



European Regional Consultation on the Draft WHO Code of Practice

Report
Geneva, Switzerland, 8 December 2009

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Introduction

World Health Assembly resolutions WHA57.19 and WHA58.17 requested the Director-General to develop, in consultation with Member States and all relevant partners, a global code of practice that provides principles and guidelines for international cooperation concerning the international recruitment of health personnel. The initial draft Code prepared by the WHO Secretariat in 2008 provided a platform for discussions. The Executive Board at its 124th session (EB124) in January 2009 noted the progress with drafting of the Code and suggested that the Regional Committee sessions in 2009 be used to enhance regional consultations with Member States on the subject, with a view to providing feedback to EB126 (January 2010).

The discussion at the fifty-ninth session of the Regional Committee for Europe in September 2009 highlighted the consequences of the financial crisis on labour markets and the need to mitigate the negative effects of migration on health systems in developing countries and “to ensure equitable access to health care services while minimizing the need to rely on the immigration of health personnel from other countries”. The resolution (EUR/RC59/R4) adopted by the Regional Committee urges Member States “to increase their efforts to develop and implement sustainable health workforce policies, strategies and plans as a critical component of health systems strengthening” and “to advocate the adoption of a global code of practice on the international recruitment of health personnel in line with the European values of solidarity, equity and participation, both within the WHO European Region and globally”.

Taking stock of the deliberations, input and resolutions of the six Regional Committees, the WHO Secretariat has revised and submitted the draft Code of Practice to the EB126 for further consideration, with a view to submitting a final draft to the Sixty-third World Health Assembly (WHA63) in May 2010 for final consideration and approval.

In compliance with the mandate given by the Regional Committee, the WHO Regional Office for Europe has continued the consultation process on the draft code leading up to EB126. This open consultation meeting on the revised draft Global Code of Practice that will be submitted to EB126 was convened by the Regional Office for European Member States and relevant partners. The meeting was held at the WHO Headquarters in Geneva, Switzerland, 8 December 2009. There were more than 60 participants from European countries (both from Permanent missions to the UN office in Geneva and/or from Ministries of Health), WHO Regional Office for Europe, Human Resources for Health Department WHO/HQ, and observers from WHO Regional Offices in Africa and Americas, Global Health Workforce Alliance, Health Worker Migration Global Policy Advisory Council.

Objectives of the meeting

The overall objective of the meeting was to seek the views of European Member States and relevant partners on the content of the revised draft Global Code of Practice on the international recruitment of health personnel submitted by the Secretariat to EB126.

Specific objectives:

- to update Member States on the progress made to date with preparation of the Global Code of Practice;
- to review the revised draft Global Code of Practice, map out the viewpoints of Member States and relevant partners on the content of the code, and highlight divergent views (if any); and
- to improve understanding and seek consensus, as appropriate, on the key issues.

Session I – Global Code of Practice: The Process

Chair of the meeting – Dr Bjørn-Inge Larsen, Executive President of the fifty-ninth session of the Regional Committee for Europe, Norway; Moderator – Professor Gilles Dussault, the Institute of Hygiene and Tropical Medicine, Lisbon, Portugal.

The meeting was opened by Dr Bjørn-Inge Larsen and on behalf of the WHO Regional Office for Europe, Dr Enis Barış, Director of the Division of Country Health Systems. The session started with the introduction to the consultation by moderator Professor Gilles Dussault on the mobility of health professionals in Europe.

Professor Dussault reminded participants that mobility is a human right as defined by Article 13 of the Universal Declaration of Human Rights and guaranteed in the European Union since 1968. He noted that health workers have the same right to mobility as all other workers. He added that while mobility has many positive facets such as remittances and personal professional improvement, it is not without potentially adverse impact on source countries' capacity to maintain effective health services and on host countries, which can become dependent on external human resources. He said health worker migration is an indicator of the efficiency of the labour market that varies according to patterns of education, retirement and attrition, emigration and immigration. Over the past decade there has been growing recognition that the cost of migration can often outweigh the benefits for source countries and make access to health services difficult. The loss of expertise coupled with low investment in health means that working conditions deteriorate and the workloads on those who stay become higher.

In looking at the response to the problem, Professor Dussault cited some of the steps that have been initiated in various countries in the European region, such as the scale-up of health workforce production (UK and Norway), retention improvements (generally based on financial incentives) and the introduction of “management” of flows of health workers. He emphasized that most of European countries have yet to develop a health workforce strategy and he concluded by saying that the Global Code that is being developed is considered a part of the effort to solve these problems.

Dr Khaled Bessaoud, Regional Advisor in the WHO Regional office for Africa outlined some realities of health systems within the African region and noted that the density of health personnel in the African region is the lowest in the world, with an average of 1.08 doctors, nurses, and midwives per 1000 people. The problem is even more complex he explained, because of the variability between countries. Not only have major urban – rural differences emerged, but there are also major differences between countries. For example, in Ghana the

dramatic shortage of physicians has made paramedics and nurses all the more important, while in Ethiopia, nurses are in short supply.

Dr Bessaoud went on to say that the shortages that are now being encountered will not be rectifiable based on current levels of production because the supply of health workers will not keep up with demand. The most important problem in Africa is the lack of investment in education and the fact that there are too few nursing and medical schools, little investment in students, and few, if any, national policies on education. Africa is producing only 10–30% of the health workers it requires, and even where trained workers are available, there may not be any jobs for them. He gave the example of how in Mozambique, newly graduated nurses can wait an average of 4 years to find a position despite a pressing need for nursing staff, and said he believed this shortcoming is due to the lack of strategic planning and investment on the part of governments. He highlighted the fact that less than 10 countries in Africa have committed themselves specifically to making their health budget a priority and said that without the political will and vested interest by governments in the implementation of foundational work, it will remain impossible to create good policies and programmes.

Dr Bessaoud urged participants to recognize that in order to fully understand and visualize a code in the context of these countries, their national policies on health worker training, recruitment and retention must also be addressed. Far more priority should be given in this regard to resource allocation, scale-up and retention of trained workers – especially in rural and remote areas – together with the strengthening of regulatory frameworks and the development and investment of integrated health education and training programmes (including continuing education).

Dr Bessaoud thinks that the voluntary (noncompulsory) aspect of the proposed code would hinder accountability, and that issues of intercountry compensation and/or reciprocity were not well addressed. It was not clear how the code would ensure an adequate return on the investment developing countries have made and make in training health workers. Many African countries find it difficult to see equitable benefits between source and destination countries and emphasis on the rights and support of migrant health workers did nothing to highlight the negative impacts of emigration on source countries. He hopes that the code would become an effective global response to health worker migration and help level the playing field between states.

Dr Mubashar Sheikh, Executive Director of the Global Health Workforce Alliance (GHWA) said it was very important to have a good understanding of the global implications of the proposed code, namely its role in ensuring universal access to health care services – not just in terms of achieving health-related MDGs – but also in terms of equity and solidarity. He stressed it was necessary to highlight the true global nature of the crisis the code responds to, and pointed out that 30% of doctors and nurses in the USA are foreign trained, as are a large percentage of those in Western Europe. The ethical and moral questions raised by the fact that, at the same time, people are dying in the source countries due to health worker and investment shortages are huge and must be addressed. Dr Sheikh noted that while the right to move is not in doubt and should not be restricted, there is still a moral issue surrounding the right to health care and he asked why countries in rich regions are not able to produce more medical personnel than poor countries with large populations, and went on to say that much more attention must be given to the infrastructures that would allow health workers to better serve their own communities and strengthening retention possibilities. He concluded by stating that the concerns of both sending and receiving countries can only be understood and

addressed by working together through bilateral agreements that help develop health systems to become more effective in providing universal access to healthcare services. He said that these challenges would grow after the Code is approved and ways must be found to improve the Code's contents and the work taking place in the field.

Dr Manuel Dayrit, Director of HRH Department in WHO headquarters, highlighted the key milestones that have been achieved since 2004, including the various reports to the EB and WHAs: the various consultations including those in Kampala at the First Global Forum on Human Resources for Health organized by GHWA in 2008 and of course the six Regional Committees that have led to the revised draft Code. He said that we all have a better understanding of the complexity of the issue, the constructive tone of the discussions seeking common solutions, and the high level calls to address health workforce issues. The July 2009 G8 statement called for action: "to address both the "pull" and "push" factors related to the international migration of health workers and encourage the ongoing process to finalize the Code of Practice on the International Recruitment of Health Personnel."

Dr Dayrit noted that the deliberations of all six Regional Committees had been used in revising the draft Code, and there were three Regional Committees (African, European, and Eastern Mediterranean) which passed resolutions in support of the finalization of the code. In summarizing the outcomes of the Regional Committees, Dr Dayrit said that the Regional Committee for Africa acknowledged "the importance of the draft code of practice for the international recruitment of health personnel" and requested the Regional Director "to report on progress on the finalization of the code at the global level, taking into account the concerns of the African Region, at the sixtieth session of the WHO Regional Committee for Africa..." next year. The Resolution adopted by the Regional Committee for the Eastern Mediterranean "urges Member States to give full support to the development, adoption, and comprehensive implementation of the provisions of a voluntary WHO code of practice..." In the South-East Asia Region, the high-level preparatory meetings for the Regional Committee included discussions on a code of practice and scheduled two meetings of its Member States in order to forge regional consensus (December 2009 and April 2010). The Western Pacific Region had pointed out that the Code could serve as a starting point towards more discussions on how national health workforce profiles in the region could be improved. Member States in the Region of Americas had "expressed a consensus view that the draft code represented only one strategy within a spectrum of interventions to deal with health workforce issues". The European Region had passed a resolution advocating for the adoption of a Global Code of Practice on the international recruitment of health personnel that would be in line with the European values of solidarity, equity and participation, both within the WHO European Region and globally".

Dr Dayrit then outlined the advantages of the WHO Code of Practice and said it is the only global framework for international cooperation on health workforce recruitment in existence and offered an opportunity for a continuous global dialogue on the issue. It would also provide a reference and guide for Member States in terms of internationally accepted principles on health worker migration and recruitment and would permit the identification of mechanisms for data collection and information exchanges that could go on to inform policies. He referred to the Code as a matter of global security and stressed that wherever there is a weak health system there is a weak link in our global security against disease.

He concluded by explaining that there is no draft resolution to accompany the progress report by the Secretariat with the revised draft Code submitted to the EB126, but it will be prepared

if and when the EB decided to address the World Health Assembly. He also mentioned the current work being done by WHO Headquarters, Regional Offices and other partners producing the global recommendations on increasing access to health workers in remote and rural areas through improved retention, which will be able to be used as a companion document to the Code, and which will be available for viewing in draft form in time for the next World Health Assembly.

Dr Enis Barış, Director, Division of Country Health Systems in the Regional Office for Europe, explained that the process of developing the draft code was accomplished through close partnership between HRH Department at WHO/HQ and the Regional Offices, Member States and relevant partners. He referred to the discussions on health workforce policies in Europe, including a global code of practice, and two recent Regional Committees (2007, 2009). Dr Barış explained that the European Regional Office initiated a policy dialogue between source and destination countries and convened a number of meetings and consultations on migration of health workers and a global code of practice for the international recruitment with Member States, health professional organisations and stakeholders. He explained that European Member States had also been invited to advocate for global standards. He went on to outline how the issue gained even more importance in the face of the global economic crisis and that because of this the European region put out a series of recommendations in 2009 to Member States to ensure that ethical principles would be respected in the migration and recruitment of health professionals. Dr Barış referred to the Tallinn Charter signed by all 53 Member States of the WHO European Region which emphasizes the importance of investing in health systems as a means of investing in the health and well-being of Member States. He concluded by stating that the work done by the European Region was carried out in close alliance and cooperation with the Global Health Workforce Alliance, regional partners, and with the help of other WHO Regional offices.

Mrs Peggy Clark, Director of the Health Worker Migration Global Policy Advisory Council stressed the importance of consultations and discussions on the draft document. This code of practice, when implemented, would only be the second voluntary global Code in the history of the WHO. She noted that the WHO has promulgated only three international legal instruments in its history: The WHO Framework Convention on Tobacco Control (legally binding international treaty), The International Health Regulations (legally binding international treaty) and The International Code on Marketing of Breast-milk Substitutes (not-binding). Mrs Clark stressed the fact that this issue will continue to touch everyone for decades to come and noted that although the Council acknowledged this latest version of the Code had been significantly improved, there were still a number of issues to be discussed and safeguarded.

She stated that the draft code now contains a central focus on the WHA resolution (2004) that called for its creation by highlighting the mitigation of the effects of migration on developing countries and that the new revised version more effectively discusses global imbalance, the right to migrate, and the right to health. Some themes still require closer examination, especially with respect to defining inconsistencies and this highlights the need for a glossary of definitions. She felt that while the code does a good job of discussing how to mitigate the negative effects of health worker migration in the source countries, it still does not speak enough to destination countries about why they should participate, reflecting the adage: 'weak health systems anywhere are weak health systems everywhere'. She explained the importance of the code to entice countries to discuss more openly how to maintain a steady supply of trained health workers and she indicated that one major change from previous versions of the

code was the reference to sustainability versus self-sufficiency. However, the language intimates that Member States should strive to meet their own health worker needs, and implies that they should not depend upon other countries for their health care workforce. This, she said, is at present impossible for countries such as the United States and Norway to comply with and Mrs. Clark said it is important that the code be written in a manner that cannot be interpreted as suggesting that there should not be a migration of health workers.

Session 2 – Global Code of Practice: The Content

2.1 General comments

Professor Dussault invited comments and views from the participants. Clarification was added that consensual views were not being solicited, but that the resulting views could be mapped into a report available to all Member States.

Sweden, speaking on behalf of the European Union, welcomed the revised draft code and stated that the shortage of health workers is a pressing problem in many countries, particularly the poorest countries in the global community. The EU remains committed to work with the WHO and Member States towards a common global solution, including the WHO global code of practice for the international recruitment of health personnel. They stated that their remarks on the revised draft code were only preliminary as they had only recently received the revised draft and had little time to study the text in-depth. They welcomed the voluntary nature of the code, and appreciated the addition of the preamble to the revised draft code because it is a good introduction to the context of the issue.

Norway expressed gratitude to the Secretariat for the preparation of the revised draft code and the European Regional Office for organizing the consultation meeting. Norway stated that the revised code was a clear improvement compared to earlier drafts. The Norwegian government is committed to abstaining from active recruitment of health workers from developing countries by focusing instead on domestic measures to increase the capacity of health personnel. Norway especially respected the better balancing of rights and obligations in the text, and between positive and negative effects of migration, namely referring to the national recruitment policies in developing countries and more targeted actions aimed at health system improvement and development of educational capacities in countries with health workforce shortages. Norway will continue supporting bilateral and multilateral efforts to health system development, including the development of increased educational capacity in countries with health workforce shortages.

Hungary also congratulated the Secretariat on the outcome of the newly revised draft, which is they think is a great improvement. Hungary supported the statements made by Sweden on behalf of the EU and stressed the urgency of adopting this code, especially during this time of economic crisis. It is important to avoid further delays, and that the three pillars in the guiding principles in the code, namely the right of health personnel to migrate, the creation of sustainable health systems, and the implementation of transparent and balanced regulations to control recruitment were properly balanced. Hungary also highlighted the problem of data collection, stating that many of the processes are as yet hidden or untapped, and stressed that in order to really improve health systems, careful data collection and research on human resources would be necessary. Hungary also supported the principle of circular migration, which requires better focus in the draft text. The issue of financial incentives for health

worker migration, both in source and destination countries, needs better clarification and requires tools to regulate the process. In conclusion, he highlighted that the biggest challenge would be to develop strategies and mechanisms to implement the code such that is understood and accepted, not just by Member States, but by nongovernmental organizations as well.

France added its support to the WHO initiative, agreeing with other representatives that it has been greatly improved, citing in particular the addition of a preamble reflecting the main challenges as well as the addition of reference to ethical principles, the emphasis put on the balance between the right to the best possible health care and the need for solidarity and equity; as well as the accent placed on the need to implement national health workforce policies such as training of health personnel, retention issues, equitable distribution of health personnel and efforts to provide continuing education. France considers that Article 6 is providing relevant proposal for action in these areas. On a general basis, France added that further clarifications were still needed on some paragraphs.

Switzerland stated that while the draft was an improvement, the wording of the code left much to be desired and felt the title no longer adequately reflected the draft in question, arguing that the draft code had gone well beyond just the concept of recruitment. Switzerland considered the terminology confusing and was concerned about the stress placed on national policies, explaining that in Switzerland, because of its confederated governance structure, national policies do not exist, as in some other countries. The drafting should therefore better encompass the national specificities of all Member States. There was also concern about the lack of reference to the private sector, and desire for more clarification on the subject of sustainability.

Monaco welcomed the revised draft with many improvements including the addition of the preamble. Monaco nevertheless voiced concern about some ambiguity in the draft that needed to be resolved, especially in terms of health workforce self-sufficiency, and stated that this goal would not be achievable in Monaco.

Spain agreed that the new draft code was an improvement, but shared the concern expressed by Switzerland on the title of the document, arguing that it was confusing (although this might be a result of language). Spain emphasized that the new preamble was a definite progress and was well balanced although it did not fully encompass the reasons why people migrate, citing the movement of many health professionals due to their desire for specialization. It is important to fully recognise the complexity of health worker migration and the need for equal treatment. Spain supported the statement by Switzerland with regard to the lack of reference to the private sector, as this is the major employer in the country.

2.2 Review of Articles

Mrs. Peggy Clark facilitated this discussion and presented a comparative analysis between the previous and current drafts, beginning with the Preamble, and subsequently reviewing each of the articles. Participants were asked to give comments as they saw fit.

Preamble: The preamble was not present in the previous draft code presented at the 124th Executive Board. It appropriately sets the vision for the WHO Code of Practice. There is a key change in the revised draft code focussing on mitigating the negative effects of the international migration of health personnel on health systems in source or developing

countries. The language of the preamble is strong and responsive to the WHA resolutions that call for the development of a WHO Code of Practice in the first place.

Switzerland suggested the title refer to migration instead of recruitment, as this better reflects the scope of the code. There were several requests for clarification on the meaning of terms, e.g., ‘managing migration flows’, and ‘accessible’ health workforce, leading to the suggestion of a glossary. This was supported by Monaco and Sweden.

Article 1: Objectives. The code aims to set voluntary principles, standards and practices for the ethical international recruitment of health personnel. The broader purpose behind the objectives is articulated to place the interests of developing country health systems/populations at the heart of the code, and to speak not simply of rights but also responsibilities of all stakeholders (governments of source and destination countries, public and private sector, organizations and individuals, etc.)

Sweden, speaking on behalf of the EU, stated that the main aim is to adopt a code that strikes a balance between providing good accessible health care for all, and the right of individuals to migrate. Nothing in the code should limit the freedom of health workers to migrate for opportunities in other countries, but there are still extensive consequences in the countries of origin because of the lack of skilled health personnel. The EU acknowledges the importance of the compromise to be achieved between source and destination countries.

Article 2: Nature and scope. This section remains largely unchanged from the previous draft. The code is voluntary and its nature is framed in the context of strengthening health systems in developing countries and promotes an equitable balance of interests among source countries, destination countries and health personnel.

Switzerland pointed out the reference to the private sector, and went on to express concern about the term ‘ethical principles’ arguing that the code would lose substance in negotiations causing the ethical principles to be trimmed down to a great extent. It was suggested to focus instead on the code’s content and not be too broad on substance.

France asked for clarification on Article 2 saying that this section directly concerned health personnel but was not clear as to how or if it would apply to individual health workers and other, non-health related organizations.

Article 3: Guiding principles. This section now includes the expansion of focus from migrant health workers to encompass the right to the enjoyment of the highest attainable standard of health and strengthened health systems. Some of the main changes include: 3.1 which now refers to the international migration of health personnel and strengthening the international health workforce; 3.2 which points out to the sovereign right and responsibility of Member States to strengthen health systems; 3.3 which deals with providing technical and financial support to health and development in developing countries, including offsetting the loss of health workers and the commitment to strengthening health systems. Member States are encouraged to create a sustainable health workforce and work towards establishing effective health workforce planning, production and retention strategies that will reduce their need to recruit migrant health personnel. The term sustainable is used instead of striving towards a self-sufficient health workforce. Special consideration is not extended to economies in transition that are particularly vulnerable to health workforce shortages and/or have limited capacity to implement the recommendations of the code. Destination countries are called to

support health system strengthening in developing countries and countries with economies in transition.

Switzerland raised the point here that 3.4 said basically the same thing as the preamble, and either should be redrafted or deleted entirely. Concern was also expressed over the clarity of 3.6 and asked for it to be reworded.

Article 4: Migrant health personnel: responsibilities, rights, and recruitment practices.

This section has a new title, which is now directed not solely at Member States, but broadening the scope to health personnel, health professional organizations, employers and recruiters. Items 4.1 and 4.2 are entirely new and emphasize the need for legal cooperation between all parties and especially destination countries should be aware of and respect the legal responsibilities of health workers to their countries of origin.

Spain and the Former Yugoslav Republic of Macedonia expressed confusion over parts of 4.2 and asked for clarification regarding the term *recruiters* and *fair and reasonable contract of service*.

Switzerland and Monaco expressed concern regarding the ability of recruiters to check the individual's *outstanding legal responsibility to the health system*. Switzerland supported the previously mentioned concerns regarding the term *fair and reasonable contract of service*. With reference to point 4.3, the comment was made that federal health authorities would not understand the content here. This concern also refers to points 4.4 through 4.7 as the federal government does not have jurisdiction over the cantons. Germany, as a federal state, agreed with this concern because the health systems are decentralized, and suggested the only option for bilateral agreements would be with Switzerland.

Moldova raised the issue of absence of mention in this article content regarding conditions upon the return of migrant health workers to their country of origin. It was proposed to add a point defining such legal mechanisms and/or good practices to this article.

Monaco suggested that consideration be given to the fact that there is no mutual recognition of qualifications, diplomas and degrees of health professionals which could cause confusion in the interpretation of point 4.4. Translation of the terms was also mentioned as a challenge in mutual understanding of the content.

Article 5: Mutuality of benefits: was described as a complex section that was closely related to article 6. Significant improvements have been made to this section clarifying the need for a system of benefits for the developing countries to ensure a balance of gains and losses have a positive impact on the health systems. Active recruitment limitations are emphasized with respect to ensuring equitable agreements between countries. A suggestion was made to add the term *shared responsibility* to the title of this article.

Monaco asked for clarification of a point mentioned earlier, namely whether or not there was a deliberate focus on developing countries alone in 5.3. The secretariat replied that this was indeed an omission.

Switzerland felt that this section was not acceptable as it was and did not agree with the second paragraph's emphasis on abstention from active recruitment by developed countries without mutual benefits. Switzerland supported this claim by citing the use of the Internet as a

worldwide tool and wanted to know how the Internet would or could be regulated and how it would be looked at in terms of recruitment issues.

Article 6: National health workforce sustainability and retention, was renamed in this draft, by adding the addition of ‘retention.’ The section was also expanded in size (going from 2 to 4 articles). The phrase ‘sustainable health system’ was added, as well as new language suggesting that all Member States should ‘strive’ to address their own needs within their countries, by using a ‘multisectoral’ approach. There had already been some concern over the definition of sustainability here, and how the section can acknowledge that both foreign and domestic workers can be used to fulfil this sustainable model.

The former Yugoslav Republic of Macedonia raised the issues of item 6.4, saying that it was inappropriately worded because it described reasons why many health workers are emigrating from their home countries and thus could not be applied to intervention strategies.

Switzerland reiterated the position that the last sentence of 6.1 needed to be deleted, and to add at the end of the previous sentence “when possible”. Commenting on the statement by the Former Yugoslav Republic of Macedonia regarding 6.4, Switzerland felt this viewpoint went too far, and argued that while rural areas are affected by the lack of health personnel most countries no longer have separate rural and urban area policies and that there are more problems in cities than in rural areas.

Sweden speaking on behalf of the EU, declined to comment on details of the section, but referred to research which shows the need for a multisectoral response, addressing underlying issues such as low pay, inadequate financing and weak institutions. The EU expressed belief in supporting circular migration in order to deflect brain drain.

Germany expressed a concern in terms of the implementation of articles 6.1 and 6.3, as well as article 4, explaining that it would be difficult to develop a national policy in countries like Germany, where the central government does not regulate state positions.

Article 7: Data gathering and research. This section is largely unchanged, but 7.4 now raises the question of how comparable data will be generated.

France was unclear as to what type of data would be collected and how WHO would guide Member States in this endeavour. The secretariat explained that WHO EURO is currently working with OECD and EUROSTAT on joint data collection on the health workforce and tools to enable Member States to improve their national data.

Sweden on behalf of the EU, voiced support of this project, and stated that the lack of data on migration flows is currently a major problem.

Spain added that there should be collection not just of data but also of good practices that might help to mitigate the many complicated issues being tabled at this meeting.

Article 8: Information exchange remains largely unchanged.

Monaco again expressed the need for caution here, and stated that because of the voluntary nature of the code, this section gave the impression of being binding without being specific

enough. Monaco asked for clarification on how this will operate, who will supply the data, and how it will be implemented.

Switzerland endorsed Monaco's statement, adding that the language and the tone for both article 8 and 9 should be reconsidered.

Article 9: Implementation of the code remains largely unchanged, but now adds that Member States are asked to apply this section 'as appropriate.' It has already been suggested that stronger language be used there.

Switzerland and Monaco expressed concern about items 9.1, 9.2, 9.6, and said 9.7, which posed a problem because it requested Member States to only use recruitment agencies that complied with the ethical consideration of the code, but did not define what was ethical.

Article 10: Monitoring and institutional arrangements is also largely unchanged, but it opens up the possibility of defining the frequency of reporting by Member States and by WHO to the WHA.

Monaco reiterated that the code is voluntary, which makes 10.1 and 10.2 difficult to apply.

Sweden speaking on behalf of the EU, stated that the periodic reporting, which is called for in this section could be valuable if frequent enough, but clarification was needed on the frequency and management of reporting by Member States.

Article 11: Partnerships, technical collaboration, and financial support. Previous comments on this section have indicated that parts of it are unclear and need better coherence and consistency. Section 11.2 has been particularly cited as requiring further attention.

Sweden added EU's support to the concept of health system strengthening, but said that more time was needed to study the financial implications of the code. The EU also wanted further clarification regarding the voluntary financial contributions. Switzerland added its support for this statement.

Moldova stated that the investment in medical education in terms of time and costs are well known, and argued for more importance to be given to a compensation system for countries losing personnel, as well as for national compensation systems for personnel who move from the public to the private sector. Moldova also expressed the need to focus on quality of education and training through building accreditation systems under the guidance of WHO.

Closing remarks

The chair, Bjørn-Inge Larsen, thanked the participants for their comments and contributions to the discussion. All the views have been captured and will be made available for the secretariat and European Member States for further consideration.

The moderator, Professor Gilles Dussault, thanked all participants for their interventions. He supported the statements made throughout the meeting, saying they were in line with the Regional Committee discussions. He thanked representatives for the reminder that many

countries have limited federal authorities and that the guidelines in the code need to be able to fit all governing structures. He explained that he was aware that for some Member States the code appears to go too far, but for others, such as those in the African region, it does not go far enough. Despite this, he felt an agreement would be made.

Dr Dayrit also thanked everyone for a useful session, especially in terms of the reactions to ambiguity and needed revisions of the text. He said that the translated documents needed to be re-examined and also commented that the Member States would want to know whether more discussion is still needed, or whether it should be deliberated as is at the World Health Assembly. He said that the secretariat would not recommend further deliberations because of the short time available. The document will now be sent to the Executive Board, and if they deem it ready, it will go to the World Health Assembly.

Dr Kökeny, Member of the Executive Board, asked everyone to reflect on what had been heard and thought the meeting was useful and that it appeared that the European region was close to reaching an agreement on the document. He urged participants of the meeting not to incur further delay in accepting the code because of the financial crisis affecting the Member States and went on to say that even if this was a voluntary code it had clear and strong language. He also commented on the fact that certain Member States were concerned about whom to address at regional and national levels, as well as in the private sector and felt that this would be an important issue to address, especially in countries where the national government does not have authority over all these issues. Though he saw a clear wish to provide a level of freedom for people to migrate, this would have to be considered along with the sustainability of the health system in both source and recipient countries. He went on to call for the creation of a transfer process for both migration and recruitment and thought there would be a good chance to come to an agreement in the Executive Board and find compromises that would not be too political.

Ms Clark's concluding statements were also positive, and she noted that the new version of the code had been significantly improved, and reflected everyone's input. She said she had the sense that people were finding a strong common ground and a sense of urgency to move forward. She urged the secretariat to find a way to address the issues that came up in the session, as they were not insurmountable, and only showed how far the group had come.

Dr Enis Barış concluded the meeting by thanking everyone for a useful and dynamic session and promised to finalise and make the report available. He reminded participants that this version of the code was much more sympathetic to source countries and asked for caution, saying that it was important that this document does not take too many steps back. He explained that this was an important topic to bring up because not all Member States of the European region were present and their concerns needed to be kept in mind as well. He recalled the Tallinn Charter where specific statements were made about taking an ethical approach in the recruitment of health workers and urged members to reassert this now, especially while trying to find a balance between the needs of both destination and source countries.

Summary of key conclusions

Participants of the meeting congratulated the secretariat for the revised version of the code prepared for EB126, noting significant improvement from the previous version presented to EB124 in January 2009.

The meeting provided an opportunity to compare the two versions, review the revised code, and collect views of Member States and relevant stakeholders on the content as well as gather specific comments on the text.

Participants welcomed the shift in focus in the revised code from migrant worker rights to mitigating the negative effects of the international migration of health personnel on health systems in source countries/developing countries in line with the World Health Assembly resolutions.

Highlights of the meeting included:

1. appreciation of the preamble which contains the principles and antecedents for code development and the nature of the code as voluntary;
2. appreciation of the text reflecting a better balance between the individual right to move and the right of populations to strong health systems;
3. expression of concern regarding the implementation of the code in consideration of national governance (federal, state and local) and effective monitoring of the implementation including data collection, reporting and information exchange; and
4. expression of a need for clarity on terminology (e.g. sustainability, recruiters, active recruitment, etc.), possibly in the form of a glossary and the necessity for accurate translations of the document.

There was consensus that the code is intended to serve as an instrument of reference for Member States in establishing or improving the legal and institutional framework for the international recruitment of health personnel and it will provide guidance in formulating and implementing national and international regulations (binding and voluntary). The code will promote and facilitate further discussions and cooperation on matters related to the ethical international recruitment of health personnel.

ANNEX 1. PROGRAMME OF THE CONSULTATION MEETING

Chair: Bjorn-Inge Larsen, Executive President of the fifty-ninth session of the Regional Committee for Europe, Norway

Moderator: Gilles Dussault, Professor, Institute of Hygiene and Tropical Medicine, Lisbon, Portugal

Time	Topic/Speaker
10:00–10:15	Welcome and opening remarks
10:15–11:00	Session I: Global Code of Practice: The process <ul style="list-style-type: none">• Introduction to the session• International migration of health personnel: trends and impact. The European perspective• The perspective of countries with critical shortages of health workers• Process towards a WHO global code of practice: progress to date
11:00–12:30	Session II. Global Code of Practice: The content Discussion on the key issues: <ul style="list-style-type: none">• Introduction• Objectives and guiding principles• International recruitment practices• Mutuality of benefits• National health workforce sustainability• Data gathering, research and information exchange• Implementation procedures
12:30–14:00	Lunch break
14:00–15:00	Session II: Global Code of Practice: The content (discussion, cont'd) <ul style="list-style-type: none">• Data gathering, research and information exchange Implementation procedures
15:00–15:20	Summary of the discussion
15:20–15:50	Session III: Global Code of Practice: The way forward <ul style="list-style-type: none">• A strategy for the period leading up to WHA63 (May 2010)
15:50–16:00	Concluding remarks

ANNEX 2. REVISED DRAFT GLOBAL CODE OF PRACTICE ON THE INTERNATIONAL RECRUITMENT OF HEALTH PERSONNEL (EB126/8, 3 DECEMBER 2009)

***Preamble* [Regional Committee for the Western Pacific]**

The Member States of the World Health Organization:

Recalling the 2009 ministerial declaration of the Economic and Social Council reaffirming its commitment to strengthening health systems that deliver equitable health outcomes as a basis of a comprehensive approach, noting with concern the lack, as well as the imbalanced distribution of health workers within countries and throughout the world, in particular the shortage in sub-Saharan Africa, which undermines health systems of developing countries, and encouraging the finalization of a Code of Practice on International Recruitment of Health Personnel;

Further recalling resolutions WHA57.19 and WHA58.17 in which the Health Assembly requested the Director-General to develop a WHO code of practice on the international recruitment of health personnel in consultation with all relevant partners;

Noting the call in the Kampala Declaration adopted at the First Global Forum on Human Resources for Health (Kampala, 2–7 March 2008) for WHO to accelerate negotiations on the WHO code of practice;

Further noting the G8 communiqués of 2008 and 2009 encouraging WHO to accelerate the development and adoption of a WHO code of practice;

Recognizing the work undertaken in the United Nations and other international organizations on strengthening the capacity of governments to manage migration flows at national and regional levels and the need for further action, at both national and global levels, on international recruitment of health personnel;

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 shortage of health workers;

Deeply concerned that the severe shortage of health workers in many Member States constitutes a major threat to the performance of health systems and undermines the ability of these countries to achieve the Millennium Development Goals and other internationally agreed development goals;

Alarmed that the migration of highly educated and trained health personnel from countries with health systems in crisis is increasing, further weakening the health systems of the countries of origin;

Deeply concerned that, as a result of global interdependence, compromised national health systems can have health and security implications for the global community;

Affirming that all Member States have the sovereign right and responsibility to 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;

Recognizing that, while international migration of health personnel can bring mutual benefits to both source and destination countries, the balance of gains and losses of health personnel migration should have a net positive impact on the health systems of developing countries; **[Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for South-East Asia, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean, Regional Committee for the Western Pacific]**

Deeply determined that this code should be implemented in such a way as to protect and strengthen the health systems of developing countries; **[Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for South-East Asia, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean, Regional Committee for the Western Pacific]**

Recognizing the importance of balancing the relation between the rights of health personnel, including their right to leave their countries and to migrate to countries that wish to admit and employ them, and the right to the highest attainable standard of health of the populations of Member States; **[Regional Committee for the Americas, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean]**

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;

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

Recognizing that the complexity of the challenge demands a comprehensive response and a multisectoral approach, encompassing all sectors associated with both migration and the determinants of health;

Recognizing the urgent need to formulate national, bilateral, regional and other international policy instruments for promoting effective international cooperation and national action in order to maximize the benefits and mitigate the negative impact of international migration of health personnel;

Emphasizing the need for technical and financial assistance to developing countries and countries with economies in transition that are working to strengthen their health systems, including health personnel development; **[Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for Europe]**

Stressing that the WHO code of practice on the international recruitment of health personnel will be a core component of national and global responses to the challenges of health worker migration;

THEREFORE:

The Member States hereby agree on the following articles which are recommended as a basis for action.

Article 1 – Objectives

The objectives of this code are:

- (a) to establish and promote voluntary principles, standards and practices for the ethical international recruitment of health personnel in order to achieve a balance between the rights, obligations and expectations of source countries, destination countries and migrant health personnel;
- (b) to serve as an instrument of reference for Member States in establishing or to improving the legal and institutional framework required for the international recruitment of health personnel and in formulating and implementing appropriate measures;
- (c) to 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;
- (d) to facilitate and promote international discussion and advance cooperation on matters related to the ethical international recruitment of health personnel as part of strengthening health systems, with a particular focus on the situation of developing countries. [**Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for South-East Asia, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean, Regional Committee for the Western Pacific**]

Article 2 – Nature and scope

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 towards Member States, health personnel, recruiters, employers, health-professional organizations, relevant sub regional, regional and global organizations, whether governmental or nongovernmental, and all persons concerned with the international recruitment of health personnel.

2.3 The code applies to all health personnel, 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 or permanent basis.

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

Article 3 – Guiding principles

3.1 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 the coordination of national policies on international health personnel recruitment are desirable in order to advance an ethical framework to equitably strengthen health systems worldwide, to mitigate the negative effects of health personnel migration on the health systems of developing countries and to safeguard the rights of health personnel. **[Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for South-East Asia, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean, Regional Committee for the Western Pacific]**

3.2 All Member States have the sovereign right and responsibility to 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. Member States should take the code into account when developing their national health policies and cooperating with each other, as appropriate.

3.3 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. Destination countries should, to the extent possible, provide technical and financial assistance to developing countries and countries with economies in transition aimed at strengthening health systems, including health personnel development [, to offset the loss of health workers]. **[Regional Committee for Africa, Regional Committee for the Americas]**

3.4 Member States should balance the relation between individual rights of health personnel to leave any country including their own in accordance with international law, and the right to the highest attainable standard of health of the populations of source countries in order to mitigate the 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 international law, to migrate to countries that wish to admit and employ them. **[Regional Committee for the Americas, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean]**

3.5 International recruitment of health personnel should be conducted in accordance with the principles of transparency, fairness and mutuality of benefits. 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. All aspects of the employment and treatment of migrant health personnel should be without distinction of any kind, such as race, colour, gender, religion, national or social origin, the country where they were trained, birth or other status.

3.6 Member States should strive to create a sustainable health workforce and work towards establishing effective health workforce planning, production and retention strategies that 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 with national development programmes.

3.7 Effective gathering of national and international data, research, and sharing of information on the international recruitment of health personnel are essential to achieve the objectives of this code and should be prioritized out of a spirit of solidarity and to achieve

global health security. **[Regional Committee for Europe, Regional Committee for the Eastern Mediterranean]**

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

Article 4 – Migrant health personnel: responsibilities, rights and recruitment practices

4.1. Health personnel and health professional organizations should seek to cooperate fully with national and local authorities in the interests of patients, health systems, and of society generally. **[Regional Committee for the Americas, Regional Committee for Europe]**

4.2 Recruiters should not seek to recruit health care personnel who have an outstanding legal responsibility to the health system of their own country such as a fair and reasonable contract of service. Destination countries should try to be aware of and respect such responsibilities. **[Regional Committee for the Eastern Mediterranean]**

4.3 Member States and other stakeholders should recognize that ethical international recruitment practices provide health personnel with the opportunity to assess the benefits and risks associated with employment positions and to make timely and informed decisions.

4.4 Member States should, to the extent possible, ensure that recruiters and employers observe fair and just recruitment and contractual practices in the employment of migrant health personnel and those migrant health personnel are not subject to improper or fraudulent conduct. Migrant health personnel 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. Recruiters and employers should provide migrant health personnel with relevant and accurate information about any health personnel position that they are offered.

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

4.6 Measures should be taken to ensure that migrant health personnel enjoy opportunities and incentives to strengthen their professional education, qualifications and status on the basis of equality of treatment with the domestically trained health workforce. All migrant health personnel should be offered appropriate induction and orientation programmes that enable them to operate safely and effectively within the health system of the destination country.

4.7 Member States should, to the extent possible, strive to ensure that the services performed in connection with the recruitment and placement of migrant health personnel are rendered free of charge to such health personnel.

Article 5 – Mutuality of benefits

5.1 In accordance with the guiding principle of mutuality of benefits, as stated in Article 3 of this code, the health systems of both source and destination countries should derive benefits from the international migration of health personnel. In developing and implementing international recruitment policies, Member States should strive to ensure that the balance of gains and losses of health personnel migration should have a net positive impact on the health systems of developing countries and countries with economies in transition. **[Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for South-East Asia, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean, Regional Committee for the Western Pacific]**

5.2 Member States are urged to enter into bilateral, regional and multilateral arrangements that comply with this code to promote international cooperation and coordination on migrant health personnel recruitment processes. Such arrangements should strive to ensure that the balance between the gains and the losses in health worker migration should especially benefit developing countries and countries with economies in transition through the adoption of appropriate measures. Such measures may include the provision of effective and appropriate technical assistance, support for health personnel retention, support for training in source countries that is appropriate for the disease profile of such countries, twinning of health facilities, support for capacity building in the development of appropriate regulatory frameworks, access to specialized training, technology and skills transfers, and the support of return migration, whether temporary or permanent. **[Regional Committee for Africa, Regional Committee for Europe, Regional Committee of the Western Pacific]**

5.3 International health personnel recruitment should be done in such a way that it seeks to prevent a drain on valuable human resources from developing countries. Member States should abstain from active recruitment of health personnel from developing countries unless there exist equitable bilateral, regional or multilateral agreement(s) to support recruitment activities. **[Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean]**

5.4 Member States should seek to ensure that international health personnel recruitment should be sensitive to local health care needs so that international recruitment from any country should not destabilize local health care provision. **[Regional Committee for the Eastern Mediterranean]**

5.5 Member States should recognize the value both to their health systems and to health personnel themselves of professional exchanges between countries and of opportunities to work and train abroad. Member States in both source and destination countries should encourage and support health personnel to utilize work experience gained abroad for the benefit of their home country. Measures should be taken to enable migrant health personnel to develop their qualifications, training, education and expertise so that, when returning home, whether on a temporary or permanent basis, they could add value to the health systems in the source country. **[Regional Committee for Europe, Regional Committee for the Eastern Mediterranean, Regional Committee of the Western Pacific]**

Article 6 – National health workforce sustainability and retention

6.1 As the health workforce is central to sustainable health systems, Member States should take effective measures to educate, 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. All Member States should strive to meet their health personnel needs with their own human resources for health, as far as possible. **[Regional Committee for the Americas, Regional Committee for Europe, Regional Committee for the Western Pacific]**

6.2 Appropriate educational and vocational training are core ingredients of a quality health workforce. Member States should consider strengthening educational institutions to scale up the training of health personnel and developing innovative curricula to address current health needs. Member States should undertake steps to ensure that appropriate training takes place in the public and private sectors. **[Regional Committee for Africa, Regional Committee for Europe, Regional Committee for the Western Pacific]**

6.3 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 consider adopting and implementing effective measures aimed at long-term financial commitment to strengthening health systems, continuous monitoring of the health labour market and coordination among all stakeholders in order to develop and retain a sustainable health workforce responsive to their population's health needs. Member States should adopt a multisectoral approach to addressing these issues in national development programmes. **[Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for Europe, Regional Committee for the Eastern Mediterranean, Regional Committee for the Western Pacific]**

6.4 Member States should consider adopting measures to address the geographical maldistribution of health workers and to support their retention in underserved areas. These measures could include changes in the educational approaches to favour the selection of students from rural backgrounds, providing clear career paths and career development programmes, improving the infrastructure such as health-care facilities, and providing a decent wage, as well as appropriate financial incentives. Member States should also consider other issues surrounding health personnel retention such as nonmonetary incentives, including improving working and living conditions, housing, and education benefits for children of health personnel. **[Regional Committee for Africa, Regional Committee for Europe]**

Article 7 – Data gathering and research

7.1 Member States should recognize that the formulation of effective policies on the health workforce requires a sound evidence base.

7.2 Member States should establish or strengthen, as appropriate, programmes for national data gathering on health personnel migration, including the migration of students in health-related fields, and its impact on health systems. Member States should collect and analyse 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 personnel migration and coordinate such research programmes through partnerships at the regional and international levels. To 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, as much as possible, that comparable data are generated and collected pursuant to paragraphs 7.2 and 7.3 above for ongoing monitoring, analysis and policy formulation.

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 personnel migration and health systems, nationally and internationally, through public agencies, academic and research institutions, health professional organizations, and sub regional, regional and international organizations, whether governmental or nongovernmental.

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

- (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 subparagraphs (a) and (b) above to the WHO Secretariat every three years, beginning with an initial data report within two years after the adoption of the code by the Health Assembly.

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

8.4 A register of designated national authorities pursuant to paragraph 8.3 above shall be established, maintained and published by WHO.

Article 9 – Implementation of the code

9.1 The code should be publicized and implemented by Member States in collaboration with health personnel, recruiters, employers, health professional organizations, sub regional, regional, and international organizations, whether governmental or nongovernmental, 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, to give effect to the code.

9.3 Member States should consult, as appropriate, with representatives of health-professional organizations, recruiters, employers, and nongovernmental organizations and other stakeholders, in decision-making processes and involve them in other activities related to the international recruitment of health personnel.

9.4 All stakeholders referred to in Article 2.2 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.

9.6 Member States should, to the extent possible, monitor and regulate public and private recruiters and employers to promote adherence with this code.

9.7 Member States should encourage and promote good practices among recruitment agencies by only employing those agencies that comply with the [ethical principles of the] code.

Article 10 – Monitoring and institutional arrangements

10.1 Member States should periodically report, as appropriate, to the WHO Secretariat on measures taken, results achieved and difficulties encountered in implementing this code. The initial report should be made within two years after the adoption of the code by the Health Assembly and [reports thereafter should be made every three years] / [the periodicity of reporting thereafter should be decided by the Health Assembly]. 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 shall keep under review the implementation of this code, on the basis of periodic reports received from designated national authorities pursuant to Articles 8.3 and 10.1 and other competent sources, and periodically report to the Health Assembly on the effectiveness of the code in achieving its stated objectives and suggestions for its improvement. The initial report shall be made within three years after the adoption of this code by the Health Assembly and [reports thereafter should be made every three years] / [the periodicity of reporting thereafter should be decided by the Health Assembly].

10.3 The Director-General shall:

- (a) support 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 nongovernmental organizations to support implementation of the code.

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

10.5 The 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 to protect and strengthen the health systems of developing countries.

11.2 International organizations, international donor agencies, financial and development institutions, and other relevant organizations should increase their technical and financial support to assist the implementation of this code and support health system strengthening in developing countries and countries with economies in transition that are experiencing critical health workforce shortages and/or have limited capacity to implement the objectives of this code. Such organizations and other entities should cooperate with countries facing critical shortages of health workers and undertake to ensure that funds provided for disease-specific interventions are used to strengthen health systems capacity, including the development of health personnel. **[Regional Committee for Africa]**

11.3 Member States recruiting health personnel from developing countries or countries with economies in transition [[should] / [may wish to] provide] technical assistance to the latter, aiming at strengthening health systems capacity, including health personnel development in those countries. **[Regional Committee for Africa, Regional Committee for the Americas, Regional Committee for Europe]**

11.4 Voluntary financial mechanisms supportive of efforts of developing countries and countries with economies in transition to strengthen health systems, including health personnel development, should be explored. **[Regional Committee for Africa, Regional Committee for the Americas]**