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Introduction

On May 21, 2010 the WHO Global Code of Practice on the International Recruitment of Health Personnel (the “Code”) was adopted by the 193 Member States of the Sixty-Third World Health Assembly. This groundbreaking instrument marks the first time that WHO Member States have used the constitutional authority of the Organization to develop a non-binding code in thirty years.

The basic concept behind the Code is to establish and promote voluntary principles and practices for the ethical international recruitment of health personnel and the strengthening of health systems. The Code was designed by Member States to serve as a continuous and dynamic framework for global dialogue and cooperation.

To address the challenges associated with the international migration of health personnel, WHO Member States are encouraged, in accordance with Articles 7.2 and 9.1 of the Code, to inform each other, through the WHO Secretariat, on issues related to health personnel and health systems, and measures taken to implement the Code in a single national report (the “Regular National Report”) every three years starting in 2012. In addition, Article 9.4 of the Code provides that the WHO Secretariat may consider reports from other stakeholders on activities related to the implementation of the Code. The reporting process is an integral component of the effective implementation of the voluntary principles and practices recommended by the Code.

To facilitate the reporting process under the Code, Member States in Resolution WHA63.16 requested the Director-General "to rapidly develop, in consultation with Member States, guidelines for minimum data sets, information exchange, and reporting on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel." In accordance with the request of the World Health Assembly, the Secretariat has developed these Guidelines on Monitoring the Implementation of the WHO Global Code (the “Guidelines”).

The Guidelines are designed to provide a user-friendly approach for governments and other stakeholders to participate effectively in the monitoring of the implementation of the Code. The Guidelines provide recommendations to WHO Member States regarding information and materials that may be useful to include in the Regular National Reports recommended by the Code. These Guidelines also identify the process of submitting information gathered by other stakeholders, including health personnel, recruiters, employers and all persons concerned with the international recruitment of health personnel. Over time, the implementation of these Guidelines will provide an ongoing source of information to evaluate progress in observing the Code and to highlight where further work is needed.

Part I of the Guidelines provides general information on the development of the Guidelines, the role of monitoring and the process that may be used by Member States and other stakeholders to report on activities relevant to the implementation of the Code. Part II of the Guidelines provides a model form for the Regular National Reports, including subparts on qualitative and quantitative information. Part III of the Guidelines provides a model form for reporting on implementation by other stakeholders.

1 Article 2.2 provides that the “Code is global in scope and intended as a guide for Member States working together with stakeholders such as health personnel, recruiters, employers, health-professional organizations, relevant subregional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel.”
PART 1 – Description of the guidelines

1.1 The development of the guidelines: a transparent and participatory process

The Guidelines were developed in a process involving consultation with Member States and other stakeholders concerned with the Code. The Guidelines were also prepared in accordance with the requirements of the WHO Guidelines Review Committee.

Two meetings were held with experts in the field of health workforce migration together with national policymakers, professional associations, civil society organizations, international lawyers and international organizations. The first expert meeting, a joint OECD/WHO technical workshop, focused on issues related to the monitoring the international health workforce and the content of the Minimum Data Set. The second meeting reviewed progress made with the development of the Minimum Data Set and discussed and provided comments on the draft Guidelines prepared by the Secretariat.

In November 2010 the Secretariat held a technical briefing describing preparation of the Guidelines to representatives of Member State missions in Geneva.

[The review process for the Guidelines following the second expert meeting in October 2010 is expected to be as follows:

- Web-based consultation March-April 2011;
- Proposed technical briefing on draft Guidelines at the Sixty-Fourth World Health Assembly, May 2011; and
- Consultations with WHO Member States in regional meetings (April-October 2011)]

1.2 Why monitor?

The Guidelines have been developed to strengthen the implementation of various provisions of the WHO Global Code. Regular monitoring of the implementation of essential provisions of the Code can provide Member States and other interested stakeholders with the evidence-base necessary to advance national action and global cooperation on the ethical international recruitment of health personnel and progressively strengthen health systems worldwide. In addition, regular monitoring can serve the following critical functions:

- To provide each Member State with a self-assessment tool to help it monitor its progress in implementation of the Code and improve decision-making at the national level on international health personnel recruitment and health system performance;
- To strengthen global and national mechanisms for information exchange on data related to health personnel migration and its impact on health systems;
- To improve comparability and reliability of health personnel data; and
- To enable WHO to describe the worldwide status of health personnel recruitment and its impact on health systems as well as trends overtime with inputs from governments and other stakeholders.

Regular and systematic review of the implementation of the Code is also an essential component in keeping the Code up to date and useful as an instrument of global health policy. Member States mandated that the Code “should be considered a dynamic text that should be brought up to date as required.” (Article 9.5)

2 The foregoing description of the review process for the Guidelines is subject to change as the process is under development.
The Guidelines are directed primarily to Member States. As outlined in Article 9.4 of the Code, other stakeholders and interested parties are also invited to provide their input on activities related to implementation of the Code. Consequently, the Guidelines include model forms for regular monitoring by Member States (Part II) and for reporting by other stakeholders (Part III).

1.3 What to monitor: information to be included in regular national reports

1.3.1 General

The Regular National Reports combine quantitative and qualitative information. Article 7.1 envisions that Member States will regularly monitor broad aspects of health personnel migration and its impact on health systems. In addition, Article 9.1 of the Code calls upon Member States to report on measures taken, results achieved, and difficulties encountered in implementing the Code to illustrate how the objectives of the Code are being achieved. The information collected on the implementation of the Code is to be included in the single Regular National Report submitted to Secretariat every three years with data on information exchange.

1.3.2 Data and information exchange on health personnel migration

Member States are encouraged, in accordance with Article 7.1, to establish and strengthen information exchange on “international health personnel migration and health systems, nationally and internationally, through public agencies, academic and research institutions, health professional organizations, and subregional, regional and international organizations, whether governmental or non-governmental,” as appropriate and subject to national law. There are two types of information that should be progressively collected and reported to the Secretariat to the extent possible. Member States are encouraged to collect and provide updated information to the Secretariat on: (1) health personnel migration data and health personnel information systems, and (2) data on laws and regulations related to health personnel recruitment and migration and, as appropriate, information related to their implementation (Article 7.2(c)).

In order to facilitate information exchange on health personnel migration data, WHO has developed, in cooperation with the OECD, the Minimum Data Set described in the Regular National Reporting Instrument in Part II below. The Minimum Data Set consists of the core data that the WHO Secretariat recommends that Member States should collect pursuant to Article 6.2. It is conceived as a progressive data collection system that can be expanded over time. As a first step, the Minimum Data Set recommends essential information that all Member States should collect. Overtime, additional types of information on health personnel migration can be collected that would allow for more in depth analysis.

1.3.3 Reporting on the implementation of the WHO Code

The scope of the monitoring envisioned under Article 9.1 covers every aspect of the Code. Member States are encouraged to monitor their own level of observance with the Code and the level of observance by recruiters, employers and other relevant stakeholders. Broadly, governments are responsible for monitoring the extent to which the overall objectives and principles of the Code are being met. Governments should bear each of these considerations in mind as they gather and report on information in response to these Guidelines.

The reporting requirements under the Code can be very useful. National reporting encourages Member States to undertake a more comprehensive and systematic review of their existing policies. This may encourage various government agencies and others to better coordinate their actions within a country.

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3 It should be noted that the Secretariat’s recommendation of the Minimum Data Set is in keeping with its Code responsibilities to address the challenges of the lack of consistency in the definition of relevant data items. Article 6.4 provides that WHO, “in collaboration with relevant international organizations and Member States, is encouraged to ensure, as much as possible, that comparable and reliable data are generated and collected for ongoing monitoring, analysis, and policy formation.”
Reporting can also serve an educational function, allowing states to benefit from the experience of others. In terms of implementation, reporting promotes transparency. Reporting also makes it possible to judge the effectiveness of the Code and assess the need for further action.

1.3.4 Strengthening monitoring capacity

Although very useful, monitoring can be a time- and resource-intensive process. In light of the challenges in monitoring in resource-limited settings, the Guidelines recommend that each Member State complete the Regular National Report to the extent possible given national circumstances and priorities. Member States are encouraged to strengthen and deepen their capacity to collect and exchange information relevant to the Code over time both at the national and international level.

1.4 Member state reporting process

1.4.1 The regular national reporting process and timeline

The regular national reporting process by Member States is one of the critical steps in the implementation of the Code. The Code establishes a systematic and regular process for information exchange and review of implementation. Member States are encouraged, in accordance with Articles 7.2 and 9.1 of the WHO Global Code, to submit a single Regular National Report every three years starting in 2012.

As part of the review process, the Code mandates that the Director-General shall keep under review the implementation of the Code on the basis of the periodic Regular National Reports received from Member States and, in conjunction with these periodic Regular National Reports, "report to the World Health Assembly on the effectiveness of the Code in achieving its stated objectives and suggestions for its improvement." (Article 9.2).

Table 1 below sets forth the timeline depicting the regular review process established by the Code. It should be noted that Member States are called upon to deliver their Regular National Report to the WHO Secretariat at the address designated in Part 1.7 by May of each year that such report is due.

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The purpose of the review process taking place at regular intervals is to keep the effectiveness of the Code under close scrutiny and continuous review. The Code provides that the World Health Assembly should periodically review the relevance and the effectiveness of the Code and that the instrument should be considered a dynamic text that should be brought up to date as required (Article 9.5).

1.4.2 The national authority

In order to facilitate the regular national reporting process, each Member State is called upon to "designate a national authority responsible for the exchange of information regarding health personnel migration and the implementation of the Code" (Article 7.3). (the “national authority”). The Code provides that 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, the WHO Secretariat and other regional and international organizations and to submit the Regular National Reports and other information recommended by the Code to the WHO Secretariat.
The regular national reporting process recommended by the Code hinges on the development of sound coordination mechanisms at the national level, including a known national authority with adequate support that plays a role in policy setting and direction. Depending upon national circumstances and preferences, the national authority can play a major coordination function through:

- Serving as the focal point for exchange of information on health personnel migration and implementation of the Code;
- Facilitating coordination across a range of sector activities related to health personnel migration;
- Informing, mobilizing and engaging a wide range of national and sub-national stakeholders on implementation of the Code;
- Communicating with the designated national authorities of other Member States, WHO and other organizations at national, regional and international levels; and
- Contributing to the development of policy on international health personnel recruitment and health services.

The Code does not specify the type of organization that should serve as the national authority and each Member State has the right to designate whatever organization it believes can best fulfil the role. It is recommended that such organization should have a strong interest in health workforce issues, be sustainable, have the capacity to build intersectoral action, and possess adequate information technology communication means. It is also recommended that each Member State designate an existing institution to serve as the national authority, such as a ministry, regulatory body, or observatory, rather than creating an entirely new institutional mechanism.

The Code calls upon Member States designating a national authority to inform WHO under Article 7.3 and mandates that a register of designated National Authorities shall be "established, maintained and published by WHO" under Article 7.4. In order to facilitate the development of the register of National Authorities, the WHO Secretariat sent a note verbale to Member States requesting that each Member State communicate to WHO the designated national authority. Information regarding the designated national authority should be regularly updated and communicated to WHO as necessary.

1.5 Other stakeholder reporting process

The Code’s provisions on monitoring differentiate between Member States and other stakeholders. Member States are encouraged to report to the WHO Secretariat on implementation of the Code and information exchange every three years pursuant to Articles 9.1 and 7.1. In addition, the Article 9.4 Code provides that the WHO Secretariat may consider reports from other stakeholders on activities related to the implementation of the Code.

Reporting by stakeholders other than Member States encompasses the full spectrum of activities related to the implementation of the Code, including those under the responsibility of governments and those responsibilities of stakeholders, such as recruiters and employers. Accordingly, stakeholders may wish to provide information relevant to the observance of any or all provisions of the Code.

A broad array of entities are encouraged to monitor and report under the Code. Article 2.2 of the Code defines stakeholders to include entities “such as health personnel, recruiters, employers, health professional organizations, relevant sub-regional regional and global organizations, whether public or private sector, including non-governmental organizations, and all persons concerned with the international recruitment of health personnel.”
1.6 Procedures and forms for reporting

1.6.1 General

A key purpose of these Guidelines is to provide a simple, user-friendly approach for use by governments and other stakeholders in the monitoring the implementation of the Code. The common use of this approach will facilitate participation as well as promote comparability of data and regularity of information flow.

To this end, Section 1.3 and 1.5 of these Guidelines set out the information that should be gathered by governments and other stakeholders as a basis to monitor the implementation of the Code. This Section sets out the procedures by which this information should be reported to WHO. The overall approach is described in Table 2.

Table 2. Monitoring and reporting on implementation of the Code

<table>
<thead>
<tr>
<th>Regular national reporting</th>
<th>Reporting by other stakeholders</th>
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<tbody>
<tr>
<td>1. Regular gathering of information on items in Part II</td>
<td>1. Gathering of information on implementation of any provision of the Code</td>
</tr>
<tr>
<td>2. Member States report to WHO every 3 years, using the form in Part II</td>
<td>2. Other stakeholders report to WHO as considered useful using the form in Part III</td>
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1.6.2 The regular national reporting instrument

In order to promote the most efficient means of information exchange and reporting, these Guidelines include a recommended Regular National Report Instrument for both qualitative and quantitative information (see Part II, Sections 1 and 2, respectively). The need for effective and efficient review indicates that Regular National Reports should be structured in a similar format as possible in order to aid comparison and assess progress.

As recognized by the Guiding Principles of the Code and Articles 3.5 and 7.5, transparency is a core principle of the ethical international recruitment of health personnel and effective sharing of information is “essential to achieve the objectives” of the Code.”. In accordance with the principle of transparency, Regular National Reports are made publicly available through their posting on the WHO website.

1.6.3 The reporting instrument for other stakeholder

Stakeholders identified in Article 2.2 are invited to submit monitoring information on specific aspects of the implementation of the Code. Such information should be provided to the WHO Secretariat using the form in Part III. The information may refer to positive aspects of implementation of the Code, problems of implementation, or other aspects of implementation as the case may be. In accordance with the principle of transparency, the Reports from Other Stakeholders, along with Regular National Reports, are made publicly available through their posting on the WHO website.

1.7 Submission of reports

[This section should include (1) the details of how to report to WHO, including email address, and (2) the details on how to fill out the report, including electronic communication.]
PART 2 – Regular national reporting instrument

Regular national report for the year 2012

Name of member state:

Date National Report submitted:

If your country has designated a national authority (the “National Authority”) responsible for the exchange of information regarding health personnel migration and the implementation of the Code as recommended by Article 7.3, please provide the following information:

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If your country has not designated a National Authority, please indicate if your country intends to establish a National Authority in the future.

___ Yes   ___ No  In addition, please provide information on the national contact responsible for the preparation of the report.

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<th>Full name of institution:</th>
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1. Responsibilities, Rights and Recruitment Practices (Article 4)

1.1 In your country do migrant health personnel enjoy the same legal rights and responsibilities as the domestically trained health workforce in terms of employment and conditions of work?

___Yes  ___No  If YES, please describe what legal mechanisms are in place to ensure that migrant health personnel enjoy the same legal rights and responsibilities.

___No  If NO, please describe how the legal rights and responsibilities of migrant health personnel differ from the domestically trained health workforce and why. In addition, does your country plan to ensure such legal rights and responsibilities in the future?

1.2 Please describe what legal safeguards and other mechanisms are in place in your country to ensure that recruiters and employers observe fair and just recruitment and contractual practices in the employment of migrant health personnel? possibilities as the domestically trained health workforce in terms of employment and conditions of work?

1.3 Do migrant health personnel enjoy equal opportunities as the domestically trained health workforce to strengthen their professional education, qualifications and career progression?

___Yes  ___No  If NO, what measures are being taken in your country to ensure that migrant health personnel enjoy opportunities on the basis of equality of treatment with the domestically trained health workforce in the future?

1.4 Please submit any other comments or information you wish to provide regarding legal, administrative and other measures that have been taken or are planned in your country to ensure fair recruitment and employment practices.
2. Health Workforce Development and Health System Sustainability (Article 5)

2.1 Does your country discourage active recruitment from developing countries facing critical shortages of health workers?
   ___ Yes  ___ No  If YES, please briefly describe the legal and policy measures used to discourage recruitment.

2.2 Has your country entered into bilateral, regional or multilateral agreements addressing the international recruitment of health personnel?
   ___Yes  ___No  If YES, please describe such agreements or arrangements in Table 1 and provide a copy of such agreements with this Regular National Report.

Bilateral, multilateral or regional agreements or arrangements

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<tr>
<th>Type of agreement (bilateral, multilateral, regional)</th>
<th>States and territories covered</th>
<th>Validity period (from–to)</th>
<th>Type of health personnel covered by agreement</th>
<th>Description</th>
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2.3 If you are a destination country, do you undertake or encourage measures aimed at strengthening health systems in source countries? Such measures may include support for training, twinning of health facilities, circular migration, and technical assistance including support for the development of appropriate regulatory frameworks or other measures to sustain or support health personnel resource development or retention in source countries.
   ___ Yes  ___ No  If YES, please describe such measures and what level of government is responsible for implementing them.

2.4 As a policy matter, does your country strive to meet its health personnel needs with its own human resources for health as far as possible?
   ___ Yes  ___ No

2.5 Has your country undertaken measures to increase the share of domestically trained health personnel in the health workforce?
   ___ Yes  If YES, please describe the measures taken and when such measures were adopted.
No

If No, does your country plan to take measures to decrease its dependence on migrant health personnel in the future?

What constraints does your country face in its efforts to increase the share of domestically trained health personnel in the health workforce?

2.6 What efforts are made in your country to coordinate among all stakeholders in efforts to develop and retain a sustainable health workforce that is appropriate to the health needs of your country?

2.7 What measures are being undertaken in your country to address geographical maldistribution of health workers and to support their retention in underserved areas?

2.8 Please submit any other comments or information you wish to provide regarding health workforce development and health system sustainability measures that have been taken or are planned in your country.
3. Data Gathering, Research and Information Exchange (Articles 6 and 7)

3.1 Does your country have human resources for health information system at the national level?

___ Yes If YES, please describe the cadres of health personnel identified by the human resources for health information system and what types of information you collect for each cadre.

___ No If NO, please describe the obstacles your country faces in establishing human resources for health information system.

3.2 Since the adoption of the Code, has your country undertaken new measures to establish or strengthen research programmes or strengthen its coordination of existing research programmes on health personnel migration through partnerships?

___ Yes If YES, please describe such measures.

___ No If NO, please describe the obstacles or difficulties your country has encountered in establishing or strengthening research programmes or strengthening coordination of existing research programmes through partnerships.

3.3 If your country has designated a national authority, are mechanisms in place at the national level for information exchange and cooperation between your designated National Authority and the National Authority of other countries, with the WHO Secretariat, and other international or regional organizations?

___ Yes ___ No If YES, please describe such mechanisms?

3.4 What are the major challenges involved in establishing mechanisms for information exchange and cooperation on health workforce migration and international recruitment between your country and other countries, WHO and other international and regional organizations?
3.5 Has your country established a database of laws and regulations related to health personnel recruitment and health personnel migration and, as appropriate, information related to their implementation

___ Yes  If YES, please enclose copies, electronically or in hard copy, of national laws and legislation on health personnel migration and the international recruitment of health personnel, along with information on implementation as available.

___ No  If NO, does your country plan to establish such a database?

3.6 What are the major difficulties your country has encountered in establishing and maintaining an updated database on laws and regulations and information about their implementation?

3.7 Please submit any other comments or information you wish to provide regarding research programs in the field of health personnel migration or information exchange measures related to health personnel migration that have been taken or are planned in your country.
### 4. Implementation of the Code (Article 8)

#### 4.1 In your country, what steps have been taken to implement the Code at the national level and by which entities?


#### 4.2 In your country, what steps have been taken to implement the Code at the sub-national or local levels and by which entities?


#### 4.3 Has an assessment of the national, sub-national and local level needs for the implementation of the Code been made?

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<th>Yes</th>
<th>No</th>
<th>If NO, does your country plan to make such an assessment?</th>
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#### 4.4 Have actions been taken to communicate and share information cross-sectorally, on health worker recruitment and migration issues as well as the Code, amongst relevant ministries, departments and agencies, nationally and subnationally?

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#### 4.5 Does your country intend to introduce changes to law or policy to bring them into conformity with the recommendations of the Code?

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<th>Yes</th>
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<th>If YES, please describe the proposed changes in law and/or policy and when you expect to introduce these changes.</th>
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#### 4.6 In your country have measures been taken to involve all stakeholders in decision-making processes involving health personnel migration and international recruitment?

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<th>Yes</th>
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<th>If YES, please describe the measures taken.</th>
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4.7 In your country what measures have been taken for dissemination and promotion of the Code in collaboration with all stakeholders?

4.8 Have actions been taken, including incentive measures, to encourage private industry to comply with the Code?
___ Yes  ___ No  If YES, please describe such measures.

4.9 Does your country require that recruiters be officially authorized to operate in your territory?
___ Yes  If YES, does your country maintain a record of all recruiters authorized by competent authorities to work with your country?

___ Yes  If YES, how frequently is this record updated? Please provide a copy of the record with this Regular National Report.

4.10 Please list in priority order the three main constraints to the implementation of the Code in your country and propose possible solutions

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<th>Main constraints</th>
<th>Possible Solutions</th>
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4.11 What have been the most successful aspects of implementation of the Code in your country?

4.12 What are your priorities for future implementation of the WHO Code?

4.13 Please submit any other comments or information you wish to provide regarding implementation of the Code in your country.
5. Partnerships, Technical Collaboration and Financial Support (Article 10)

5.1 Has your country received assistance from one or more countries or other stakeholders to support implementation of the Code?

___ Yes ___ No

If YES, please provide additional information on the names of the countries or organizations and the type of assistance provided.

5.2 Has your country provided assistance to one or more Member States or other stakeholders to support its implementation of the Code?

___ Yes ___ No

If YES, please provide additional information on the names of the countries or other stakeholders and the types of assistance provided.

5.3 Does your country need technical and/or financial support in order to strengthen implementation of the Code?

___ Yes ___ No

If YES, please describe the types and amounts of assistance needed.

5.4 Please submit any other comments or information you wish to provide regarding partnerships, technical and financial support for the implementation of the Code in your country.
6. Concluding questions and comments

6.1 The Code urges that the special needs of developing countries be taken into account when implementing provisions of the Code. Please provide any comments you may have regarding cooperation in implementing the Code between your country and other countries.

6.2 Please provide any suggestions for further development and revision of the reporting instrument.

6.3 Please provide any suggestions for further development and revision of the reporting instrument.
Draft guiding principles for the compilation of a Minimum Data Set for the monitoring of health workforce migration

Improving the availability and international comparability of migration data and statistics for health personnel is key to helping countries develop more evidence-based policies. Central to this is the compilation of a minimum data set (MDS) to effectively monitor international health workforce migration. Such MDS is a key element for monitoring the implementation of the WHO Global Code of Practice, and resolution WHA63.16 specifically requested the rapid development of guidelines, including for a MDS.

The objective of these draft guiding principles for the monitoring of the health workforce migration is to provide guidance and recommendations for data collection and to describe the possible nature and scope of data to be collected in the context of the MDS.

The first section of the document presents the basic principles for the MDS and data collection, then a structure for the MDS is proposed and the information to be provided by Member States reviewed. In the final section of the document, data sources to enable the collection of the requested information are briefly presented. Finally, Annex 1 provides a definition of key variables for the MDS and Annex 2 contains the proposed excel tables for Member States to fill.

These guiding principles have been developed jointly by the WHO Secretariat and the OECD Secretariat and build upon the longstanding cooperation between these two Organizations on health workforce issues.

Basic principles for the MDS data collection

- **Coverage of health professions**: ideally, the monitoring would include all categories of health personnel, including general and specialist medical doctors (with a possible distinction to be made between both), nurses, midwives, pharmacists, dentists, physiotherapists, medical laboratory technologists, health management and support workers, etc., because all these personnel are engaged in actions with the primary intent to enhance health.

  However, to keep the data collection process manageable, it is proposed to initially focus the data collection effort on medical doctors (all categories included) and nurses (including nurse assistants and all categories of professional nurses) and midwives. Nonetheless, countries could also be encouraged to provide data for other professions than medical doctors, nurses and midwives when these are, or can be made available. Over time, the MDS will be extended for other categories of health personnel.

- **Identifying/defining international migrant health personnel**: the proposed main priority is to collect data on international health worker migrants according to the country where first education/training qualification leading to a health profession was completed/obtained. Given the increasing internationalization of higher education, it is also useful to complement the information on place of education/training with information on country of birth/nationality in order to identify those who studied abroad but then returned to practice in their home country or moved on to another country. It is also proposed to limit the data collection to health personnel actually residing in the destination countries (i.e. excluding health professionals who are registered but who are currently living and working abroad).
• **Focusing data collection on destination countries initially, while supporting efforts to improve health workforce information systems in lower income source countries:** While health workforce migration is a serious concern for countries that are losing skilled workforce to other countries, emigration statistics are currently scarce and often not very reliable. Statistics on exits are available only in a limited number of countries and generally not by occupation. Therefore, it is proposed to focus on immigration statistics as such data are available in a larger number of countries and more reliable. In order to quantify and characterize the scope and impact of international migration on source countries, the information collected in countries of destination can be aggregated by country of first qualification and, to the extent possible, country of birth or nationality.

• **Collecting data on migrant health workers** is of limited use if it is not complemented by other efforts to improve information on domestic health workers in origin countries. This is why it is also crucial to support the improvement of health workforce information systems in lower income countries, including systems to monitor international migration.

• **Monitoring both stocks and, to the extent possible, flows of migrant health workers:** Data on both stocks (total number of health workers in the country at a specific point in time) and flows (total number of new recruitments of health workers/new registrations in the previous year, or latest year available) of international health personnel migrants should be collated, reported and used to provide a comprehensive picture of migration patterns over time. Based on existing data sources in countries, comparable data on stocks may be more widely available. Regularly collected data on stocks can also provide an indirect measure of net flows.

• **Distinguishing immigrant health workers active in the health sector from those who are not:** From the perspective of both source and destination countries, it is important to differentiate between migrant health personnel working in the health sector, those who are inactive and those working outside the health sector. In general, existing data sources may only have basic information on the employment status of registered health professionals, if any. Most of the data collection will therefore be limited to migrant health workers working in the health sectors.

• **Finally, the data collection for the MDS should build on current data sets as much as possible.**

**Structuring the MDS**

The proposed MDS may be conceived as a pyramid (Figure 1), identifying a core minimum of variables for international reporting in the short-term, supported by additional variables that would allow more in-depth analyses and which might be expanded over time. The proposed framework is based on a hierarchy of three levels of information needs reflecting the proposed order of priorities (that is, level A, B and C).

Following the first principle mentioned above, the first and most important level of priority for data to be collected is level A (monitoring the country of first qualification of migrant health personnel). However, such information would need, to the extent possible, to be cross tabulated with other variables from the second level, i.e., level B, to permit a more precise and comprehensive identification of different groups of migrant health workers as well as to better assess the potential impact of health workforce migration on origin countries. Level C is less essential, but would still be highly valuable to better monitor the characteristics, role and the status of migrant health workers in the labour market of destination countries.
Information to be provided by Member States

Reflecting the order of priorities depicted in Figure 1, the three levels of information priorities (levels A, B and C) are summarized in the set of Tables included in Figure 2 I for doctors and Figure 2 II for nurses. As mentioned, level A represents the core data that Member States would be expected to provide. Level B captures other key information that Member States would be strongly encouraged to provide. Finally, Member States are also encouraged to consider providing level C information whenever possible.

The following paragraphs describe in a bit more detail the requested information for doctors and nurses proposed in Figure 2 I and 2 II respectively. Further specifications of the proposed definitions of each variable in these tables are provided in Annex 1. The actual data would to be entered and provided in Excel tables, and Annex 2 provides examples of the proposed template of these Excel tables.

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4 As previously stated however, the MDS should be extended to include all categories of health personnel whenever possible.
Part 2 – Regular national reporting instrument – Section 2: Quantitative information – Minimum Data Sets

Draft guidelines on monitoring the implementation of the WHO Global Code on the International Recruitment of Health Personnel

Figure 2a. Data to be collected for medical doctors according to priority levels

- Table A1 (stock and flow) All
  - Country of first qualification

- Table B1 (stock) Working in the health sector
  - Country of first qualification
  - Country of birth or of nationality

- Table B2 (stock) Working in the health sector
  - Country of first qualification
  - Age

- Table B3 (stock) Working in the health sector
  - Country of first qualification
  - Specialisation

- Table C1 (stock) Working in the health sector
  - Country of first qualification
  - Duration of stay in the country

- Table C2 (stock) Working in the health sector
  - Country of first qualification
  - Duration of stay in the country

- Table C3 (stock) Working in the health sector
  - Country of first qualification
  - Type of licence to practice or registration

Figure 2b. Data to be collected for nurses and midwives according to priority levels

- Table A1 (stock and flow) All
  - Country of first qualification

- Table B1 (stock) Working in the health sector
  - Country of first qualification
  - Main categories

- Table B2 (stock) Working in the health sector
  - Country of first qualification
  - Age

- Table B3 (stock) Working in the health sector
  - Country of first qualification
  - Main categories

- Table C1 (stock) Working in the health sector
  - Country of first qualification
  - Duration of stay in the country

- Table C2 (stock) Working in the health sector
  - Country of first qualification
  - Duration of stay in the country

- Table C3 (stock) Working in the health sector
  - Country of first qualification
  - Working hours
1) Level A information: Core data to be supplied by Member States

This level of information constitutes the core data set that Member States would be expected to provide.

Under level A, Member States would be asked to provide the following data:

A.1) Separately for doctors and nurses/midwives: total stock (1995, 2000, 2005 and 2010 or most recent year available) and inflow (1995 up to the most recent year available):

Tabulate the stock by the name of the country of first qualification. See in Annex 2, Excel sheets “Table A1 Doctor Stock” and “Table A1 Nur/Mid Stock”.

Tabulate the number of new registrations, new work permits or entry in the health workforce by name of the country of first qualification. See in Annex 2, Excel sheets “Table A1 Doctor Flow” and “Table Nur/Mid Flow”.

2) Level B information:

Members States would also be strongly encouraged to provide information related to level B which focuses on health personnel working in the health sector.

Member States would be asked to cross-tabulate information from Level A (country of first qualification) with additional information on country of birth or nationality, age and gender, or specialization, thus allowing a better characterization of the scope and type of migration. While for level A, both information on stocks and flows would be requested, only information on stocks might be requested in level B.

B.1) Separately for doctors and nurses/midwives: stock (2010 or most recent year available):

Tabulate the total number of doctors and nurses/midwives working in the health sector, by the following variables:
- Name of the country of first qualification
- Country of birth or nationality

See in Annex 2, Excel sheets “Table B1 Doctors” and “Table B1 Nur/Mid”. Cross-tabulating the information presented in Table B1 will provide a more accurate assessment of international health worker migration in comparison to relying solely on level A information. For instance, with information from Table B1, it will be possible to identify medical students going abroad to study and then returning home which is not possible with information that would be derived solely from Table A.

B.2) Separately for doctors and nurses/midwives: stock (2010 or most recent year available):

Tabulate the total number of doctors and nurses/midwives working in the health sector, by the following variables:
- Name of the country of first qualification
- Age
- Sex

See in Annex 2, Excel sheets “Table B2 Doctors” and “Table B2 Nur/Mid”.
**B.3) Separately for doctors and nurses/midwives : stock (2010 or most recent year available):**

Tabulate the total number of doctors and nurses/midwives working in the health sector, by the following variables:

- Name of the country of first qualification
- Specialization for doctors or main categories for nurses/midwives

See in Annex 2, Excel sheets “Table B3 Doctors” and “Table B3 Nur/Mid”.

### 3) Level C information:

Member States might also be encouraged to provide, whenever possible, level C information which as Level B also focuses on health personnel working in the health sector. The data collected at this level would only focus on the stock of doctors, nurses and midwives working in the health sector. This information is presented in Tables C1 to C3. Level C information would complement the data already obtained in levels A and B. In addition to the variable "country of first qualification", level C information includes variables like “type of license to practice or registration” (only for doctors), "duration of stay in the country/year of registration", “working hours" and country where last qualification was obtained”. See in Annex 2, See in Annex 2, Excel sheets “Table C1 Doctors”, “Table C1 Nur/Mid”, “Table C2 Doctors”, “Table C2 Nur/Mid”, as well as, “Table C3 Doctors”, “Table C3 Nur/Mid”, and finally, “Table C4 Nur/Mid”.

### Data sources

Various data sources can be used to obtain information on international health workforce migration. The main sources, from a destination country point of view, include the following:

- Work permits
- Licensing & recognition of foreign credentials
- Professional registers registries
- Surveys of health personnel
- Labour force surveys
- Population censuses

Based on a preliminary review of available data sources across countries, professional registries and existing surveys of health personnel seem to be the most promising data sources as they often offer both stock and flow data by country of education (foreign-trained health workers) and possibly also the required information on employment status. Nonetheless, there is no intention to prescribe the use of any specific data sources to report on the MDS, and countries would have sufficient flexibility to use the most appropriate and reliable sources at their disposal to collect and report the necessary information.

**Annex 1** – Key variables and definitions for the minimum data set

[http://www.who.int/hrh/migration/draft_guidelines_annex_1.pdf](http://www.who.int/hrh/migration/draft_guidelines_annex_1.pdf)

**Annex 2** – Data for nurses and midwives

[http://www.who.int/hrh/migration/code/mds_nurses_midwives.xls](http://www.who.int/hrh/migration/code/mds_nurses_midwives.xls)

**Annex 2** – Data for doctors

[http://www.who.int/hrh/migration/code/mds_doctors.xls](http://www.who.int/hrh/migration/code/mds_doctors.xls)
PART 3 – Reporting instrument for other stakeholders

Submitted by:

Contact details:

Name of entity submitting the report:

Responsible and/or contact person:

Mailing address:

Telephone number:

Fax:

Email:

Website url:

Description of the entity submitting the report:

* This form should be used by entities recognized under the Code that wish to provide information on activities related to the implementation of the Code. Article 2.2 describes stakeholders to include entities “such as health personnel, recruiters, employers, health-professional organizations, relevant subregional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel.” The requested information should be included on attached sheets.
Please describe the entity submitting this Report and the nature of its involvement or interest in international health personnel migration issues relevant to the Code.

Information to be included in the Report:

Please provide information that you consider appropriate relevant to activities related to the implementation of the Code, in accordance with the provisions of the Code and the Guidelines to which this form is attached. In order for the information to be considered, it should:

- Indicate what provision(s) of the Code is/are being addressed.
- Address a matter relating to the implementation of the provision(s).
- Describe the factual basis on which the Report is being submitted and how these facts relate to the implementation of the Code.
- Provide sufficient information to enable the Secretariat to compile a summary of the issue(s) relating to implementation.
- Be provided for the purpose of promoting implementation of the Code.