Monitoring the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel

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Objective To present the findings of the first round of monitoring of the global implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel ("the Code"), a voluntary code adopted in 2010 by all 193 Member States of the World Health Organization (WHO).

Methods WHO requested that its Member States designate a national authority for facilitating information exchange on health personnel migration and the implementation of the Code. Each designated authority was then sent a cross-sectional survey with 15 questions on a range of topics pertaining to the 10 articles included in the Code.

Findings A national authority was designated by 85 countries. Only 56 countries reported on the status of Code implementation. Of these, 37 had taken steps towards implementing the Code, primarily by engaging relevant stakeholders. In 90% of countries, migrant health professionals reportedly enjoy the same legal rights and responsibilities as domestically trained health personnel. In the context of the Code, cooperation in the area of health workforce development goes beyond migration-related issues. An international comparative information base on health workforce mobility is needed but can only be developed through a collaborative, multi-partnered approach.

Conclusion Reporting on the implementation of the Code has been suboptimal in all but one WHO region. Greater collaboration among state and non-state actors is needed to raise awareness of the Code and reinforce its relevance as a potent framework for policy dialogue on ways to address the health workforce crisis.

Abstracts in عربي, 中文, Français, Русский and Español at the end of each article.

Introduction

The health workforce is at the core of a health system. Global health targets and universal health coverage (UHC) are not likely to be attained unless health systems employ a sufficient number of health workers who are appropriately skilled and motivated, equitably distributed and well supported.[1,2] In any setting currently facing a critical shortage of health workers, extending health-care coverage and offering a broader health service package will not be possible.[2] Staff shortages are exacerbated by the international migration of health workers who seek better employment opportunities, wages and working conditions abroad. This unplanned or uncontrolled outflow of health workers can weaken a health system, undermine planning projections and erode its current and future skills base.[3]

In May 2004, the World Health Assembly (WHA) petitioned the World Health Organization (WHO) to develop – in consultation with its Member States and all relevant partners – a code of practice on the international recruitment of health personnel as a global framework for dialogue and cooperation on matters concerning health personnel migration and health systems strengthening. In drafting the code, inputs were received during several global fora and in response to calls within the Kampala Declaration adopted at the First Global Forum on Human Resources for Health.[4] The adoption in 2010 of the WHO Global Code of Practice on the International Recruitment of Health Personnel ("the Code") furnished a guide to international cooperation and facilitated a platform for continuing dialogue on the critical problem of health worker migration.[5] The Code negotiation process was a vigorous one in which maturity and a favourable evolution in global health diplomacy were displayed.[5,6]

The Code was developed around the principle that everyone has a right to the highest attainable standard of health and that all individuals, including health workers, have the right to migrate from one country to another in search of employment.[4,7] The Code contains 10 articles covering the following: objectives; nature and scope; guiding principles; responsibilities, rights and recruitment practices; health workforce development and health systems sustainability; data gathering and research; information exchange; implementation of the Code; monitoring and institutional arrangements; and partnerships, technical collaboration and financial support.[7] As a voluntary, non-legal instrument with no impact on state practice, the Code incorporates potent but flexible procedural mechanisms to advance implementation.[5] Article 9.1 of the Code calls upon Member States to report to the Secretariat every three years on measures taken, accomplishments and difficulties encountered in implementing the Code to illustrate how the objectives of the Code are being achieved.[7] The objective of this paper is to

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Table 1. **Countries that designated national authorities and that completed and returned the National Reporting Instrument on the implementation of the Global Code of Practice on the International Recruitment of Health Personnel, by WHO region**

Region	Countries that designated a national authority	
	No. (%)[a]	Name
AFR (*n* = 46)	13 (28)	Angola, Cameroon,[b] Congo, Democratic Republic of the Congo, Ghana, Kenya, Mauritania, Mauritius, Namibia, Rwanda,[b] Seychelles, Swaziland, Uganda
AMR (*n* = 35)	11 (31)	Canada, Chile, Colombia, El Salvador,[b] Guatemala, Mexico,[b] Nicaragua, Panama, Paraguay, Saint Vincent and the Grenadines, United States of America[b]
EMR (*n* = 21)	8 (38)	Lebanon,[b] Oman, Pakistan,[b] Qatar, Saudi Arabia, Sudan,[b] Syrian Arab Republic, Yemen
EUR (*n* = 53)	43 (81)	Albania,[b] Armenia,[b] Austria,[b] Azerbaijan,[b] Belarus,[b] Belgium,[b] Bosnia and Herzegovina,[b] Croatia,[b] Cyprus,[b] Czech Republic,[b] Denmark,[b] Estonia,[b] Finland,[b] France, Georgia,[b] Germany,[b] Hungary,[b] Ireland,[b] Israel, Italy,[b] Kazakhstan,[b] Kyrgyzstan,[b] Latvia,[b] Lithuania,[b] Monaco,[b] Montenegro,[b] Netherlands,[b] Norway,[b] Poland,[b] Portugal,[b] Republic of Moldova,[b] Romania, Russian Federation,[b] Slovakia,[b] Slovenia,[b] Spain,[b] Sweden,[b] Switzerland,[b] Tajikistan,[b] Turkey,[b] Turkmenistan,[b] United Kingdom of Great Britain and Northern Ireland,[b] Uzbekistan[b]
SEAR (*n* = 11)	4 (36)	Indonesia,[b] Maldives,[b] Myanmar, Thailand[b]
WPR (*n* = 27)	6 (22)	Brunei Darussalam, Federated States of Micronesia,[b] Japan,[b] Philippines,[b] Republic of Korea, Singapore[b]
Total (*N* = 193)	**85 (44)**	–

AFR, African Region; AMR, Region of the Americas; EMR, Eastern Mediterranean Region; EUR, European Region; SEAR, South-East Asia Region; WHO, World Health Organization; WPR, Western Pacific Region.

[a] Percentage of all countries in the region.

[b] Completed and returned the National Reporting Instrument.

present the findings from the first round of reporting on the Code implementation process. The paper concludes with several key messages aimed at national and global health development partners.

Methods

Two elements were central in monitoring the implementation of the Code: the designation of national authorities and the development of a survey tool. As a first step, WHO called on each Member States to designate a national authority who could take charge of the exchange of information regarding the migration of health and the implementation of the Code. At the time of writing, 85 (44%) of the 193 Member States (Table 1) have complied. Of the designated national authorities, 79% are in ministries of health, 11% are in public health institutes and the rest are spread among health authorities, health boards and human resources for health (HRH) observatories. In a second step WHO developed the National Reporting Instrument (NRI),[8] a 15-question tool created for use in cross-sectional country-based self-assessment surveys. Delegated national authorities were contacted between March and June 2012 and asked to complete and return information on the Code implementation process using the NRI. They entered the information securely via a web-based interface that linked to a databank hosted by WHO. At the time of writing, 56 countries, mainly in the European Region, have completed and returned the NRIs (Table 1). The reporting countries represent more than 80% of the population living in destination countries and comprise a small fraction of the known source countries.

Results

Of the 56 countries that completed and sent NRIs, 37 (66%) had taken steps to implement the Code. Table 2 describes the range of actions and measures undertaken to communicate with multiple stakeholders and involve them in matters concerning health workforce migration and international recruitment. Countries adopted different approaches to raise awareness about and promote dialogue concerning the Code. For example, the Government of Canada is disseminating materials to raise awareness of the Code among foreign workers entering the country at embassies and high commissions abroad. Many countries had translated the Code into their national languages for dissemination among state and non-state actors. In El Salvador, the Ministry of Labour conducted an analysis of the correspondence between the Code and the country's labour laws and legal framework. During Belgium's presidency of the European Union (EU), a ministerial conference was organized for the purpose of discussing the articles contained in the Code in light of the European Region's health workforce priorities. In addition, Be-cause health, a Belgian international health platform, developed a charter designed to better harmonize health worker recruitment practices – and to improve their equity and effectiveness – among Belgian cooperation stakeholders providing support to health workers from partner countries.[9] Finland's ministries of social affairs and health, in collaboration with national stakeholders, are developing recommendations and taking other measures to ensure that the international recruitment of social service and health personnel is conducted in conformity with the Code. Following the Code's adoption in Thailand, the country's human resource committee appointed a national multisectoral subcommittee to oversee implementation of the Code by all relevant international partners.

Recruitment practices, rights and responsibilities

Table 3 summarizes the responses given by countries in the different WHO regions to NRI questions concerning recruitment practices and the rights and responsibilities of migrant health professionals. Migrant health professionals are those whose current practice is outside their country of origin and/or outside the country where they were first

Table 2. **Measures taken or being considered by countries in support of the Global Code of Practice on the International Recruitment of Health Personnel, by WHO region**

Measure	Countries that reported on Code implementation status						
	AFR (*n* = 2)	AMR (*n* = 4)	EMR (*n* = 3)	EUR (*n* = 40)	SEAR (*n* = 3)	WPR (*n* = 4)	Total (*n* = 56)
Countries that responded "yes" to "Has the country taken steps to implement the Code?"	1	4	2	26	2	2	37
Information is shared across sectors on matters pertaining to health worker recruitment and migration, as well as on the Code.	1	4	2	21	2	3	33
All stakeholders have been involved in decision-making processes involving the migration and international recruitment of health personnel.	1	2	1	9	1	3	17
Changes to laws or policies pertaining to the international recruitment of health personnel are under consideration.	1	0	0	10	2	2	15
Records are maintained of all recruiters authorized by competent authorities to operate within their jurisdictions.	1	1	0	4	2	2	10
Good practices are encouraged and promoted among recruitment agencies.	1	1	0	4	2	1	9

AFR, African Region; AMR, Region of the Americas; EMR, Eastern Mediterranean Region; EUR, European Region; SEAR, South-East Asia Region; WHO, World Health Organization; WPR, Western Pacific Region.

trained.[10] Remarkably, 51 (91%) countries confirmed that migrant health professionals enjoy the same legal rights and responsibilities as health workers who are domestically trained. Broadly speaking, recruitment is based on qualifications, particularly in the case of physicians, dentists, nurses and midwives. Generally speaking, in all countries health personnel are required to take a national certifying examination and those who pass must apply to a national certifying authority, such as a medical board or a council of registered nurses, to obtain a licence to practise.

Data gathering and research

As shown in Table 4, countries varied widely in their capacity to gather data and conduct research on matters relating to health personnel migration. Marked regional disparities were noted in this respect. In addition, evidence of the existence of technical cooperation agreements related to the recruitment, management and migration of international health personnel was found in only 13 countries (23%). Thirty-four (61%) countries keep statistical records of health personnel whose initial qualification was obtained in a foreign country. Comparably, thirty-six (64%) countries have mechanisms for granting internationally recruited health personnel authorization to practice and keep statistical records of all such authorizations. In contrast, only 11 (20%) countries have a database of laws and regulations pertaining to the recruitment and migration of international health personnel.

Health workforce development and health system sustainability

According to NRI reports, several countries have in place bilateral, multilateral and regional agreements in connection with the recruitment of international health personnel. Most of these agreements preceded the Code; others were developed or refined after the Code was adopted. Some of the agreements are between neighbouring countries – e.g. Cyprus and Greece; Egypt and Sudan; Monaco and France; Denmark, Finland, Iceland, Norway and Sweden; Kazakhstan, Kyrgyzstan, the Russian Federation, Tajikistan and Uzbekistan. Some are between countries having different income levels – e.g. Armenia and Qatar; Croatia and Germany; Finland and the

Table 3. **National recruitment practices and rights and responsibilities of migrant health professionals,[a] by WHO region**

Practices/rights and responsibilities	Countries that reported on Code implementation status						
	AFR (*n* = 2)	AMR (*n* = 4)	EMR (*n* = 3)	EUR (*n* = 40)	SEAR (*n* = 3)	WPR (*n* = 4)	Total (*n* = 56)
Migrant health professionals enjoy the same legal rights and responsibilities as domestically-trained health personnel.	2	4	1	38	3	3	51
Migrant health professionals are hired, promoted and remunerated on the basis of criteria that are as objective as those that apply to domestically-trained health personnel.	2	4	1	33	2	1	43
Migrant health professionals enjoy the same education, qualifications and career progression opportunities as domestically-trained health personnel.	2	4	1	28	0	2	37
Recruitment mechanisms allow migrant health professionals to assess the benefits and risks associated with their employment.	1	2	1	15	1	1	21

AFR, African Region; AMR, Region of the Americas; EMR, Eastern Mediterranean Region; EUR, European Region; SEAR, South-East Asia Region; WHO, World Health Organization; WPR, Western Pacific Region.

[a] Migrant health professionals are those whose current practice is outside their country of origin and/or outside the country where they were first trained.

Table 4. **Country capacity for gathering data and conducting research on matters relating to health personnel migration, by WHO region**

Capacity	Countries that reported on Code implementation status						
	AFR (*n* = 2)	AMR (*n* = 4)	EMR (*n* = 3)	EUR (*n* = 40)	SEAR (*n* = 3)	WPR (*n* = 4)	Total (*n* = 56)
Has at least one entity or mechanism for the professional certification of internationally recruited health personnel and for statistical record keeping.	1	0	1	28	3	3	36
Has at least one entity or mechanism for maintaining statistical records on health personnel whose first training was overseas.	1	4	3	22	3	1	34
Has government or non-government programmes or institutions that conduct research on the migration of health personnel.	0	4	1	19	2	1	27
Has a technical cooperation agreement related to international health personnel recruitment or to the management and migration of such personnel, or provides or receives financial assistance for these activities.	1	2	0	9	1	0	13
Has a database of laws and regulations pertaining to international health personnel recruitment and migration.	0	2	0	7	1	1	11

AFR, African Region; AMR, Region of the Americas; EMR, Eastern Mediterranean Region; EUR, European Region; SEAR, South-East Asia Region; WHO, World Health Organization; WPR, Western Pacific Region.

Philippines; Ireland and Pakistan; Italy and Tunisia; the Philippines and Bahrain. Transatlantic bilateral agreements exist between Cuba and Portugal, Portugal and Uruguay and Portugal and Costa Rica. Multilateral agreements include "mobility partnerships". These consist of non-legally-binding frameworks for the proper management and monitoring of health personnel movements between the EU and individual countries. Prominent regional agreements include those between Brunei Darussalam, Cambodia, Indonesia, the Lao People's Democratic Republic, Malaysia, Myanmar, the Philippines, Thailand and Viet Nam as part of the Association of Southeast Asian Nations network. Agreements cover doctors and nurses and, in a few cases, midwives. Many agreements were concluded at the national level and others at the subnational level. The agreements between Canada and the Philippines and between Egypt and Rwanda were concluded at the subnational level.

Countries also reported on a range of broader financial and technical cooperation agreements. Some examples are certain agreements between members of the Ibero-American Network on Migration of Health Professionals (headed by the Ministry of Public Health of Uruguay and supported by the European Commission); the Triple Win pilot project involving Albania, Bosnia and Herzegovina, Germany and Viet Nam; and the Indonesia–Japan collaboration on the enhancement of nursing competency through in-service training.

Support of the principles espoused by the Code was demonstrated in the form of several global health initiatives, particularly health systems strengthening and HRH development initiatives spearheaded by the Government of the United States of America. As a member of the European ESTHER Alliance, Ireland supports a similar initiative in which health institutions in the EU are matched with institutions in less developed countries to strengthen the latters' health workforce.

Several countries reporting on the Code indicated being involved in the EU Joint Action on Health Workforce Planning, a collaborative platform for countries striving to prepare a sustainable health workforce in keeping with their economies and population-based needs.[11]

The challenges of implementation

As part of the reporting, countries were asked to name the three main impediments to the implementation of the Code. The one most often reported was the difficulty in engaging multiple stakeholders – at the national and subnational levels and in the public and private sectors – in efforts concerning health personnel migration and international recruitment. The second most commonly reported factor was the lack of coordinated and comprehensive data on health personnel migration of the type normally shared between agencies and entities within and among developed countries. The third most common factor was the lack of a shared understanding of the interrelatedness, at the country level, of workforce migration, current and future health workforce needs, and short- and long-term planning of the workforce.

Country-specific experiences

As a destination country, Norway reported using a multisectoral approach – under the Ministry of Health and Care Services and the Ministry of Foreign Affairs – to address its health workforce challenges and follow the implementation of the Code.[12] It described three strategic directives, all coherent with the Code. One directive is geared towards developing sufficient domestic educational capacity to meet the country's needs in health-care provision, which would reduce the pull on foreign health workers and the country's dependency on foreign-trained personnel. Norway is also adapting regulations to attract more people to the health workforce. For instance, it is converting part-time contracts into full-time contracts and trying to improve working conditions for better worker retention. Internationally, Norway supports several technical cooperation agreements aimed at strengthening the performance of foreign health systems to reduce the push effect in less developed, source countries. Forecasts of health personnel needs reveal a substantial shortage of workers requiring short-term training, such as nurse assistants, a situation that attracts foreign migrant health workers into Norway.[13] On the other hand, the country seems to have enough health workers requiring long-

term training. The interplay of supply and demand affects the sustainability of UHC in Norway and the country's self-sufficiency in terms of the health sector labour market.

The Department of Health of the Philippines, an important source country, conducted an assessment of the implementation of the Code with the participation of multiple stakeholders.[14] It did so at the initiative of the International Labour Organization, in partnership with the Department of Labour and Employment and with support from WHO's Western Pacific Regional Office.[15] Five groups were identified as key stakeholders in the Code implementation process: the government, trade unions, employers' organizations, recruitment agencies and professional organizations. Philippines policies and programmes pursue the promotion and protection of the rights and welfare of Filipino migrant health personnel to raise awareness with respect to migrant workers' rights and welfare through pre-employment and pre-departure orientation seminars for migrants. They are also intended to facilitate the monitoring of personnel agency international recruitment practices. The five groups of stakeholders pointed out two important challenges: (i) a lack of awareness of the Code domestically among migrant health workers, trade unions and personnel recruiters; and (ii) pressure to migrate abroad owing to unemployment in the national health sector. Furthermore, no dialogue on the subject of the Code takes place between receiving countries and migrant health personnel and no sanctions are in place for penalizing recruiters and employers who violate the Code. A final recommendation, intended to promote ethical recruitment, was to create a system of awards for proper implementation of the Code based on the quality rather than the quantity of processed transactions for foreign recruitment.

Discussion

The fact that 85 WHO Member States have designated a national authority, most often in the health ministry, in charge of reporting on the implementation of the Code may be a positive lead for countries who have not yet taken this step. About one fourth of WHO's 193 Member States responded to the NRI, and this limits the generalizability of the conclusions. The NRI performed adequately in terms of the completeness and comprehensiveness of the answers to the questions addressed, but it will be developed further to enable it to capture subtle differences in the extent to which source and destination countries implement the Code. The information gathered with the NRI formed the basis for a progress report on the Code implementation process that was presented and discussed by the WHA in 2013.[16]

The implementation of the Code has triggered domestic and international policy-making processes that could mark the beginning of a move from principle to action. Several key messages should be considered:

- Countries have used promising approaches to engage multiple stakeholders in efforts to make the principles articulated in the Code internally coherent and to have them properly implemented. Given the Code's non-binding nature, more potent and flexible ways of advancing the Code implementation process should follow.
- The choice of the Code as a non-binding instrument for addressing dynamic, complex and highly sensitive HRH issues testifies to a more nuanced understanding by Member States of the nature and utility of binding and non-binding international legal instruments for furthering global health.[5] Yet countries in all WHO regions but one – particularly source countries – have failed to report on the status of its implementation. The reasons may be that: (i) information about the Code and its utility has not reached all actors involved in HRH development; (ii) actions to promote implementation of the Code, whose observance is voluntary, have not been taken; or (iii) source countries struggling to strengthen their HRH information systems are deterred by requests for information on HRH mobility and migration. A strategic approach to promoting implementation of the Code must be adopted. Regional and national observatories and similar mechanisms can be used to build capacity and encourage policy dialogue so that the principles articulated in the Code can guide health workforce production, recruitment, deployment, retention and mobility.
- There is a need for global action and consensus on the building of an international database for health personnel migration statistics. Data on health workforce mobility appear to be available, especially in destination countries. However, in countries where such data exist, there needs to be consensus on which key indicators to collect.[17] The feedback from reporting countries suggests a need for technical cooperation to improve existing health information systems, including those pertaining to laws and regulations on health personnel recruitment. Existing population-based data sources, such as censuses and household surveys, could perhaps be extended to include items on migration.[18]

Health workforce migration is an important problem, especially in countries with fragile health systems and scarce resources, yet migration alone is not the root of the health workforce crisis. According to WHO estimates, the need for health workers in developing countries is far greater than the number of immigrant health workers in countries of the OECD.[10] On the other hand, health worker mobility can help to alleviate unemployment or under-employment in the health sector and can lead to gains in knowledge and skills transfer.[19] The effects of health worker mobility will depend on how a country stands in terms of workforce shortages, unbalanced skill mix, geographical maldistribution of workers, workforce and population ageing and attrition, and/or underproduction of health professionals.[20,21]

To conclude, renewed political and technical commitment at the national, regional and global levels is crucial to invigorate observance of the Code and fulfil its aspirational objectives, which were unanimously adopted by WHO Member States in 2010. The WHA periodically reviews the progress made by countries in implementing the Code and Member States should seize the opportunity they are given to report on their actions and share their concerns. The political imperative of moving towards UHC serves as a driver of greater integration between the planning of the health workforce and policy-making and of overall efforts to strengthen health systems. ■

Competing interests: None declared.

ملخص

رصد تنفيذ مدونة منظمة الصحة العالمية لقواعد الممارسة بشأن توظيف العاملين الصحيين على المستوى الدولي

الغرض عرض نتائج الجولة الأولى لرصد التنفيذ العالمي لمدونة منظمة الصحة العالمية لقواعد الممارسة بشأن توظيف العاملين الصحيين على المستوى الدولي ("مدونة القواعد")، وهي مدونة قواعد طوعية تم إقرارها في عام 2010 بواسطة جميع الدول الأعضاء في منظمة الصحة العالمية (WHO) البالغ عددها 193 دولة.

الطريقة طلبت منظمة الصحة العالمية أن تعين الدول الأعضاء فيها هيئة وطنية لتيسير تبادل المعلومات حول هجرة العاملين الصحيين وتنفيذ مدونة القواعد. وتم فيما بعد إرسال استقصاء مقطعي يتضمن 15 سؤالاً حول عدد من المواضيع المتعلقة بالمواد العشرة الواردة في مدونة القواعد إلى كل هيئة معينة.

النتائج قام 85 بلداً بتعيين هيئة وطنية. وقام 56 بلداً فقط بالإبلاغ عن حالة تنفيذ مدونة القواعد. وقام 37 منها باتخاذ خطوات نحو تنفيذ مدونة القواعد، وتم ذلك بشكل أساسي من خلال إشراك الجهات المعنية ذات الصلة. وفي 90 ٪ من البلدان، أظهرت التقارير أن العاملين الصحيين المهاجرين يتمتعون بنفس الحقوق القانونية والمسئوليات مثلهم مثل العاملين الصحيين المدربين محلياً. وفي سياق مدونة القواعد، يتجاوز التعاون في مجال تطوير قوة العمل الصحية المسائل المرتبطة بالهجرة. وتوجد حاجة إلى قاعدة معلومات مقارنة دولية حول تنقل قوة العمل الصحية ولكن لا يمكن تطويرها إلا عبر نهج تعاوني متعدد الأطراف.

الاستنتاج كان الإبلاغ عن تنفيذ مدونة القواعد دون المستوى الأمثل في جميع أقاليم منظمة الصحة العالمية باستثناء إقليم واحد. وتوجد حاجة إلى تعاون أكبر بين الجهات الفاعلة للدول وغير الدول لزيادة الوعي بمدونة القواعد وتدعيم ملاءمتها كإطار عمل فعال من أجل حوار سياسي حول سبل التعامل مع أزمة قوة العمل الصحية.

摘要

监控世卫组织卫生人员国际招聘方面全球行为守则的实施

目的 描述对世界卫生组织（WHO）在全球实施卫生人员国际招聘全球行为守则（"守则"）进行第一轮监控的调查结果，守则是 2010 年由世卫组织所有 193 个成员国采纳的自律守则。

方法 WHO 要求其成员国指定一个促进卫生人员移民信息交流和守则实施的全国性主管机关。然后，向每个指定的主管机关发出一份包含 15 个问题的横断面调查，这些问题与守则中 10 项条款的一系列主题相关。

结果 有 85 个国家指定了全国性主管机关。仅有 56 个国家报告了守则实施的状态。在这些国家中，有 37 个采取措施实施守则，其主要手段是让有关的利益相关者参与进来。在 90% 的国家中，移民卫生专业人士据报告与在本国培养的卫生专业人士享有同样的法律权利和责任。在守则的背景下，卫生劳动力发展领域的合作超越了移民相关问题。需要建立一个有关卫生劳动力流动性的国际比较信息库，而这只能通过协作、多方参与的方法实现。

结论 除了一个 WHO 区域外，其他所有地区中报告的守则实施都未达到最为理想的状态。国家和非国家参与者之间需要加强协作，唤起对守则的意识，强化其在解决卫生劳动力危机过程中作为政策对话有效框架的相关性。

Résumé

Suivi de la mise en œuvre du Code de pratique mondial de l'OMS pour le recrutement international du personnel de santé

Objectif Présenter les résultats du premier tour de suivi de la mise en œuvre mondiale du Code de pratique mondial de l'OMS pour le recrutement du personnel de santé («le Code»), un code de conduite volontaire adopté en 2010 par l'ensemble des 193 États membres de l'Organisation mondiale de la Santé (OMS).

Méthodes L'OMS a demandé à ses États membres de désigner une autorité nationale pour faciliter l'échange d'informations sur la migration du personnel de santé et la mise en œuvre du Code. Chaque autorité désignée a ensuite reçu une enquête transversale comportant 15 questions sur une gamme de sujets concernant les 10 articles inclus dans le Code.

Résultats Une autorité nationale a été désignée par 85 pays. Seuls 56 pays ont signalé l'état de la mise en œuvre du Code. Parmi eux, 37 ont pris des mesures pour appliquer le Code, principalement par le biais des parties concernées. Dans 90% des pays, les professionnels de santé migrants disposeraient des mêmes droits et des mêmes responsabilités que le personnel de santé formé localement. Dans le contexte du Code, la coopération dans le domaine du développement des travailleurs de la santé va au-delà des questions liées à la migration. Une base de données comparative internationale sur la mobilité du personnel de santé est nécessaire, mais elle ne peut être développée que par une approche collaborative et multipartite.

Conclusion Les rapports sur la mise en œuvre du Code de pratique mondial ont été insuffisants en général, sauf dans une région de l'OMS. Une meilleure collaboration entre les acteurs étatiques et non étatiques est nécessaire pour sensibiliser au Code et renforcer sa pertinence en tant que structure efficace pour le dialogue politique sur les moyens de remédier à la crise des effectifs du personnel de santé.

Резюме

Мониторинг процесса внедрения Глобального кодекса ВОЗ по практике международного найма персонала здравоохранения

Цель Представить выводы, сделанные в результате первого этапа мониторинга процесса внедрения на глобальном уровне Глобального кодекса ВОЗ по практике международного найма персонала здравоохранения (далее в тексте «Кодекс»). Данный Кодекс является добровольным и был принят в 2010 году всеми 193 государствами-членами Всемирной организации здравоохранения (ВОЗ).

Методы В соответствии с рекомендациями ВОЗ, государства-члены должны были назначить национальный орган, ответственный за соблюдение Кодекса и содействие обмену информацией по вопросам миграции персонала здравоохранения. Всем назначенным органам была направлена анкета, включающая в себя 15 вопросов по различным темам, относящимся к 10 включенным в Кодекс статьям.

Результаты Национальные органы были назначены в 85 странах. Отчет о текущем состоянии процесса внедрения Кодекса предоставили только 56 стран, из которых 37 предприняли определенные шаги по внедрению Кодекса, заключающиеся в основном в определении обязательств для вовлеченных сторон. По имеющимся данным, в 90% стран мигрировавшие работники здравоохранения обладают теми же законными правами и несут такую же ответственность, что и персонал здравоохранения, подготовленный внутри страны. Согласно Кодексу, сотрудничество в области подготовки трудовых ресурсов здравоохранения выходит за рамки вопросов, относящихся к миграции. Требуется создание международной сравнительной информационной базы данных по мобильности трудовых ресурсов здравоохранения, чего можно достигнуть только в результате совместной работы множества партнеров.

Вывод Предоставленные отчеты по внедрению Кодекса не содержали достаточных данных для всех регионов ВОЗ, кроме одного. Чтобы повысить информированность о Кодексе и его значимость как потенциальной основы для проведения диалога по вопросам поиска путей для выхода из кризиса в сфере трудовых ресурсов здравоохранения требуется более высокий уровень взаимодействия между государственными и негосударственными учреждениями.

Resumen

Seguimiento de la aplicación del Código de prácticas mundial de la OMS sobre la contratación internacional de personal sanitario

Objetivo Presentar los resultados de la primera ronda de seguimiento de la aplicación global del Código de prácticas mundial de la OMS sobre la contratación internacional de personal sanitario («el Código»), un código voluntario adoptado en 2010 por los 193 Estados miembros de la Organización Mundial de la Salud (OMS).

Métodos La OMS pidió a los Estados miembros que designaran a una autoridad nacional para facilitar el intercambio de información sobre la migración del personal y la aplicación del Código. Se envió una encuesta transversal con 15 preguntas sobre una variedad de temas relacionados con los 10 artículos incluidos en el Código a las autoridades designadas.

Resultados Un total de 85 países designaron a una autoridad nacional. Solo 56 informaron sobre el estado de aplicación del Código, de los cuales 37 tomaron medidas para la aplicación del mismo, principalmente a través de la participación de las partes interesadas. En el 90 % de los países, los profesionales sanitarios migrantes disfrutan supuestamente de los mismos derechos y responsabilidades legales que el personal sanitario formado en el país. En el marco del Código, la cooperación en el ámbito del desarrollo del personal sanitario transciende las cuestiones sobre migración. Se necesita una base internacional de datos comparativos sobre la movilidad del personal sanitario, la cual solo puede desarrollarse mediante un enfoque de asociación múltiple colaborativo.

Conclusión La elaboración de informes sobre la aplicación del Código ha sido insuficiente en todas las regiones de la OMS, excepto en una. Se requiere una mayor colaboración entre los actores estatales y no estatales a fin de dar a conocer el Código y reforzar su importancia como un marco eficaz para el diálogo político sobre las diversas formas de abordar la crisis del personal sanitario.

References

1. *The world health report: working together for health*. Geneva: World Health Organization; 2006. Available from: http://www.who.int/whr/2006/en/ [accessed 23 August 2013].
2. *The world health report – health systems financing: the path to universal coverage*. Geneva: World Health Organization; 2010. Available from: http://www.who.int/whr/2010/en [accessed 23 August 2013].
3. Buchan J. *Health worker migration in Europe: policy issues and options*. London: HLSP Institute; 2007. Available from: http://www.hlsp.org/LinkClick.aspx?fileticket=SM55vQDY0bA%3D&tabid=1702&mid=3361 [accessed 23 August 2013].
4. *User's guide to the WHO Global Code of Practice on the International Recruitment of Health Personnel*. Geneva: World Health Organization; 2010 (WHO/HSS/HRH/HMR/2010.2). Available from: http://whqlibdoc.who.int/hq/2010/WHO_HSS_HRH_HMR_2010.2_eng.pdf [accessed 23 August 2013].
5. Taylor AL, Dhillon IS. The WHO Global Code of Practice on the International Recruitment of Health Personnel: the evolution of global health diplomacy. *Glob Health Gov* 2011;V. Available from: http://scholarship.law.georgetown.edu/facpub/733/ [accessed 23 August 2013].
6. Robinson M, Clark P. Forging solutions to health worker migration. *Lancet* 2008;371:691–3. doi: http://dx.doi.org/10.1016/S0140-6736(08)60310-4 PMID:18295029
7. WHA63.16. WHO Global Code of Practice on the International Recruitment of Health Personnel. In: World Health Organization [Internet]. Sixty-sixth World Health Assembly, Geneva, 20–28 May 2013: main documents. Geneva: WHO; 2013. Available from: http://www.who.int/hrh/migration/code/code_en.pdf [accessed 23 August 2013].
8. *WHO Global Code of Practice on the International Recruitment of Health Personnel: National Reporting Instrument*. Geneva: World Health Organization; 2012. Available from: http://www.who.int/hrh/migration/code/WHO_CODE_NationalReportingInstEn.pdf [accessed 29 August 2013].
9. The Belgian development cooperation stakeholders' charter on the recruitment and support to the development of human resources for health in partner countries. *Be-cause health matters* 2012;5:1–7. Available from: http://www.be-causehealth.be/media/33192/be_cause_health_matters_n_5.pdf [accessed 29 August 2013].

10. Part III. Immigrant health workers in OECD countries in the broader context of highly skilled migration. In: *International migration outlook: SOPEMI 2007 edition*. Paris: Organisation for Economic Co-operation and Development; 2007. Available from: http://www.oecd.org/els/mig/41515701.pdf [accessed 23 August 2013].
11. Dussault G, Perfilieva G, Pethick J. *Implementing the WHO Global Code of Practice on International Recruitment of Health Personnel in the European Region*. Geneva: World Health Organization; 2012. Available from: http://www.euro.who.int/__data/assets/pdf_file/0013/173020/BRIEF_NRI_annex_060912VeryFinal.pdf [accessed 23 August 2013].
12. Rø OC. The health workforce crisis – What are the future challenges? Does the WHO Code work? In: *World Health Summit; 21–24 October 2012: Berlin, Germany*: speaker presentations [Internet]; 2012. Available from: http://www.worldhealthsummit.org/member/whs-2012/presentations-2012.html?L=0 [accessed 23 August 2013].
13. *Arbeidstilbudet fra sykepleiere og leger ved endret studie- og arbeidsmønster*. Oslo: Statistisk sentralbyrå; 1997. Norwegian. Available from: http://www.ssb.no/a/histstat/rapp/rapp_199708.pdf [accessed 29 August 2013].
14. Department of Health, Department of Labor and Employment, International Labour Organization. (Philippines) & World Health Organization (Philippines and Western Pacific Regional Office). *Monitoring of the WHO Global Code of Practice on the International Recruitment of Health Personnel: the Philippines multi-stakeholders approach*. Manila: DOH, DOLE, ILO & WHO; 2012. Available from: http://www.wpro.who.int/philippines/publications/phil_multistakeholders_approach/en/index.html [accessed 23 August 2013].
15. International Labour Organization. *Promoting decent work across borders: a project for migrant health professionals and skilled workers funded by the European Union*. Geneva: ILO; 2013. Available from: http://www.ilo.org/manila/whatwedo/projects/lang--en/index.htm [accessed 29 August 2013].
16. Document A66.25. The health workforce: advances in responding to shortages and migration, and in preparing for emerging needs. In: World Health Organization [Internet]. Sixty-sixth World Health Assembly, Geneva, 20–28 May 2013: main documents. Geneva: WHO; 2013. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_25-en.pdf [accessed 23 August 2013].
17. *International migration of health workers: improving international co-operation to address the global health workforce crisis*. Paris: Organisation for Economic Co-operation and Development; 2010 (OECD/WHO Policy Brief). Available from: http://www.who.int/hrh/resources/oecd-who_policy_brief_en.pdf [accessed 23 August 2013].
18. *Migrants count: five steps toward better migration data – report of the Commission on International Migration Data for Development Research and Policy*. Washington: Center for Global Development; 2009. Available from: http://www.cgdev.org/files/1422146_file_CGD_migration_FINAL_web.pdf [accessed 23 August 2013].
19. Dussault G, Fronteira I, Cabral J. *Migration of health personnel in the WHO European Region*. Geneva: World Health Organization; 2009. Available from: http://www.euro.who.int/__data/assets/pdf_file/0010/95689/E93039.pdf [accessed 23 August 2013].
20. Glinos IA, Wismar M, Maier CB, Palm W, Figueras J. Health professional mobility and health systems in Europe: conclusions from the case-studies. In: Wismar M, Maier CB, Glinos IA, Dussault G, Figueras J, editors. *Health professional mobility and health systems: evidence from 17 European countries*. Geneva: World Health Organization; 2011 (Observatory Study Series No. 23). Available from: http://www.euro.who.int/__data/assets/pdf_file/0017/152324/e95812.pdf [accessed 23 August 2013].
21. *The looming crisis in the health workforce, how can OECD countries respond*? Paris: Organisation for Economic Co-operation and Development; 2008 (OECD Health Policy Studies). Available from: http://www.oecd.org/els/health-systems/41509461.pdf [accessed 23 August 2013].