

HUMAN RESOURCES FOR HEALTH: THE WHO CODE OF PRACTICE ON THE INTERNATIONAL RECRUITMENT OF HEALTH PERSONNEL

This fact sheet gives information on the World Health Organization's Code of Practice on the International Recruitment of Health Personnel (WHO Code).

In May 2018, WHO Member States will **report for the third time on their efforts to ensure fair international recruitment and employment of health personnel**. They have committed to these reports when they adopted the WHO Code at the World Health Assembly of 2010. The third round of reporting is an excellent **opportunity for civil society organizations** to hold their governments accountable and to submit their own reports on Code-related efforts.

Background

More and more health workers are migrating internationally. In OECD countries¹, the number of migrant doctors and nurses has increased by 60% in ten years. Health workers from low- and middle-income countries (LMIC) look for better working conditions and career opportunities abroad, as in their country there are often not enough job opportunities, and working conditions are difficult or unattractive.

This brain drain leads to more inequality between countries. Low- and middle-income countries invest in training health workers to meet the need of their population, but lose them to countries with better employment opportunities and prospects. The so-called destination countries welcome those health workers to cover their own health worker shortages and, that way, secure better health coverage for their own population.

An international agreement is needed to control this mobility. Otherwise universal health coverage – healthcare to everyone everywhere – will not be realized. Strong calls for joint measures to address the

international recruitment of health personnel finally led to the adoption of the Code in 2010.

Use and restrictions

The Code is considered an important instrument to **raise awareness** on the ethical aspects of active international recruitment efforts and to **stimulate national actions** to invest in countries' own health workforce development. The Code also has its drawbacks. It is a **voluntary instrument** and not a binding agreement, so there are no repercussions for non-adherence. Also, despite in-depth discussions on the topic, the issue of compensation for source countries, to make up for the loss of their health workers, has not been integrated into the Code.

Nevertheless, implementation of the Code has provided a **better understanding** of health worker migration. South-North movement of health workers has been a main concern, but there is now also better understanding of the substantial intra-regional, South-South and North-South movement of health workers. Temporary migration, including professional registration and employment in multiple countries, is also evidenced. For example, over 50% of emigrant general practitioners from Uganda (2010-2015) are estimated to have moved within Africa, primarily to Southern and Eastern Africa with Namibia and Kenya as leading destinations. And almost one third of general practitioners who registered in Uganda (2010-2015) were trained and held nationality in Europe or North America².

¹ A list of OECD countries is to be found on the [OECD website](#)

² [A dynamic understanding of health worker migration](#). WHO, 2017

The Code

Health workforce development and health system sustainability are at the core of the document. The Code provides a detailed account of how countries should practice fair international recruitment and employment. It provides a set of ethical principles and practices. It also describes how countries can develop their own sustainable health workforce and implement the Code. It emphasizes, however, the freedom of health personnel to migrate to countries that wish to admit and employ them.

Key elements:

- ▶ Urges all WHO member states to **create a home grown sustainable health workforce** (through adequate planning, training, and retention strategies), discouraging active recruitment from countries with critical health workforce shortages;
- ▶ Encourages member states to facilitate **circular migration**, so that skills and knowledge can be acquired to the benefit of both source and destination countries;
- ▶ Calls for international recruitment to be **transparent**, and in respect of **fair labour practices** for all health personnel;
- ▶ Calls upon high-income countries to **provide technical and financial assistance for strengthening** of health systems, to low-income or transition countries particularly vulnerable to health personnel shortages and/or with limited capacity to implement the Code.

The implementation includes stakeholder consultations, and it also means that WHO member states keep record of international recruitment, gather data, conduct research and share information. Next to this, the countries are supposed to report on progress every three years. WHO provides technical and financial support to the process. The Member States should appoint a so-called Designated National Authority (DNA) as a dedicated point of contact in their country.

Reporting on implementation

To monitor the progress in implementing the Code, and to facilitate information exchange on issues related to health personnel and health systems in the context of health worker mobility, member states agreed to report every three years on the measures they have taken.

A national self-assessment tool was created and used for the **first round of reporting in 2012-2013**. At that time, 85 countries had appointed a DNA, and 56 countries had completed and submitted a report. The majority of these were European countries, while 13 African countries had appointed a DNA and 2 of these had reported.

For the **second round of reporting in 2015-2016**, the [National Reporting Instrument](#) was extended to also cover all 10 articles of the Code, and to allow for reporting on the current stock and inflow (by country of first training) of foreign-trained doctors and nurses³. Importantly, an **Independent Stakeholders Reporting instrument** was added to facilitate contribution from relevant stakeholders and to enrich knowledge on the Code's implementation. This time, a total of 74 countries reported fully, amongst which 9 African countries (including Uganda). According to WHO, the vast majority of countries that had submitted reports were those that are the known source and destination countries for the international migration of health personnel.⁴

Preparing for the next round of reporting

Governments and Ministries of Health were approached by WHO Secretariat in May 2018 to start reporting on the third three-year period since the adoption of the Code. The WHO Secretariat will report the findings to the 72nd World Health Assembly in May 2019. **This provides an appropriate window of opportunity for civil society organizations to join hands in-country** and, if possible, at a regional level, and **push governments to take measures** in the spirit and letter of the Code, and to report on their progress adequately. In order to be able to do so, civil society organizations need to acquire a solid understanding of the state of affairs in their country. The reporting format should provide a clear and useful checklist to address all the relevant issues with your government officials.

Next to this, stakeholders will be called upon to contribute their views on the issues regarding health worker migration, and wider issues of development and retention, which in many countries need urgent attention and action.

³ Capturing immigration data is easier and more reliable than emigration data.

⁴ The national reports submitted to the NRI 2015 can be consulted in the [National Reporting Instrument \(NRI\) reports database](#). For the status of the implementation see this [WHO infographic](#).