce". The principles surrounding development of "a self-sustaining health

workforce" needs to be further flushed out through this article, pointing to the idea that Member States should make every effort to train sufficient numbers of health workers to meet domestic need. Linked to this idea, if a Member State is indeed a global employer then acceptance of some shared responsibility to support the local source country health workforce (through training, aid etc.) should be encouraged.

Discussion: The Council pointed to the fact that it is difficult to ensure a self-sufficient health system. The example of the United Kingdom was provided, which even though it is self-sufficient today might not be so in the future. The strong prevailing view in the Council is that if a country is indeed a global employer then it should share some of the responsibility to support development of the local source country health workforce. It is to be noted that a minority within the Council do not feel that the concept of responsibility should arise in a non-binding instrument.

ARTICLE 6.2: Change "means of" to "step in".

Discussion: The Draft COP as drafted currently implies that improving living, economic, and social status of health workers is alone sufficient to overcome health worker shortages. It is probably more appropriate to state that the adoption of such measures is an important step, among other necessary measures, to overcoming existing shortages.

Articles 7 and 8

GENERAL: Combine into one article titled Data Gathering, Research, and Information Exchange.

Discussion: The content in the two articles are related closely enough such that the Council feels that they should be combined in one article. Combining these two articles not only will allow for a Code of Practice that is more concise but also one that has a better balance between the various areas of focus.

Add sub-article at the beginning of this section emphasizing the importance of data sharing and collaboration and WHO's responsibility to define and facilitate this effort, taking into consideration the potential administrative and financial burden on Member States.

Discussion: The Council feels that the importance of data sharing and collaboration be highlighted by beginning the section with this sub-article. Moreover, the Council feels that it is important to clarify WHO's responsibility in both defining the common data to be collected and shared and to facilitate data sharing and collaboration. Specifically, many members of the Council believe that the WHO can, by defining specifically the content of the information to be collected and shared, limit the administrative and financial burden on Member States. It is the concern of a small minority of the Council that some Member States might not want to share their data, and that this would be well within their rights.

ARTICLE 7.2: Replace with the following:

• Destination countries should regularly and systematically collect comparable data on numbers of migrant health workers by country of origin, health worker category and, where appropriate, by specialty and level of seniority.

• Member states should regularly and systematically collect comparable data on numbers of established posts, which have health workers in-place, by health worker category and, where appropriate, by specialty and level of seniority.

• Member States should keep up-to-date estimates of future health workforce needs, by health worker category and, where appropriate, by specialty, so as to establish and scale-up indigenous training programmes to become self-sufficient.

Discussion: Article 7.2 in the Draft COP asks Member States to establish and strengthen national data gathering efforts on health worker migration, its impact on health systems, and on human resources for health planning. The article as drafted however does not give guidance on what specific data is to be collected. To ease the burden on countries and also to better guide Member States the Council felt that specific guidance on the data to be collected should be provided. The recommended change reflects the Council's perspective on this issue.

Add sub-article emphasizing technical assistance and capacity building for developing countries in relation to this article.

Discussion: Numerous Council members spoke to the financial and capacity related burden and challenge for developing countries to put into practice the recommendations contained in articles 7 and 8. It was felt important that a provision for technical assistance and capacity building for developing countries in relation to the two articles be provided, as well as for demands on countries to be kept to a minimum.

Article 9

ARTICLE 9.1: Greater definition of WHO's responsibility as related to implementation.

Discussion: Many amongst the Council pointed to the fact that publication and international system for overseeing implementation of the Code of Practice is primarily the responsibility of WHO. As such it is felt that WHO's responsibility in relation to implementation of the Code of Practice should be more clearly articulated. A minority viewpoint within the Council believes that the term implementation should not be used in a non-binding instrument.

ARTICLE 9.2: Add "including administrative and management capacity to form and undertake bilateral agreements on the movement of health workers" after the word "level". Also instead of as appropriate for the code, state "to give effect to the articles of this code".

Discussion: This addition was suggested in order to respond to the limited capacity that many Member States have, as well as the reduced priority they give, to undertaking bilateral agreements related to the movement of health workers. This addition is important as encouraging and influencing the content of bilateral agreements is a major focus of the Draft COP. There are however some members who believe that bilateral agreements should not be so heavily relied upon. See in particular discussion related to article 5.2. There is another minority view within the Council that administrative and legal frameworks are not needed in the context of a voluntary code. There is a strong contrary view amongst many Council members that such frameworks are appropriate and to be encouraged.

ARTICLE 9.5: Add at the end of the sentence, "as well as of recruiters supplying health workers to their health system from other countries".

Discussion: This addition is recommended to extend monitoring of recruiters to those which provide destination countries with migrant health workers, a key focus of the Draft COP. There are present minority viewpoints that believe this is not appropriate as it would require governments to monitor private agencies and/or that the new wording should replace, not compliment, the existing wording as countries cannot be expected to monitor/regulate overseas agencies operating in their territory.

Add sub-article stating that the code "should be implemented with recognition of existing bilateral agreements and multi-lateral instruments, and in harmony with other developmental efforts".

Discussion: This language is proposed by Council members in order to reflect and build upon the variety of other international mechanisms that also touch upon the migration of health workers. Additionally, there is a strong sentiment amongst Council Members that the code of practice should be implemented in harmony with broader developmental efforts taking place. These include in particular the Paris Declaration on Aid Effectiveness and the Accra High Level Forum on Aid Effectiveness. It is to be noted that a minority view amongst the Council is not comfortable with the use of the term implementation with regard to a non-binding code.

Article 10

ARTICLE 10.1: Include "further reporting is to be conducted biannually" after the word "and" in the second sentence.

Discussion: There is a strong view within the Council that the time period of reporting should be defined in order to make certain that the code stays alive and is not shelved. The prevailing view of the Council is that reporting should be done on a biannual basis. The example of the International Code of Marketing of Breast Milk Substitutes was provided, which is monitored biannually by WHA and has remained relevant over the last twenty seven years. There however is a contrary view which felt that reporting should be conducted every five years, as conducting it more often might deflect scarce resources from other actions that could lead to improvements the Code was intended to encourage.

Add sub-article after 10.1, specifying the areas that should be monitored, including bullets one and two of modified section 7.2, in order to making certain that burdens placed on developing countries in particular are commensurate to benefits ensuing from the code. Greater clarity is needed on how WHO and other relevant stakeholders might help in easing this burden.

Discussion: The suggestion was made in order to reduce the burden of implementing the code, taking into particular consideration the practical difficulties for developing countries (some members suggested all countries should be considered). Many amongst the Council feet that WHO could

reduce the burden by specifying exactly the areas and data that need to be collected at the country level.

ARTICLE 10.2: Replace "provide periodic reports" with "provide biannual reports". Additionally, add "in achieving its stated objectives" after the words "effectiveness of the code".

Discussion: The Council feels that the periodicity of reporting should be defined, with two years suggested as the appropriate time frame for reporting. Again, there was a contrary view that reporting should only take place every five years due to the additional burden on countries, as well as WHO. Moreover, it is felt that an assessment of the effectiveness of the code be done with specific focus on the objectives of the code.

Article 11

ARTICLE 11.2: Include "and to support health system strengthening in developing countries, especially those affected negatively by out-migration of health workers" after "code" and delete phrase beginning "taking into consideration..".

Discussion: The recommended change is inserted to place specific focus on health systems, see discussion related to article 2.4, as well as to broaden the areas where technical and financial support might be provided so that it is not restricted to implementation of the Code.

APPENDICES

APPENDIX I

HEALTH WORKER MIGRATION GLOBAL POLICY ADVISORY COUNCIL

Sir George Alleyne
Chancellor, University of the West Indies
Director Emeritus
Pan American Health Organization/World Health Organization (PAHO/WHO)
United States of America

Dr. Tewodros Adhanom *(invited)*
Minister of Health
Ethiopia

Mr. Ibrahim Awad
Director, International Migration Program
International Labor Organization
Switzerland

Dr. Gladys Norley Ashitey *(invited)*
Deputy Minister of Health
Ghana

Dr. El Sheikh Badr
Director, State Affairs
Ministry of Health
Sudan

Dr. Titilola Banjoko
Managing Director
AfricaRecruit/FindaJobinAfrica.com
United Kingdom

Mr. David Bowen
Majority Health Policy Office,
Senator Edward M. Kennedy
Health, Education, Labor and Pensions Committee (HELP), United States Senate
United States of America

Prof. Ruairí Brugha
Head, Dept of Epidemiology and Public Health
Population Health Sciences Division
Royal College of Surgeons
Ireland

Dr. Lincoln Chen
President, China Medical Board
United States of America

Lord Nigel Crisp
Former Co-Chair, GHWA Task Force on Scaling up Education & Training
United Kingdom

Dr. Marc Danzon
Regional Director, World Health Organization
Regional Office for Europe
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Dr. Manuel Dayrit
Director, Human Resources for Health
World Health Organization
Switzerland

Hon. Dr. Nimal Siripala de Silva
Minister of Healthcare and Nutrition
Sri Lanka

Mr. Bjarne Garden
Senior Adviser, Global Health and AIDS
Department Norwegian Agency for Development
Cooperation - Norad
Norway

Senator Chuck Hagel (ret.)
Nebraska, Republican
United States Senate

Ms. Janet Hatcher-Roberts
Executive Director, Canadian Society
for International Health
Canada

Hon. Dr. Soccoh Kabia
Minister of Health
Sierra Leone

Ms. Huguette Labelle
Chair, Transparency International
Chancellor, University of Ottawa
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Hon. Eyitayo Lambo
Former Minister of Health
Nigeria

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Deputy Director-General of Human Resources,
Department of Health
South Africa

Dr. Anna Maslin
International Officer, Health Professions
Leadership Team
Department of Health
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Dr. Ernest Massiah
Head of Health, Commonwealth Secretariat
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Dr. A.J. Mohammad *(invited)*
Adviser on Health Affairs, Ministry of Health
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Dr. Davide Mosca
Director of Health, International Organization
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Switzerland

Dr. Anders Nordström
Director-General and Head
Swedish International Development
Cooperation Agency (Sida)
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Dr. Francis Omaswa (co-chair)
Executive Director, African Centre for Global
Health and Social Transformation (ACHEST)
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Hon. Major Courage Quarshie
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Hon. Mary Robinson (co-chair)
President, Realizing Rights
United States of America

Ms. Kelly Ryan
Deputy Assistant Secretary, Bureau of Population,
Refugees and Migration
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Mr. Peter Scherer
Counsellor to the Director, Directorate for Employment, Labor and Social Affairs
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Vice Director, Head of division of international affairs
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Chairperson Patricia Santo Tomas
Chair, Bank of the Phillipines
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Hon. Dr. Safiatou Thiam Sy *(invited)*
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Prof. Sheila Dinotshe Tlou
Member of Parliament
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APPENDIX II

HEALTH WORKER MIGRATION INITIATIVE GLOBAL POLICY ADVISORY COUNCIL MEETING

September 18- 19 2008 • Commonwealth Secretariat Headquarters • Marlborough House
Pall Mall, London SW1Y 5HX

Council Members in Attendance and/or Submitted Written Comments

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Lord Nigel Crisp
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Ministry of Health
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Former Minister of Health
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APPENDIX III

DRAFT FOR DISCUSSION

The WHO code of practice on the international recruitment of health personnel

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Article 1: Objectives of the code

The objectives of this code are to:

(a) establish and promote voluntary principles, standards and practices for the international recruitment of health personnel;

(b) serve as an instrument of reference to help Member States to establish or to improve the legal and institutional framework required for the international recruitment of health personnel and in the formulation and implementation of appropriate measures;

(c) provide guidance that may be used where appropriate in the formulation and implementation of bilateral agreements and other international legal instruments, both binding and voluntary; and

(d) facilitate and promote international discussion and advance cooperation on matters related to the international recruitment of health personnel.

Article 2: Nature and scope of the code

2.1 The code is voluntary. Member States and other stakeholders are strongly encouraged to comply with the code.

2.2 The code is global in scope and is directed toward Member States, Associate Members of WHO, health workers, recruiters, employers, health professional organizations, relevant sub regional, regional and global organizations, whether governmental or non-governmental, and all persons concerned with the international recruitment of health personnel.

2.3 The code applies to all health workers, including all people engaged in actions in the public and private sectors whose primary intent is to enhance health, and covers those working on a temporary, locum or permanent basis.

2.4 The code provides principles applicable to the international recruitment of health personnel in a manner that promotes an equitable balance of interests among health workers, source countries and destination countries.

Article 3: Guiding principles

3.1 Addressing present and anticipated shortages in the health workforce is of critical importance to protecting global health. International recruitment can make a legitimate contribution to the development and strengthening of a national health workforce. However, the development of voluntary international standards and the coordination of national policies on international health worker recruitment are desirable in order to maximize the benefits to and mitigate the potential negative impact on countries and to safeguard the rights of health workers.

3.2 All Member States have the sovereign right to develop and strengthen their health systems in order to progressively achieve full realization of the right of everyone to the enjoyment of the highest attainable standard of health.

3.3 Nothing in this code should be interpreted as impinging on the rights of health workers to migrate to countries that wish to admit and employ them.

3.4 International recruitment of health personnel should be conducted in accordance with the principles of transparency, fairness and mutuality of benefits.

3.5 Member States, in conformity with national legislation and applicable international legal instruments to which they are a party, should promote and respect fair labour practices for all health personnel. In all terms of employment and conditions of work, migrant health personnel should enjoy the same legal rights and responsibilities as the domestically trained health workforce, without discrimination.

3.6 Member States should work towards establishing effective health workforce planning that will reduce their need to recruit migrant health personnel. Policies and measures to develop the health workforce should be appropriate for the specific conditions of each country and should be integrated with national development programmes.

3.7 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 and/or have limited capacity to implement the recommendations of this code, should be considered.

3.8 Effective national and international data gathering, research and information sharing are essential to achieve the objectives of this code.

3.9 All aspects of the employment and treatment of migrant health workers should be without distinction of any kind, such as to race, color, gender, religion, age, economic position, marital status, nationality, or national, ethnic or social origin.

3.10 Member States, health workers, recruiters, employers, health professional organizations, relevant sub-regional, regional and international organizations, whether governmental or non-governmental, and all persons concerned with the international recruitment of health personnel should collaborate in the fulfillment and implementation of the objectives contained in this code for the benefit of present and future generations in all countries.

Article 4: Recruitment practices

4.1 Member States and other stakeholders should recognize that ethical international recruitment practices provide health workers with the opportunity to assess the benefits and risks associated with employment positions and to make timely and informed decisions. In accordance with the principle of fairness, ethical recruitment practices should also promote equality of treatment of migrant health workers with the domestically trained health workforce by ensuring that migrant health workers are not subjected to improper or fraudulent conduct.

4.2 Member States should ensure that, subject to national laws and relevant international agreements to which they are a party, migrant health workers enjoy the same legal rights and responsibilities as the domestically trained health workforce in all terms of employment and conditions of work.

4.3 Member States should ensure that recruiters and employers provide migrant health workers with relevant and accurate disclosure about any health worker position that they are offered.

4.4 Member States should ensure that recruiters and employers observe fair contractual practices in the employment of migrant health workers.

4.5 Migrant health workers should enjoy opportunities for employment commensurate with their level of education, experience and competence on the basis of equality of treatment with the domestically trained health workforce.

4.6 Migrant health workers should be hired, promoted and remunerated based on objective criteria such as levels of qualification, years of experience and degrees of professional responsibility on the basis of equality of treatment with the domestically trained health workforce.

4.7 Measures should be taken to ensure that migrant health workers enjoy opportunities and incentives to improve their professional education, qualifications and status on the basis of equality of treatment with the domestically trained health workforce.

4.8 Member States should, to the extent possible, regulate and monitor recruiters and employers to ensure that the services performed by recruiters and employers in connection with the recruitment and placement of migrant health workers are rendered free of charge to health workers.

4.9 All migrant health workers should be offered appropriate induction and orientation programs that enable them to operate safely and effectively within the health system of the destination country.

Article 5: Mutuality of benefits

5.1 In accordance with the principle of mutuality of benefits, both source and destination countries should derive benefits from international recruitment of health personnel.

5.2 Member States are strongly urged to enter into bilateral and multilateral agreements that comply with this code to promote international cooperation and coordination on migrant health worker recruitment processes. Such agreements should maximize the benefits and mitigate the potential negative impact of international recruitment of health workers through the adoption of appropriate measures. Such measures may include the provision of targeted technical and developmental assistance, access to specialized training, technology and skills transfers, and the support of return migration, whether temporary or permanent.

5.3 Member States should recognize the value both to their health systems and to health workers themselves of professional exchanges between countries and of opportunities to work abroad. Member States in both source and destination countries should encourage and support health workers to utilize work experience gained abroad for the benefit of their home country.

Article 6: National health workforce sustainability

6.1 As the health workforce is central to sustainable health systems, Member States should take effective measures to train, retain and sustain a health workforce that is appropriate for the specific conditions of each country, including areas of greatest need, and is built upon an evidence-based health workforce plan.

6.2 Member States should recognize that improving the social and economic status of health personnel, their living and working conditions, their opportunities for employment and their career prospects is an important means of overcoming existing shortages and improving retention of a skilled health workforce. Member States should adopt a multisectorial approach to addressing these issues in national development programmes.

Article 7: Data gathering and research

7.1 Member States should recognize that the development of an effective health workforce policy requires a sound evidence-base.

7.2 Member States should establish or strengthen, as appropriate, programmes for national data gathering on health worker migration and its impact on health systems. Member States should collect and analyze data that are required to support effective health workforce human resource policies and planning.

7.3 Member States should establish or strengthen, as appropriate, national research programmes in the field of health worker migration and coordinate such research programmes through partnerships at the regional and international levels. Towards this end, Member States should ensure that appropriate research is conducted into all aspects of international recruitment of health personnel.

7.4 Member States should ensure that comparable data are generated, collected and reported pursuant to Articles [7.2] and [7.3] for ongoing monitoring, analysis and policy formulation. Towards this end, WHO should develop appropriate guidelines to support implementation of this Article.

Article 8: Information exchange

8.1 Member States should, as appropriate and subject to national law, promote the establishment or strengthening of information exchange on international health worker migration and health systems, nationally and internationally, through national institutions, academic and research institutions, health professional organizations, and sub regional, regional and international organizations, whether governmental or non-governmental.

8.2 In order to promote and facilitate the exchange of information that is relevant to this code, each Member State should:

(a) progressively establish and maintain an updated database of laws and regulations related to health personnel recruitment and migration and, as appropriate, information about their implementation;
(b) progressively establish and maintain updated data from national data gathering programmes in accordance with Article [7.2]; and

(c) provide data collected pursuant to paragraphs (a) and (b) of Article [8.2] to WHO on a biennial basis.

8.3 For purposes of international communication, each Member State should designate a national authority responsible for the exchange of information regarding health worker migration and the code. The designated national authority should be authorized to communicate directly or, as provided by national law or regulation, with designated national authorities of other Member States and with WHO and other regional and international organizations concerned, and to submit reports and other information to WHO pursuant to Articles [8.2(c)] and [10.1].

8.4 A register of designated national authorities pursuant to Article [8.3] should be established, maintained and published by WHO.

Article 9: Implementation of the code

9.1 The code should be published and implemented by Member States in collaboration with health workers, recruiters, employers, health professional organizations, sub regional, regional, and international organizations, whether governmental or non-governmental, and other interested stakeholders.

9.2 Member States should establish and maintain an effective legal and administrative framework at the local and national level, as appropriate, for the code.

9.3 Member States should ensure that representatives of health professional organizations, recruiters, employers, non-governmental organizations and other stakeholders are consulted in decision-making processes and involved in other activities related to the international recruitment of health personnel.

9.4 All stakeholders should understand their shared responsibilities to work individually and collectively to ensure that the objectives of this code are achieved. All stakeholders should observe this code, irrespective of the capacity of others to observe the code. Recruiters and employers should cooperate fully in the observance of the code and promote the principles expressed by the code, irrespective of a Member State's ability to implement the code.

9.5 Member States should, to the extent possible, maintain a record, updated at regular intervals, of all recruiters authorized by competent authorities to operate within their jurisdiction.

Article 10: Monitoring and institutional arrangements

10.1 Member States should periodically report, as appropriate, to other Member States, through WHO, on measures taken, on results achieved and on difficulties encountered in implementing this code. The initial report should be made within two years after the adoption of this code by the World Health Assembly and the periodicity of reporting thereafter should be decided by WHA. The purpose of the monitoring process is to identify challenges and successes in implementing the code and to assist countries in building capacity to implement the code.

10.2 The Director General of WHO should keep under review the implementation of this code, on the basis of periodic reports received from designated national authorities and other competent sources and provide periodic reports to the World Health Assembly on the effectiveness of the code and suggestions for its improvement.

10.3 WHO should:

(a) coordinate the information exchange system and the network of designated national authorities specified in Article [8];

(b) develop guidelines and make recommendations on practices and procedures and such joint programmes and measures as specified by the code or as may be required to make the code effective; and

(c) maintain liaison with the United Nations, the International Labour Organization, the International Organization for Migration, and other competent regional and international organizations as well as concerned non-governmental organizations to support implementation of the code.

10.4 Non-governmental organizations and other interested stakeholders are invited to report their observations on activities related to the implementation of the code to WHO.

10.5 The World Health Assembly should periodically review the relevance and effectiveness of the code. The code should be considered a dynamic text that must be brought up to date as required.

Article 11: Partnerships, technical collaboration and financial support

11.1 Member States and other stakeholders should collaborate directly or through competent international bodies to strengthen their capacity to implement the objectives of the code, taking into account the needs of developing countries and countries with economies in transition.

11.2 International donor agencies and financial institutions should increase their technical and financial support to assist the implementation of this code, taking into consideration the needs of developing states and countries with economies in transition that are experiencing health workforce shortages and/or have limited capacity to implement the objectives of this code.

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