

## **Draft Evidence Brief No. 10**

# **Non-state actor reports on the WHO Global Code's Implementation**

Corinne Hinlopen, Wemos Foundation

Prepared for the 2<sup>nd</sup> Review of Relevance and Effectiveness of the  
WHO Global Code of Practice on the International Recruitment of  
Health Personnel

# Non-state actor reports on the WHO Global Code's implementation

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## Abstract (247 words)

The present evidence brief analyzes 14 Independent Stakeholders Reports on the implementation of the WHO Code of Practice on the International Recruitment of Health Personnel, with a view to inform the Expert Advisory group tasked to conduct the second review of the Code's relevance and effectiveness, taking place from May-October 2019. The information was analyzed in a qualitative manner by coding it according to five categories based on the Code's main objectives and guiding principles: ethical recruitment practices and fair treatment of migrant health workers; health workforce development and health systems sustainability; data gathering, research and information exchange; implementation of the Code; partnerships, technical collaboration and financial support. The 14 reports provide a broad range of interesting and relevant information, relating to many different aspects of the Code, showing the Code's relevance to these fourteen organizations. The evidence presented points to limited implementation of the Code, suggesting a lack of awareness about the Code and/or a disregard for the Code's principles, possibly related to a perceived lack of relevance. However, it is difficult to draw definitive conclusions on the Code's relevance and effectiveness as the data presented lack in quantity and quality. Recommendations to improve the data submitted by Independent Stakeholders include the development of a more fit-for-purpose reporting format, the clarification of roles and responsibilities to elicit more and better reports, the organization of practical support and guidance to (potential) submitters, and ways to substantiate and validate the information before submitting it, thus yielding better data.

## Introduction

Since its adoption by the World Health Assembly in 2010 (WHA63.16), the WHO Code of Practice on the International Recruitment of Health Personnel (hereafter: the Code) came with an agreed monitoring and review mechanism. Member States were to report on the Code's implementation in their jurisdiction every three years. In addition, every five years a review of the Code's relevance and effectiveness is due, in a Member State driven process.

The first round of reporting took place in 2012-2013, during which 56 Member States submitted their reports. The second round of reporting took place in 2015-2016, yielding 74 Member States' reports. This second round also facilitated contributions from other relevant stakeholders, consistent with the Code's scope as stipulated in Article 2.2: "The Code is global in scope and is intended as a guide for Member States, working together with stakeholders such as health personnel, recruiters, employers, health-professional associations, relevant sub-regional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel." One report was received from the EU-funded Health Workers for All partnership, comprising eight different case studies illustrating how the Code is translated into practical measures in several European local and national contexts.

The third round of reporting in 2018-2019 resulted in 80 Member States' reports and 14 Independent Stakeholders Reports. The Member States' reports have been summarized by WHO Headquarters

and published in preparation for the World Health Assembly in May 2019 (document A72/23). The Independent Stakeholders Reports – summarized in the present evidence brief – will be used by the Expert Advisory group tasked to conduct the second review of the Code’s relevance and effectiveness, taking place from May-October 2019.

## Sources and methodology

The data and information for this analysis are derived from the 14 Independent Stakeholders Reports that were submitted to WHO Secretariat in 2018, within the context of the third round of reporting on the Code’s implementation. These reports have been shared with Wemos by WHO Secretariat and will also be made available online<sup>1</sup>.

The information was analyzed in a qualitative manner, where relevant information was coded into five broad categories and subsequently summarized. These five categories are based on the Code’s main objectives and guiding principles: Ethical recruitment practices and fair treatment of migrant health workers (FAIR); health workforce development and health systems sustainability (DEV); Data gathering, research and information exchange (DATA); Implementation of the Code (IMPL); Partnerships, technical collaboration and financial support (PART).

## Summary of findings

### Submitters

Table 1 presents an overview of the fourteen submitting organizations, their main geographic focus, type of organization and their stated nature of involvement with the Code.

Name of organization (in alphabetical order)	Main geographic focus	Type of organization <sup>2</sup>	Stated nature of involvement in the Code <sup>3</sup>
African Centre for Global Health and Social Transformation (Achest), Zambia office	National (Zambia)	The African Centre for Global Health and Social Transformation is an independent Think Tank and Network, that focuses on issues to do with Human Resources for Health and Health Systems (Leadership, governance, advocacy, financing).	Achest Zambia is partner in the Health Systems Advocacy partnership whose main aim is to foster Health Systems Strengthening in Sexual and Reproductive Health, with focus on Human Resources for Health, Health Commodities and Health Financing, Leadership and Governance.
African Centre for Global Health and Social Transformation (Achest), Uganda office	National (Uganda) / regional	Civil society health systems think tank	Health workforce is a focus area of analytic research work of the Achest Think Tank.
Commission on Graduates of Foreign Nursing Schools (CGFNS)	Global	CGFNS International is an immigration neutral nonprofit organization that helps foreign educated healthcare professionals	CGFNS and its Alliance division are concerned with, respectively, enabling health personnel to bring their human capital across

<sup>1</sup> At the time of writing this evidence brief, this is not yet the case.

<sup>2</sup> As stated in their submitted reports and/or found on their websites.

<sup>3</sup> As stated in their submitted reports and/or found on their websites.

<b>Name of organization (in alphabetical order)</b>	<b>Main geographic focus</b>	<b>Type of organization<sup>2</sup></b>	<b>Stated nature of involvement in the Code<sup>3</sup></b>
		live and work in their country of choice by assessing and validating their academic and professional credentials.	borders, and ensuring that that occurs in an ethical manner.
Standing Committee of European Doctors (CPME) <sup>4</sup>	European region	Represents national medical associations across Europe	Long-standing supporter of the Code's principles
European Health Parliament	European region	The EHP is a platform of 55 young professionals / students from across Europe with a diverse range of (health related) backgrounds. They aim to shape the future of health care in Europe.	In the recognition that systematic brain drain from one country to another is not beneficial, sustainable HWF planning has been an important topic to EHP, in particular the Health Workforce Planning committee.
European Public Health Association (EUPHA)	Europe	EUPHA is an umbrella organisation for public health associations and institutes in Europe.	EUPHA's section on Health Workforce Research aims to serve as a network for researchers interested in HWF issues. Takes a broader perspective on global developments in HWF research and welcomes international comparison, knowledge exchange and networking.
International Council of Nurses (ICN)	Global	The International Council of Nurses (ICN) is a federation of more than 130 national nurses associations (NNAs), representing the more than 20 million nurses worldwide.	The association represents nurses who migrate, advocate for decent standards of work and employment and have experience with countries compliance with the Code. Constituency: member organizations from over 100 countries.
Kenya Medical Practitioners, Pharmacists & Dentists Union (KMPDU)	National (Kenya)	Kenya Medical Practitioners, Pharmacists and Dentists Union (KMPDU) is the trade union that represents all labour interests of doctors, dentists and pharmacists in Kenya and unites them to collectively bargain for strong and resilient health care systems for all citizens.	KMPDU engages the Kenya Government on sustainable health workforce planning, education, training and retention through collective bargaining.
Medicus Mundi Switzerland (MMS)	National (Switzerland) / global	Medicus Mundi Switzerland, the network for health for all, is a voluntary union of around 50 Swiss organizations active in international health cooperation.	MMS advocates for the WHO Global Code in Switzerland. Has built up a Civil Society Platform.
Organisation for Workers' Initiative and Democratisation (OWID)	Croatia	Established in 2012, OWID is committed to the protection and promotion of workers' rights, democratic decision-making	Among other activities, OWID has carried out research on the healthcare system in Croatia and the effects of privatization and

<sup>4</sup> CPME submitted a letter of support to the Code's principles, endorsing the implementation of these principles, without further elaborating on their perceived relevance or effectiveness of the Code.

Name of organization (in alphabetical order)	Main geographic focus	Type of organization <sup>2</sup>	Stated nature of involvement in the Code <sup>3</sup>
		processes among workers, and economic democracy.	transition processes on the accessibility of health care, as well as on working conditions of health personnel.
Royal College of Nursing (RCN)	National (United Kingdom)	The RCN is the world's largest nursing union and professional body, representing more than 435,000 nurses, student nurses, midwives and nursing support workers in the UK and internationally.	RCN advocated for introduction of UK's ethical recruitment code in 2000. International recruitment of health professionals makes a significant and valuable contribution to health and care services across the UK.
Sikika	National (Tanzania)	Sikika is a non-governmental Organization, concerned with fundamental health outcomes namely Health Governance and Financing, Human Resources for Health, Medicines and Medical Supplies and HIV & AIDS	Sikika has been working in the health sector advocating for improved health service delivery for 15 years, including research on the country's health workforce.
Wemos	National (Netherlands) / global	Independent civil-society organisation (CSO) advocating access to health for everyone, everywhere.	Wemos advocates for sustainable and fair health worker policies, worldwide.
World Family Doctors Europe (WONCA)	Europe	WONCA Europe is the academic and scientific society for general practitioners in Europe. It has 47 member organisations and represents more than 120.000 family physicians in Europe.	WONCA and its networks promote professional exchanges between countries and opportunities to train abroad. We encourage and support health personnel to utilize work experience gained abroad for the benefit of their home country. We also encourage decision makers to develop retention strategies for the health care workforce, such as clear and meaningful opportunities for professional development.

Table 1: Submitters and their involvement with the Code

## Themes addressed

The themes addressed by the fourteen submitters are summarized in table 2, according to the previously mentioned five categories: Ethical recruitment practices and fair treatment of migrant health workers (FAIR); health workforce development and health systems sustainability (DEV); Data gathering, research and information exchange (DATA); Implementation of the Code (IMPL); Partnerships, technical collaboration and financial support (PART). Please bear in mind that there is overlap between these five categories; some subjectivity in assigning the themes to one of the five categories is therefore inevitable. However, this has no significant implications for the conclusions and/or recommendations.

Name of organization (in alphabetical order)	Themes addressed				
	FAIR	DEV	DATA	IMPL	PART
Achest Zambia					
Achest Uganda			X	X	X
CGFNS	X			X	
CPME					
European Health Parliament		X	X		X
EUPHA	X				
ICN	X	X	X		X
KMPDU	X	X			X
MMS	X	X		X	X
OWID	X	X	X		
RCN	X	X	X		X
Sikika		X			
Wemos	X	X	X	X	X
WONCA Europe		X			X
<b>Total times addressed</b>	<b>8</b>	<b>9</b>	<b>6</b>	<b>4</b>	<b>8</b>

Table 2. Overview of themes addressed in the 14 Independent Stakeholders' Reports

## Main findings per theme

### Ethical recruitment practices and fair treatment of migrant health workers (FAIR)

Eight submissions contain specific information on ethical recruitment practices and fair treatment of migrant health workers.

One submission reports a case of active and targeted recruitment of nurses and doctors before they even graduate (OWID). Two submissions mention that fair treatment is ensured by law in their country of residence, although de-skilling has been observed (Wemos, MMS). RCN mentions the use of a 'proscribed list of countries' from where no recruitment should take place, and also specifies the exceptions to that list that have been formally agreed upon. One submission reports underpayment of immigrant nurses (RCN), another reports overpayment of immigrant doctors (KMPDU). Two organizations have an explicit aim to assist nurses who want to re-locate, thus ensuring their fair treatment (ICN, CGFNS). EUPHA has presented a case study on the practices of recruitment agencies operating on behalf of the NHS. This regulated route offers noticeable benefits to individual nurses in terms of better benefits packages, longer induction periods and temporary accommodation.

### **Health workforce development and health systems sustainability (DEV)**

Nine submissions contain specific information on the efforts (or lack thereof) by their governments to build a sustainable health system by (further) developing a strong health workforce.

Six submissions mention a lack of investments by governments (Sikika, Wemos, MMS, RCN, OWID, ICN), resulting in urban/rural maldistribution, poor retention schemes, low production of health workers, lack of deployment, lack of (access to) career development programmes, work overload and lack of motivation. The causes for the lack of investments are reported to be privatization, decentralization and austerity measures. One effect mentioned specifically is that health worker shortages fuel international mobility as well as ‘the global fight for health personnel’, leaving many bereft of access to adequate health care.

There is one specific mention of a lack of a credible health workforce strategy to address shortages (RCN). The European Health Parliament points towards the growing mismatch between skills learned/taught and skills needed in the European region. Wonca Europe gives details on their own efforts to support development and implementation of continuous professional development, through exchange programmes and courses.

### **Data gathering and research and information exchange (DATA)**

Six submitted reports make specific mention of challenges related to data gathering, research and information exchange.

The assessment (by submitters) of the quality of data and of data collection and data collection capabilities in their geographic focus region varies widely. Challenges reported are: incomplete, inconsistent, incomprehensive or irrelevant data; outdated information; fragmented data collection; lack of funding necessary to strengthen data collection and research. It is interesting to note that there is no clear north-south gradient in these (subjective) assessments of capabilities and overall data quality. RCN explicitly mentions that these challenges hinder the possibility to assess the disconnect between what countries say they do and what they actually do and achieve (in terms of health workforce development).

### **Implementation of the Code (IMPL)**

Four submitters report on the implementation of the Code. Three report a lack of awareness of the Code and its implications among the relevant stakeholders, in spite of (some) efforts on the part of Government to publicize and implement the Code and its provisions (Achest Uganda, Wemos, MMS). Reasons mentioned for low awareness are high staff turnover in government, or the lack of consistent and continued efforts.

One of the submitters (CGFNS) has an explicit mandate to help protect migrating healthcare professionals by advocating for ethical recruitment practices and continuously monitoring the global landscape for trends in employment, recruitment and workplace norms. They provide practical guidance for stakeholders across the sector to implement the principles of the WHO Code on the ground, and educate foreign educated health professionals – both potential migrants and those who have already migrated to the United States – about their legal rights.

### **Partnerships, technical collaboration and financial support (PART)**

Eight reports make references to partnerships, technical collaboration and financial support in relation to Code implementation. Two submitters elaborate on the technical support they

themselves provide to partner organizations, especially by offering guidance to health employers and internationally recruited nurses on their rights and responsibilities, or through activities to foster exchange of doctors between different countries, thus broadening the knowledge in both recipient and sending countries (RCN, Wonca Europe).

Wemos and MMS are critical of the lack of development co-operation policy in their country to invest in health systems in low and middle income countries, and specifically in human resources for health. KMPDU ventilates its discontent with the recent bilateral agreement between the Kenyan and Cuban Governments, stating that the deal does not do justice to the needs of the Kenyan health system or its doctors.

Achest Uganda touches on the fragmented approach to health systems strengthening by development partners, including efforts to support implementation of the Code. They also report that there is little evidence that the principle of mutuality of benefits is adhered to in south-south migration, or that the benefits from bilateral and/or regional and/or multilateral arrangements go towards building capacity for provision of effective and appropriate technical assistance, support for health personnel retention, support for training in source countries, etc.

Two other submitters, on a more general note, report on the financial loss of having paid to train staff who are then recruited overseas, or mention the growing imbalances in supply of healthcare staff in certain regions, due to either cross-country mobility flows or a national imbalance between certain geographical regions.

## Conclusions

Before drawing any conclusions on the relevance and effectiveness of the Code on the basis of the 14 Independent Stakeholders Reports, it is important to put this information in the right perspective. Firstly, the Independent Stakeholders Reporting instrument is developed to elicit constructive feedback on the Code implementation from non-state actors worldwide. The information in this evidence brief is based on just 14 submitted reports, of varying quality and level of substantiation. For example, even though the lack of implementation of the Code is evident in many comments, not all these comments are based on systematic research or adequately referenced. Generalisation of conclusions is therefore difficult. Secondly, the contents of the submitted reports relate to different levels of engagement with the Code: some present what the submitting organizations have done themselves to implement the Code (ICN, CGFNS); others elaborate on what they observe about the level of implementation of the Code by the duty bearers in their (geographical) area of work (for example Achest Uganda, KMPDU, Wemos, MMS, OWID, RCN, Sikika). Thirdly and more fundamentally, the reporting instrument is developed to monitor Code *implementation*, while they are currently being used to assess the Code's *relevance and effectiveness*, in view of the on-going Code's second review process. The assumption that information about Code implementation is directly associated with its relevance and effectiveness is not self-evident.

Nevertheless, there are a number of conclusions that can be drawn from the submitted reports. The 14 reports provide a broad and rich range of interesting and relevant information, relating to many different aspects of the Code, including international recruitment and fair treatment of migrant health workers; data collection and exchange, on (domestic) health workforce planning and forecasting and on international health worker mobility. But most information relates to the lack of



efforts (or results thereof) by national governments to invest in a better equipped, supported, fit-for-purpose and effectively deployed health workforce, which in turn fuels health worker mobility. The fact that so many aspects of the Code are addressed shows that *it is a relevant instrument – for these 14 organizations*.

In addition, it is clear that the submitting organizations themselves are very knowledgeable about the Code, its philosophy and its provisions, and that for them, the Code is an important guiding document in health workforce issues. This cannot be said about other stakeholders in their (policy) environment, as the reports also make clear that many of the Code's guiding principles are not being adhered to. This indicates *a low general level of awareness about the Code and/or a disregard for the Code's principles*.

Furthermore, it is interesting to note that only 5 of fourteen submissions hail from organizations in countries with a pronounced health worker deficit and substantial net outflow problems: Achest Zambia, Achest Uganda, KMPDU from Kenya, OWID from Croatia and Sikika from Tanzania. This suggests that *the Code is either not well-known in countries with health worker shortages, or not considered relevant enough to engage with, and thus: to report on*. And as long as the level of implementation of the Code is low, its effectiveness cannot be assessed.

## Discussion

These conclusions beg a number of questions. For example, why are so few reports submitted and how can this be improved? Possible reasons are: the Code is largely unknown; the reporting opportunity is not known; the relevance of the Code is perceived as low, leading to lack of interest in submitting a report; even if aware and interested, not every organization has the capacity to collect and analyze data and make a full report on them. In addition, it is unclear what efforts are being made to elicit more reports, and by whom. After 10 years of the Code's existence, receiving just fourteen Independent Stakeholders Reports can hardly be considered a success. The information available, although undoubtedly interesting, is simply too little. More voices will yield more meaningful input that will help improve the Code's implementation.

Raising the level of awareness and knowledge about the Code and its reporting mechanism seems a sensible strategy, as well as providing more stimulus for Code implementation (by national governments and other duty bearers) and for regular reporting (including by civil society). The question is who is mainly responsible for what, and where funding (if necessary) should come from. Although the Code is an instrument adopted by WHO Member States, their interest in its effective implementation seems to be waning, if the 14 Independent Stakeholders Report are representative for the situation worldwide. At the same time, there are some strong examples of how the Code's principles have been translated into binding laws and regulations (Germany, and, according to this report: The Netherlands and Switzerland). It is important to learn from these examples.

An important bottleneck relating to the quality of the reports is rooted in their format: the instrument – a web survey - is an open format questionnaire. While this enables the capturing of an interesting range and diversity of information, this hampers systematic data collection, which in turn renders meaningful analysis and comparison problematic. Overall comparability of the total body of information submitted is low. This can be improved by developing a more guiding set of questions. However, it has been suggested that open format surveys yield more results, and rigid, closed format

questionnaires will result in fewer responses. This is a trade-off that needs to be re-assessed. Another improvement of the information quality may be achieved if the information submitted by the independent stakeholder is first discussed with duty bearers in their country or region. And vice versa: country reports could also benefit when their data are first scrutinized by/with independent stakeholders in their country. The data submitted in both formats may be subjective and possibly biased. Cross-checking the information before submitting it will improve the quality of the data. Intrinsically, scrutinizing the data in a consultative process will create a better understanding of facts, figures and arguments among all stakeholders involved. At the very least, the effect of such an open, consultative process is increased mutual understanding on the positions and arguments of all stakeholders involved in the Code at country level.

## **Recommendations to the Expert Advisory Group**

Based on the findings of this research, the following recommendations can be put forward:

- Develop a strategy for concerted action to elicit more responses during the Code's reporting rounds, including a clarification of roles and responsibilities of the different stakeholders in awareness raising on the Code and its reporting mechanisms.
  - Mobilize more actors and stakeholders in Code implementation and support them in their efforts to submit reports themselves or reach out to potential submitters, for example by organizing a series of 'how-to'-webinars or developing a toolkit.
  - Review the Code's User's Guide and define the different roles and responsibilities more clearly.
- Re-think the format of the reporting instrument for Independent Stakeholders.
  - Develop a more closed format, including (at the very least) guiding questions on what kind of information is desired from the submitter, and on which specific aspects of the Code or Code implementation. Since the next reporting round will take place in 2021, this process ideally starts now.
  - Include separate questions on the Code's perceived relevance and effectiveness, so that this information can feed into the 5-yearly review of the Code.
- Reconsider how to elicit reliable (substantiated), solid (quantitatively) and relevant information from the Independent Stakeholders.
  - Request some level of proof for the data and information submitted, including documented resources and other references.
- Promote an in-country multi-stakeholder consultation process prior to the submission of both the National Reporting Instruments and the Independent Stakeholder Reports, on the evidence to be submitted.
  - Request that all submissions are endorsed by or at least 'seen by' a certain number of other relevant stakeholders.