World Health Organization

SIXTY-NINTH WORLD HEALTH ASSEMBLY **A69/37 Add.1**
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WHO Global Code of Practice on the International Recruitment of Health Personnel: second round of national reporting

Report by the Secretariat

1. The present report supplements the information provided in document A69/37 on the second round of national reporting, which is being submitted in line with the requirements of Articles 9.2 and 7.2(c) of the Code.

Background

2. The second round of national reporting on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel was initiated in March 2015 for a period extending until February 2016. One hundred and seventeen Member States notified the Secretariat of their designated national authorities for reporting on the progress made during that period using the national reporting instrument.[1] The national reporting instrument comprises three modules facilitating: (i) a comparative assessment of implementation relative to the 10 main articles of the Code (module 1); (ii) reporting on the current stock and inflow (by country of first training) of foreign-trained doctors and nurses (module 2); and (iii) contributions by independent stakeholders to the national reporting process describing their experiences.

3. This addendum contains four main sections: (i) additional analysis of the information collected in the national reporting instrument (module 1); (ii) key findings of the data collected on foreign-trained doctors and nurses (module 2); (iii) key findings of the single report from independent stakeholders (eight country studies) describing the role of non-State actors in supporting implementation of the Code (primarily in the European Region); and (iv) preliminary results of a programme of work entitled "Brain drain to brain gain"[2] that supports implementation of the Code in five countries.

The national reporting instrument

4. Table 1 presents the number and regional distribution of national authorities designated in the second round of reporting (2015–2016) and the status of reporting by those designated national authorities. Overall, there is a marked improvement in the number of Member States designating national authorities since the first round (2012–2013), with a 37% increase (from 85 to 117).

[1] Available in multiple languages at http://who.int/hrh/migration/en/(accessed 22 March 2016).

[2] A three-year (2014–2017) initiative co-funded by the European Commission and Norad.

5. Map 1 provides further insight into the status of reporting by country and the designated national authorities: 92 of the 117 submitted a complete or partial response. Reports from the designated national authorities will be made available after the Sixty-ninth World Health Assembly.[1] Selected highlights are presented in the following sections.

Table 1. List (by WHO region) of WHO Member States with a designated national authority and the status of response to the national reporting instrument (2015–2016)

Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
Angola*	Argentina	Bangladesh	Albania**	Afghanistan**	Australia
Benin*	Bahamas	Bhutan	Armenia	Bahrain**	Brunei Darussalam*
Burundi	Belize	India**	Austria	Djibouti	Cambodia
Cameroon	Brazil	Indonesia	Azerbaijan**	Iran (Islamic Republic of)	Cook Islands
Chad*	Canada	Maldives	Belarus**	Iraq*	Fiji**
Ghana	Colombia	Myanmar	Belgium	Jordan	Japan
Namibia	Costa Rica**	Thailand	Bosnia and Herzegovina	Lebanon*	Kiribati
Nigeria	Ecuador*		Croatia	Morocco	Lao People's Democratic Republic
Sao Tome and Principe	El Salvador		Cyprus	Oman*	Malaysia
South Africa	Guatemala*		Czech Republic	Qatar	Marshall Islands**
Togo**	Paraguay**		Denmark	Saudi Arabia**	Micronesia (Federated States of)
Uganda	Peru**		Estonia	Sudan	Mongolia**
United Republic of Tanzania*	Trinidad and Tobago		Finland	Syrian Arab Republic**	New Zealand
Zimbabwe	United States of America		France	Yemen	Niue**
	Uruguay*		Georgia		Palau
			Germany		Papua New Guinea*
			Hungary		Philippines
			Ireland		Samoa**
			Israel**		Singapore
			Italy		Solomon Islands*
			Kazakhstan**		Tonga**
			Kyrgyzstan		Tuvalu**

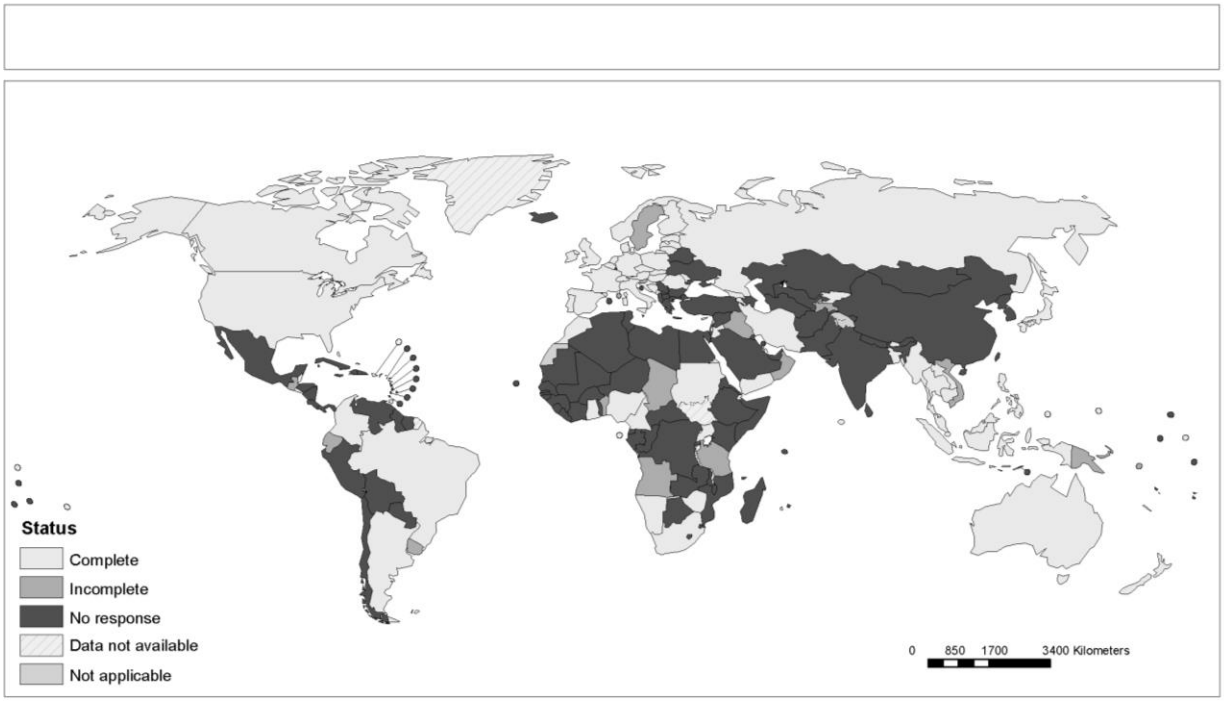
[1] To be made available at http://who.int/hrh/migration/en/.

Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific
			Latvia		Vanuatu**
			Lithuania		Viet Nam*
			Monaco*		
			Montenegro		
			Netherlands		
			Norway		
			Poland		
			Portugal		
			Republic of Moldova		
			Romania		
			Russian Federation		
			Slovakia		
			Slovenia*		
			Spain		
			Sweden*		
			Switzerland		
			Tajikistan*		
			Turkey**		
			Turkmenistan**		
			United Kingdom of Great Britain and Northern Ireland		
			Uzbekistan**		

* Member States with an incomplete national reporting instrument from the designated national authority

** Member States with no response received from the designated national authority (latest 29/02/2016)

Map 1. Status of reporting by country and designated national authority (2015–2016)



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization
Map Production: Information Evidence and Research (IER)
World Health Organization

World Health Organization

6. The national reporting instrument requests information on whether countries have engaged in bilateral agreements that take into account the needs of developing countries and economies in transition. Table 2 provides an overview of suggested measures and responses received. The majority of countries that responded to this question indicated that investments have been made in training and education programmes to increase the number of graduate health professionals to meet domestic demand and that there has been an increase in quotas of posts supported by public funds and scholarships for pre-service and in-service training.

7. With regard to technical cooperation in implementation of the Code, the following 10 Member States indicated that they have provided assistance to one or more countries or other stakeholders to support implementation: El Salvador, France, Germany, Iran (Islamic Republic of), Ireland, Italy, Norway, Switzerland, Thailand and the United States of America. Seven Member States indicated that they have requested assistance from other Member States or national stakeholders to support implementation of the Code, namely: Bangladesh, Canada, El Salvador, Indonesia, Nigeria, Philippines and the Republic of Moldova.

Table 2. Selected measures of support (provided or requested) reported by countries through bilateral/multilateral agreements that take account of the needs of developing countries or those with economies in transition (by WHO region)

Training	Twinning of health institutions	Promotion of circular migration	Retention strategies	Education programmes	Other measures
African Region					
Sao Tome and Principe	South Africa		Sao Tome and Principe	Sao Tome and Principe	
South Africa					
Region of the Americas					
Bahamas	Bahamas	Brazil	Ecuador	Bahamas	United States of America
Belize	United States of America	Colombia	United States of America	Belize	
Brazil				Brazil	
United States of America				Ecuador	
				United States of America	
South-East Asia Region					
Bangladesh	Bangladesh		Indonesia	Bangladesh	Indonesia
Indonesia				Indonesia	
Myanmar				Myanmar	
Thailand				Thailand	
European Region					
Czech Republic	Germany	Germany	Germany	Czech Republic	Finland
France	Ireland	Republic of Moldova	Norway	France	Germany
Germany	Norway			Germany	Ireland
Ireland				Ireland	
Norway				Norway	
Republic of Moldova				Romania	
Romania					
Eastern Mediterranean Region					
Djibouti	Morocco	Qatar	Morocco	Morocco	
Morocco	Oman	Sudan	Qatar	Qatar	
Qatar	Yemen			Yemen	
Sudan					
Yemen					
Western Pacific Region					
Australia	Kiribati	Cambodia	Cook Islands	Australia	Australia
Cambodia	Philippines	Kiribati	Kiribati	Cook Islands	Philippines
Cook Islands		Philippines		Philippines	
Malaysia					
Philippines					

Data on migration (foreign-trained doctors and nurses)

8. The national reporting instrument requests countries to specify four critical counts of stock for doctors and nurses for the years 2000–2014 in order to differentiate between the total stock and the percentage of foreign-born and foreign-trained health professionals. In addition, data were requested on the annual inflow of foreign-born, foreign-trained health professionals (i.e. as distinct from those native-born but foreign-trained). The results obtained indicate that concerted efforts are required to strengthen and institutionalize migration data reporting.

9. The analyses[1] indicate that foreign-born doctors accounted for 22% of active doctors in OECD countries in 2010–2011 (up from 20% in 2000–2001), whereas foreign-born nurses represented 14% of all nurses (up from 11% in 2000–2001). The share of foreign-trained health professionals is lower (17% for doctors and 6% for nurses in 2012–2014), suggesting that host countries provide some of their training. India and Philippines provide the largest shares of migrant doctors and nurses to OECD countries. The top five non-OECD countries providing migrant doctors, in order of share, are India, China, Pakistan, Philippines and the Islamic Republic of Iran, while for nurses, they are Philippines, India, Jamaica, Nigeria and Haiti.

10. Countries outside the OECD also show varying levels of dependence on foreign-trained doctors – ranging from 0–2% in Cambodia, Lao People's Democratic Republic, Philippines and Thailand, to 2–10% in Argentina, Brazil and Latvia, 10–20% in Kiribati, the Maldives, the Federated States of Micronesia and South Africa, and more than 20% in Belize, Namibia, Singapore, and Trinidad and Tobago. Country reports also described the dimensions of intra- and interregional dependence on foreign-trained health professionals – for example, one third of Argentina's 6.7% of foreign-trained doctors originate in the Plurinational State of Bolivia and one third in Colombia; all of Belize's 23.5% of foreign-trained doctors originate in Cuba; close to all of the 17.6% of foreign-trained doctors in Kiribati originate in Fiji; almost half of the doctors in Trinidad and Tobago are foreign-born and foreign-trained, and of those one third come from India, a quarter from Jamaica and a quarter from Nigeria. Overall, countries with high dependence rates (that is, of more than 50%), such as Namibia and Singapore, are not yet able to provide detailed information on the origins of their foreign-trained doctors.

The role of nongovernmental actors in supporting implementation of the Code

11. The second round of monitoring of the implementation of the Code also facilitated contributions from other relevant stakeholders, consistent with the Code's scope as stipulated in Article 2.2. One report was received from the "Health Workers for All" partnership on the efforts of nongovernmental actors in eight European countries. The studies focused on key areas, primarily: (i)[2] mobility,

[1] International migration outlook 2015. Paris: OECD Publishing; 2015 (http://www.oecd-ilibrary.org/social-issues-migration-health/international-migration-outlook-2015_migr_outlook-2015-en, accessed 22 March 2016).

[2] The Netherlands and the United Kingdom of Great Britain and Northern Ireland.

migration, recruitment; (ii)[1] planning and forecasting; (iii)[2] rights, working conditions and protection; and, (iv)[3] coherence, collaboration and solidarity.

12. The country case studies provide evidence concerning the multistakeholder approach to promoting the principles of the Code and translating them into practical measures in many local and national contexts. The culmination of the effort is the Call to Action entitled "A health worker for everyone, everywhere",[4] formulated to advise policy-makers at the European Union and Member State level on supporting implementation of the Code, with a view to developing and maintaining strong health systems and sustainable health workforces both within and outside Europe.

"Brain drain to brain gain"

13. The "Brain drain to brain gain" programme exemplifies a multipartner initiative to generate momentum and accelerate progress in implementation of the Code for better management of health worker migration. The initiative is focused on promoting global policy dialogue and advocacy on the Code's relevance and effectiveness, and on supporting its implementation in three source countries (India, Nigeria and Uganda), a destination country (Ireland), and a country that is both a source and a destination for migratory flows of health workers (South Africa).

14. The initiative focuses on engaging in the Code and improving data on international health personnel migration, as improved information in this area is a prerequisite for better management of migratory flows. A research protocol guided data gathering, analysis and interpretation. As a result, there was new engagement in the second round, with India, Nigeria, South Africa and Uganda all confirming a designated national authority and Nigeria, South Africa and Uganda submitting full reports. Ireland continued its engagement from round 1, re-confirming a designated national authority and submitting a full report.

15. As a result of the first year of action under the initiative, evidence on the migration of selected cadres has been strengthened. A key finding is that while information on the production and supply of health workers was readily available, none of the countries had a routine mechanism to capture the "flow" of health workers. Early results from the analysis of proxy measures point to international migratory flows that are more complex than the traditional perception of unidimensional mobility from South to North. As an example, with certificates of good standing as a proxy for outmigration, two thirds of Uganda's migrating surgical workforce was destined to work in other African countries.

16. The policy dialogue at national level has informed key actions and decisions. The Government of Uganda reviewed a proposed bilateral agreement with Trinidad and Tobago and Ireland is establishing a national database for tracking physicians, based on a unique identifier.

17. At the global level, the initiative is supporting a special supplement of the journal Human Resources for Health, which reviews the relevance and effectiveness of the Code.[5] Fifteen

[1] Poland and the United Kingdom of Great Britain and Northern Ireland.

[2] Germany, Italy and Spain.

[3] Belgium, Italy, the Netherlands, Poland and Romania.

[4] See www.bit.ly/hw4all-call, accessed 30 March 2016.

[5] Adhering to the definitions of "relevance" and "effectiveness" provided by the Executive Board at its 136th session (January 2015). See http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_32Add1-en.pdf.

peer-reviewed manuscripts describe global, regional and national experiences. The evidence reveals persistent gaps in aspects of health systems (for example, health personnel training, recruitment and retention) that are necessary to maintain the "pull effect" for health workers to practise in underserved areas. Promising results show that where mentoring is practised, retention improves, particularly among specialist physicians. The "pull back" factors for returning migrants remain safety, security and structural stability. Migration management policies (in dialogue with State and non-State actors) remain a high priority for a number of traditional source countries experiencing the dual burden of outmigration and poor health outcomes.

Conclusions

18. The results of the second round of reporting show a substantial global improvement in the number of countries designating a national authority to facilitate national dialogue, support implementation and coordinate information exchange and reporting. As called for by the recommendation of the Expert Advisory Group on the Relevance and Effectiveness of the Code,[1] the rate of response to the national reporting instrument increased from 56 (of 85 countries) in 2012–2013 to 74 (of 117 countries) in 2015–2016. This testifies to a significant increase in awareness, commitment and dialogue with regard to implementation of the Code.

19. The core findings continue to relate to the attention countries should place on workforce planning and policy development perspectives in line with the principles of the Code. The internalization of the health (and health education) labour market creates new challenges for countries in the management of their health professionals as well as in reaching adequate levels of self-sufficiency. The principles of the Code remain a relevant and effective framework to guide future solutions.

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[1] See document A68/32.