

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

Report of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel

Report by the Director-General

INTRODUCTION

1. In response to decision WHA68(11) (2015) and following the process set forth for consideration by the Seventy-second World Health Assembly,¹ the Director-General convened an Expert Advisory Group to conduct the second review of relevance and effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel.
2. On this, the tenth anniversary of the Code's adoption, the Director-General has the honour to transmit to the Seventy-third World Health Assembly the report of the Expert Advisory Group (see Annex).
3. The Expert Advisory Group's report presents the outcomes of deliberations held during the period June 2019 to January 2020, including two in-person meetings held in Geneva. Full documentation underpinning the Expert Advisory Group's review, including 13 evidence briefs, two working group papers, and 17 public hearing presentations, as well as meeting agendas and notes, is available on the WHO website.²
4. The Expert Advisory Group's contribution reaffirms the centrality of the Code to the universal health coverage and health security agenda. To promote health, keep the world safe, and serve the vulnerable the support and safeguards called for by the Code need to be in place. In this respect, the Expert Advisory Group's review and update of a list of countries that stand to benefit from health workforce related support and safeguards are most welcome.

FINDINGS OF THE EXPERT ADVISORY GROUP

5. The Expert Advisory Group's report provides a comprehensive review of the Code's relevance and effectiveness. Its findings that the Code's relevance is high and growing, as well as evidence of

¹ See document A72/23, paragraphs 24 to 27.

² Available at <https://www.who.int/activities/addressing-the-international-migration-of-health-workers>, accessed 28 April 2020.

improved Code effectiveness, are notable. Nonetheless, the Expert Advisory Group identified important gaps with respect to the Code's implementation, particularly in several countries and regions most severely affected by health workforce challenges.

6. Ten years after its adoption, the Expert Advisory Group found the Code to be widely recognized as the universal ethical framework linking the international recruitment of health workers and the strengthening of health systems. The Code's call for health workforce and health system related support and safeguards through strengthened international cooperation, with priority given to the most vulnerable countries, is highly relevant in today's global context of political prioritization of universal health coverage, escalating health security challenges, persistent health workforce challenges, and increasing international mobility of health personnel.

7. The Expert Advisory Group found that full implementation of the Code is needed to realize the global vision of "building a healthier world together". As called for by the Political Declaration of the High-Level Meeting on Universal Health Coverage, strengthened implementation of the Code's principles, objectives and articles is needed to ensure that progress towards universal health coverage in Member States serves to support rather than compromise similar achievement in others.¹

SYNERGIES WITH THE GLOBAL AGENDA ON THE NURSING AND MIDWIFERY WORKFORCE

8. The Seventy-second World Health Assembly designated 2020 as the International Year of the Nurse and the Midwife. The Expert Advisory Group's report and recommendations are highly relevant to the International Year of the Nurse and the Midwife. The issues of nurse migration and a call for strengthened implementation of the Code feature prominently in the 2020 State of the World's Nursing report, to be launched on 7 April 2020.²

9. Across countries, the nursing workforce is an essential component of primary health care and national health systems and constitutes over half of all health professionals globally. The 2020 State of the World's Nursing report also estimated that migrant nurses constitute approximately one in eight of all nurses globally and that demographic factors are likely to contribute to accelerating international nurse mobility over the next decade. In parallel, the report evidenced the limited production of, and employment capacity for, nurses in many low- and lower middle-income countries.

10. Both the report of the Expert Advisory Group and the 2020 State of the World's Nursing report highlight the importance of strengthening health workforce related data, education, governance and partnerships, with targeted support and safeguards for countries in greatest need.

11. Investment in the health workforce, particularly in countries most in need, is required to deliver priority health and broader development goals related to education, employment, economic growth, and youth and gender empowerment. The Covid-19 pandemic demonstrates the importance of such investment. To support this effort, the Secretariat is actively working with international financing institutions, including the European Investment Bank and the World Bank, to leverage additional

¹ See Political Declaration of the High-level Meeting on Universal Health Coverage "Universal health coverage: moving together to build a healthier world", 2019. Available at <https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf>, accessed 28 April 2020.

² Available at <https://www.who.int/publications-detail/nursing-report-2020>.

investment in health workforce related education, skills and jobs in low- and lower middle-income countries.

12. The International Year of the Nurse and the Midwife represents an important opportunity to secure the necessary health workforce-related investments and international cooperation that were called for by the Code a decade ago. The 2020 State of the World's Nursing Report, launched in April 2020, also provides a solid foundation to update the *Global strategic directions for strengthening nursing and midwifery 2016–2020*¹ – an important resource for Member States and stakeholders on investment and policy reforms for these key occupational groups.

ACTION BY THE HEALTH ASSEMBLY

13. The Health Assembly is invited to note the report and to consider the following draft decision:

The Seventy-third World Health Assembly, having considered the report by the Director-General, as well as that of the WHO Expert Advisory Group on the Relevance and Effectiveness of the Code, acknowledging also the stewardship role of WHO, decided:

- (1) to commend the successful conclusion of the work of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel, the leadership of its co-chairs, and the dedication of its distinguished members;
- (2) to note the report of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel;
- (3) to urge Member States and invite all relevant stakeholders to fully implement, the recommendations of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel;
- (4) that the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel should conduct a further assessment of the Code's relevance and effectiveness that should be considered following the fifth round of national reporting in 2023–2024 and presented to the Seventy-ninth World Health Assembly; and
- (5) to request the Director-General to:
 - (a) promote effective implementation of the recommendations of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel and;
 - (b) to engage with all WHO regions to update the Global Strategic Directions for Nursing and Midwifery.

¹ Global strategic directions for strengthening nursing and midwifery 2016–2020. Geneva: World Health Organization; 2016.

ANNEX

**WHO EXPERT ADVISORY GROUP'S REPORT ON THE RELEVANCE AND
EFFECTIVENESS OF THE WHO GLOBAL CODE OF PRACTICE ON THE
INTERNATIONAL RECRUITMENT OF HEALTH PERSONNEL**

February 2020

Moving Together to A Healthier World:

*Code implementation, through health system support and safeguards, is necessary to
ensure that universal health coverage (UHC) related progress in Member States
reinforces rather than compromises similar achievement in others*

EXECUTIVE SUMMARY

The Director-General, responding to decision WHA68(11) in 2015, convened an Expert Advisory Group (“EAG”) with the mandate to conduct the second review of relevance and effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”). The EAG was asked to (1) advise the Director-General of evidence on the relevance and effectiveness of the Code, and (2) provide guidance on measures needed to ensure and strengthen the Code’s relevance and effectiveness. The EAG was composed of 27 individuals, including representatives from Member States, international organizations, civil society, and individual experts.

The work of the EAG was conducted during the period July 2019 to January 2020. The EAG review process benefited from information gathered through 13 technical briefs, two EAG working group papers, and an open public hearing where government and non-State actors provided evidence on the Code’s relevance and effectiveness.

Following its review, and as substantiated in the body of this report, the EAG unanimously confirms that the relevance of the Code is high and growing. The EAG additionally finds that both Code effectiveness, and the underlying availability of information to assess its effectiveness, have strengthened considerably since the first Code review in 2015. However, the EAG finds critical gaps in the Code’s implementation, with the current level of implementation insufficient to realize the Code’s full potential as required to progress towards universal health coverage (UHC) and achieving the Sustainable Development Goals.

The EAG notes that incorporation of Code recommendations into national law, policy and agreements, regional policies, and associated implementation has largely been on an ad hoc basis and based on country leadership rather than achieved through targeted financial resources. Indeed, limited financial and technical assistance for Code implementation has accompanied the Code since its adoption. As a result, and as a matter of concern, several countries and regions particularly in need remain to benefit from the Code’s full potential. The EAG also finds notable gaps in the Code’s engagement with non-State actors.

Upon the tenth anniversary of the Code’s adoption, the EAG re-emphasizes the value of providing health workforce related support and active recruitment-related safeguards for countries facing the greatest challenges. The EAG finds that the UHC service coverage index (UHC SCI) and health workforce density should be used to identify and target support and safeguards to countries with the most pressing UHC-related health workforce challenges.

A concerted focus on Code implementation by WHO, Member States, and relevant stakeholders is needed to achieve its substantial potential. To bridge existing gaps and to leverage fully the Code’s high potential, the EAG recommends the following measures:

- (a) The EAG recommends that WHO strengthen technical cooperation with Member States, the capacity of the WHO Secretariat, and engagement with relevant non-State actors to accelerate implementation of the Code through actions on priority activities over the next two biennia (See Box 2).
- (b) As called for by the Code, the EAG urges all WHO Member States to mobilize the necessary investments in the education, recruitment and retention of health workers to effectively deliver UHC. The EAG further calls on leading destination countries and development partners,

as well as others interested in providing health workforce related support and safeguards, to commit multi-year flexible funds towards Code implementation as a global public good.

(c) Emphasizing the central importance of health workforce education and employment to the UHC agenda, the EAG encourages the Director-General to allocate sufficient non-earmarked funds to support the Secretariat's health workforce activities.

(d) The EAG recommends a further assessment of the Code's relevance and effectiveness to be considered following the fifth round of national reporting in 2023–2024 and presented to the Seventy-ninth World Health Assembly.

Background

1. The education and employment of health workers, the health sector's human capital, is central to accessing health services: one of the two objectives of universal health coverage ("UHC"). It is also the leading investment for governments and societies in the pursuit of UHC.¹
2. Migrant health workers – moving permanently or temporarily for employment – are taking an increasing role in delivering UHC. Recent data confirm substantial and growing reliance on migrant health workers.² This is true across WHO Member States of all income groups. However, for several WHO Member States escalating international health worker migration threatens achievement of UHC.
3. The need for improved management of health worker mobility grows, not only within, but also outside the health sector. Improved management of international health worker mobility is today recognized as bringing important value across several other Sustainable Development Goals, including decent work and economic growth, human capital development, international trade, and safe, orderly and regular migration.
4. In 2010, following multiple resolutions and six years of debate, the Sixty-third World Health Assembly, in resolution WHA63.16, adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel (hereafter "the Code"). The Code is widely recognized as the universal ethical framework that links the international recruitment of health workers and the strengthening of health systems.
5. The Code is one of only a handful of international legal instruments under WHO's stewardship. Unusually for a non-binding international legal instrument, the Code benefits from a robust implementation, monitoring, and effectiveness review mechanism. The presence of implementation, reporting and review mechanisms is rare in both non-binding and binding international legal instruments.³
6. To date, the procedural elements of the Code have resulted in three rounds of national reporting (see documents A66/25, A69/37 and A69/37 Add.1, and A72/23), as well as an independent Member State-led review of its relevance and effectiveness (document A68/32 Add.1). Findings from the reporting and review have been discussed and actions taken by respective World Health Assemblies.

Expert Advisory Group: constitution, mandate and process

7. The Code, through Article 9.5, makes explicit that "the World Health Assembly should periodically review the relevance and effectiveness of the Code". In preparation for the ten-year anniversary of the Code in 2020, the Sixty-eighth World Health Assembly called for a second review of the Code's relevance and effectiveness (decision WHA68(11)). The Secretariat report to the Seventy-second World Health Assembly (document A72/23) confirmed that the second review of Code

¹ See Karin Stenberg et al, Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries, *Lancet Global Health* 2017;5:e75-87. Available at [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(17\)30263-2/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30263-2/fulltext).

² See paragraphs 18 and 19 below.

³ See Raustiala, K, Reporting and Review Institutions in 10 Multilateral Environmental Agreements, United Nations Environment Programme, 2001. Available at <https://www.peacepalacelibrary.nl/ebooks/files/C08-0025-Raustiala-Reporting.pdf>. As illustration, a review of 10 binding multilateral environmental agreements identified that over half did not contain either an implementation or an effectiveness review mechanism.

relevance and effectiveness would adopt the same mechanism as applied for the first review and would be presented to the Seventy-third World Health Assembly.

8. Responding to decision WHA68(11) in 2015, the Director-General convened an Expert Advisory Group (“EAG”) with the mandate to prepare and conduct the second review. The EAG was comprised of 27 individuals, including representatives from Member States (two Member States were nominated from each WHO region), international organizations, civil society representatives, and individual experts with knowledge of the Code’s development, negotiation and implementation (See Appendix, List of EAG Members).

9. The work of the EAG was conducted during the period July 2019 to January 2020. Deliberations of the EAG included two in-person meetings, held in June and October 2019, as well as virtual exchanges. EAG deliberations were also supported by select regional processes: i.e., the communications and engagement process with European Region Member States and the associated Member States Reference Panel, which provided input to the EAG process, regional discussion in the South-East Asia Region, and by letter from the Ministers of Health of Benin and Namibia to the Regional Director for Africa to further advocate and sensitize Member States of the African Region on the Code.

10. At the first meeting, the EAG members elected by consensus, Dr Erlend Aasheim, Director of Global Health and Health Intelligence, Directorate of Health, Norway, and Dr Untung Suseno, Senior Policy Analyst, former Secretary General, Ministry of Health, Indonesia, as co-chairs of the Expert Advisory Group.

11. In common with the first review (document A68/32 Add.1), the purpose of the EAG was to (1) advise the Director-General of evidence on the relevance and effectiveness of the Code, and (2) provide guidance on measures needed to ensure and strengthen the Code’s relevance and effectiveness.

12. As per the first review, the following definitions were used to guide the EAG’s review of the Code’s relevance and effectiveness:

(a) **Relevance:** the extent to which the objectives, principles and articles of the Code continue to be pertinent and can inform solutions related to the global challenge of the migration of health personnel and health system strengthening.

(b) **Effectiveness:** the extent to which the implementation of the Code’s objectives, principles and articles have influenced actions and policies concerning health workforce strengthening at country, regional and global levels.

13. The EAG notes that reviewing the effectiveness of an international legal instrument is an area of active international legal debate,¹ with differing philosophical views and methodological challenges across approaches. With respect to Code effectiveness, the EAG considered two dimensions: the legal

¹ See Louis Henkin, *How Nations Behave*, 2nd edition, 1979 and Raustiala, Kal, *Compliance & Effectiveness in International Regulatory Cooperation*, *Case Western Journal of International Law*, Volume 32, No. 421, 2000.

and behavioural effectiveness¹ of the Code, recognizing the greater difficulty of technically assessing and impacting the latter.

14. The EAG review process benefited from evidence generated by 13 technical briefs and two EAG working group papers developed specifically to inform the second review of the Code's relevance and effectiveness. Moreover, the EAGs' review benefitted from an open public hearing where 17 speakers from academia, civil society, international agencies, national governments, the private sector, including employers, credentialing agencies and recruitment agencies, provided evidence on the Code's relevance and effectiveness.

Relevance

The extent to which the objectives, principles and articles of the Code continue to be pertinent and can inform solutions related to the global challenge of the migration of health personnel and health system strengthening.

15. The EAG unanimously confirms the continued high relevance of the Code's objectives, principles and articles to monitor and inform solutions related to the international migration and mobility of health personnel, and towards building sustainable health workforces within strengthened health systems. The EAG additionally finds Code provisions highly relevant to the achievement of UHC and the broader Sustainable Development Goals, with the Code's call for health workforce and health systems-related support and safeguards central to advancing the sustainable development agenda.

16. Numerous factors have contributed to the high and increasing relevance of the Code since the first Code review in 2015. These include a change in global context, including significant growth in health worker demand that is outpacing supply capacity in a number of destination countries; persistence of long-standing health workforce challenges; and increasing awareness and interest in international health worker mobility across sectors and stakeholders.

A change in global context

17. The Sustainable Development Goals ("SDGs"), adopted in 2015, emphasize the need for a more coherent approach to together deliver a better future for all. The SDGs reflect and can help drive the Code's call for improved coherence and collaboration across governments and interdependent sectors with respect to international health worker migration, building sustainable health workforces and health system strengthening. Adoption of the SDGs has resulted in two particularly important changes that further reinforce Code relevance:

(a) Increased prioritization of UHC by WHO and its Member States.

(i) The commitment to UHC has revived attention to the need for a functioning and effective health system, to which a sustainable health workforce is key, as explicitly highlighted by the Code. Notably, the Code links the substantial health workforce related needs present across WHO Member States with the imperative to deliver mutual benefits through strengthening international cooperation. The Code's objectives, principles and articles are particularly relevant in the global effort to "move together to build a healthier

¹ Legal effectiveness can be understood as the extent to which Member State and non-State actor behaviour conforms with Code principles and recommendations. Behavioural effectiveness, in turn, seeks to identify the extent to which the Code has resulted in an observable desired change in behaviour.

world”, where UHC-related progress in Member States should serve to support rather than compromise similar achievements in others.

(ii) The EAG notes that multiple United Nations and World Health Assembly resolutions, including the Political Declaration of the High-level meeting on Universal Health Coverage (document A/74/L.4), reiterate the importance of the Code in delivering UHC.

(iii) The EAG further notes that in terms of its normative standing, the Code stands as the foremost UHC-related instrument under WHO’s stewardship and should be further leveraged as such.

(b) The non-binding Global Compact on Safe, Orderly and Regular Migration (“Global Compact”) was adopted in 2018 by 152 United Nations Member States and the United Nations Network on Migration was established. There was significant discussion during the EAG on synergies between the Global Compact and workstreams of the United Nations Network on Migration.¹ The Code is critical in ensuring that health system concerns and health stakeholder engagement are explicitly considered in fora, such as the United Nations Network on Migration, where topics related to international health worker mobility are discussed.

18. The increasing volume of international health worker mobility reaffirms growing Code relevance. Recent data confirms substantial and increasing reliance on migrant health workers across countries. Data from over 80 WHO Member States indicate that across countries over a quarter of doctors and over a third of dentists and pharmacists (unweighted averages) are foreign-trained and/or foreign-born.² The State of the World’s Nursing Report additionally identifies that about one in eight of all nurses globally is practising in a country different from where they were born.³

19. The previous EAG’s 2015 report hypothesized that powerful demographic, economic and epidemiological trends would result in an acceleration of international health worker mobility.⁴ This reality is confirmed today. In 2016, the OECD identified that the number of migrant doctors and nurses

¹ As illustration:

- i. Related to Global Compact Objective 1 on data collection and utilization, health workforce density and distribution for evidence-based policy has been identified by the United Nation Secretary General’s Report on International Migration and Development (A/RES/71/159) as one of 6 tier 1 migration-related data indicators.
- ii. The importance of government to government agreements and improved recognition of qualifications is reflected in the Global Compact under the broader aim of facilitating highly skilled mobility, ensuring employment and addressing demographic-related global labour market challenges. The health sector is key to this effort. For example, Germany’s presentation to the EAG identified that over a third of the applications in 2018 for recognition and licensing of foreign qualifications were from health personnel.
- iii. An idea in the Global Compact, and as discussed by the EAG, was the creation of global partnerships to invest in skills development in countries of origin to better meet global labour demand. Nursing was the example given during deliberations, with investment in nursing education in countries of origin to help meet nursing shortages in others.

² Data extracted from the WHO NHWA Data Platform, accessed June 2019.

³ See State of the World Nursing 2020, WHO, to be released 7 April 2020.

⁴ See Report to the Director-General of the Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel, WHO document A 68/32 Add.1, available on http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_32Add1-en.pdf.

practising in OECD countries had increased by 60% over the previous decade.¹ Evidence presented by the Global Strategy on Human Resources for Health: Workforce 2030 forecast a substantial increase in demand for health workers in upper-middle and high-income countries, which rigid supply systems might fail to meet, contributing to increased reliance on international migration.² Evidence provided to the present EAG suggests further acceleration of international mobility of health workers in the near term in line with these anticipated forecasts. As illustration, the European Union has identified health alongside information and communications technology workers as the two areas of greatest skills need in the European Union, with an additional 1.8 million health workers needed by 2025.³ Estimates from Germany point to a potential shortage of approximately 500 000 health workers by 2030, with shortages particularly prominent in nursing and elder care personnel.⁴ The Health Foundation, Nuffield Trust and United Kingdom Kings Fund has identified current shortages of 100 000 staff across the United Kingdom's National Health Service, with the number to potentially rise to 250 000 health workers by 2030.⁵ Japan has also adopted a new visa programme that is expected to attract up to 60 000 nursing helpers.⁶ Moreover, as reported to the Seventy-second World Health Assembly (document A72/23), the movement of health workers is not solely or primarily from the global south to the global north.⁷ The Brain Drain to Brain Gain project, implemented by WHO with support from the European Union and Norway, highlighted substantial intraregional, South–South, and North–South movement.⁸ Analysis of currently available data from 80 countries on the National Health Workforce Accounts portal confirms that health systems of most countries are simultaneously challenged with managing both the in- and out-flow of health workers.

20. Complex emergencies and humanitarian crises across several regions of the world have contributed to aggravating the imbalances in the supply and demand of health workers. These situations and settings pose particular challenges in terms of skills recognition of health professionals. The globalization of health personnel education has also increased complexity in relation to international health worker mobility, with the Educational Commission for Foreign-Medical Graduates based in the United States of America evidencing that for the first time more applicants for United States certification

¹ Dumont JC, Lafortune G, International migration of doctors and nurses to OECD countries, in Buchan J, Dhillon I, Campbell J, Health Employment and Economic Growth: An Evidence Base, World Health Organization, 2017.

² Global Strategy on Human Resources for Health: Workforce 2030, WHO, 2016, available at https://www.who.int/hrh/resources/pub_globstrathrh-2030/en/.

³ See 2014 EU Skills Panorama 2013–2025, available at https://skillspanorama.cedefop.europa.eu/sites/default/files/EUSP_AH_SocialCare_0.pdf.

⁴ See Theme Report on Care 2030, Bertelsmann Stiftung, available at <https://www.bertelsmann-stiftung.de/de/publikationen/publikation/did/themenreport-pflege-2030/>.

⁵ See Closing the Gap, Kings Fund, 2019 available at <https://www.kingsfund.org.uk/sites/default/files/2019-06/closing-the-gap-full-report-2019.pdf>.

⁶ See 2018 Nikkei Asian Review article, available at <https://asia.nikkei.com/Spotlight/Japan-immigration/Japan-to-receive-60-000-nursing-helpers-in-new-visa-program>.

⁷ As illustration, and as presented in Secretariat report A72/23, the following percentages of health workers were reported as having been foreign trained: 83% of medical doctors in Bhutan; 12% of medical doctors in El Salvador; 10% of dentists in the Islamic Republic of Iran; 70% of medical doctors in Jordan; 11% of medical doctors, 9% of pharmacists and 7% of nurses in the public sector in Lao People's Democratic Republic with numbers rising to 40% in the private sector; and 17.5% of medical doctors and 50% of pharmacists in Zimbabwe.

⁸ See summary of EU project findings, A Dynamic Understanding of Health Worker Migration, (https://www.who.int/hrh/HWF17002_Brochure.pdf?ua=1), including evidence from India, Ireland, Nigeria, South African and Uganda.

had trained in a country other than that of their citizenship.¹ The increased volume and complexity of international health worker mobility point to the need for strengthened data, policy and international cooperation, further reaffirming the continued relevance of the Code.

21. Growth in the international mobility of health workers has been accompanied with a corresponding rise in private recruitment agencies. This has been illustrated in different parts of the world, including for instance Sudan and the United States.² Evidence on the unethical treatment of migrant health workers in the recruitment process was presented and discussed by the EAG.³ The EAG also discussed the overall experience of migrant and refugee health workers who transition from one country to another, including the substantial challenges they face in adapting, adopting, acculturating, integrating and resettling into a new health system, culture and environment.⁴ The voices and lived experiences of an increasing proportion of the global health workforce further emphasizes the relevance of Code articles related to fair recruitment, supportive induction and orientation programmes, equitable career development, and appropriate oversight of relevant non-State actors in receiving Member States.

Longstanding health workforce challenges

22. The EAG recognizes that health workforce challenges that underpinned the Code's development are as prominent today – if not more so due to demographic and epidemiological factors – as they were a decade ago. The Global Strategy on Human Resources for Health: Workforce 2030 evidenced global health workforce shortages, maldistribution, and substantial mismatches between health workforce needs and financial capacity for employment. Education capacity and ability to retain health workers in areas of greatest need remain constrained across countries. Active and unethical recruitment practices remain an important concern for many countries. Health workforce data, as well as leadership, management and planning capacity to effectively govern the health workforce, and associated mobility also require strengthening in many countries. The EAG additionally discussed the importance of a variety of health occupations working in team settings for the delivery of UHC services, including occupations such as clinical officers, physicians' assistants, allied health workers and others.

23. Developing countries and economies in transition are especially challenged in planning for and educating, employing, managing and retaining the health workers they need. Analysis of SDG 3 related financing gaps evidenced the limited domestic financing capacity in many low-income countries.⁵ The

¹ Presentation of the Educational Commission for Foreign Medical Graduates to the present EAG (to be available on WHO's website).

² As illustration, the Commission on Graduates of Foreign Nursing Schools (CGFNS), the world's largest credentialing organization for nursing and allied health professionals, identified a growth in the size and scope of international recruitment firms (both staffing and placement) in the United States. The EAG representative from Sudan similarly identified that private recruitment firms in Sudan had grown from a few at the time of the adoption of the Code to approximately 300 in 2019. See, Healthcare Staff Recruitment Agencies Industry Market Research report, which points to substantial growth in both the number of businesses and annual growth. See <https://www.ibisworld.com/united-states/market-research-reports/healthcare-staff-recruitment-agencies-industry/> and Shaffer, Franklin et al, The Recruitment Experience of Foreign-Educated Health Professionals to the United States, American Journal of Nursing, 2020, at https://journals.lww.com/ajnonline/Fulltext/2020/01000/CE__Original_Research__The_Recruitment_Experience.19.aspx.

³ See Pittman P and Pulver A, Unethical International Nurse-Staffing Agencies – The Need for Legislative Action, New England Journal of Medicine, 2020.

⁴ See EAG Working Group paper 2 and Evidence Brief.

⁵ See Karin Stenberg et al, Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries, Lancet Global Health 2017; 5:e75-87. Available at [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(17\)30263-2/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30263-2/fulltext).

Code's articles which call on donor nations, destination countries, international organizations and financial institutions to provide additional technical and financial assistance to health personnel development in countries with pronounced health workforce related vulnerability, thus, remain highly relevant.

24. Evidence presented to the EAG, confirms the limited overseas development assistance (ODA) provided for health personnel development in recent years, running counter to the Code's objectives, principles and articles. A review of donor financing for health for the period 1990 to 2016 found that less than 7% of total ODA for health was allocated to health workforce strengthening activities. In 2016, the figure was only 4% of total ODA for health. Resources were also mainly spent on short-term project-related running costs and activities, with limited resources used to resolve systemic health workforce challenges in recipient countries.¹ The limited ODA support to health workforce activities contrasts starkly with the investments required for UHC, with health workforce education and employment accounting for the largest cost component for delivering UHC across low- and middle-income countries.

Escalating interest across sectors and stakeholders

25. The health sector is today recognized as a leading and growing employment sector.² As such, the importance of facilitating international health workers' mobility to meet labour demand, particularly in upper-middle and high-income countries, has been growing in priority across a variety of sectors and international stakeholders.

26. Evidence presented to the EAG suggests a growth in government to government agreements related to international health worker mobility.³ However, agreements notified to the WHO Secretariat also reveal that ministries of health and health stakeholders are not systematically engaged in the negotiation and implementation of these agreements. Examples were provided to the EAG where health system and health workforce concerns are explicitly addressed, as called for by the Code, through engagement of ministries of health and health stakeholders in the bilateral agreement negotiation and implementation process.⁴

27. Ten years after its adoption, the EAG finds that the Code is well established as the universal ethical standard for the international recruitment of health personnel and the strengthening of health systems.⁵ The Code through its objectives, principles and articles, serves as a framework to guide global dialogue, cooperation, and action on health system and health workforce strengthening. The Code is comprehensive, wide ranging and advances a mutual agenda rather than simply protection of national interests. It is relevant across countries of different income groups and addresses both Member State and

¹ See Micah, Angela et al, Donor Financing of Human Resources for Health, 1990 to 2016: an examination of trends, sources of funds, and recipients, Globalization and Health. Available online at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6192106/>.

² See Buchan J, Dhillon I, Campbell J, Health Employment and Economic Growth: An Evidence Base, World Health Organization, 2017.

³ Bilateral agreements notified to the Secretariat increased between rounds 2 and 3. The WHO provided additional evidence to the EAG on broader growth of bilateral trade agreements in recent years, with a number including provisions on health workforce mobility.

⁴ Noteworthy examples were provided with respect to agreements negotiated by Germany, Ireland, Jamaica, Japan, Sudan and the United Kingdom of Great Britain and Northern Ireland.

⁵ As an illustration, a Google scholars citation search for the key word "WHA63.16" resulted in the retrieval of 4031 citations. As identified earlier, the Code is also recognized across a variety of State and Non-State Stakeholders.

relevant non-State actors. As evidenced to the EAG, including through the examples of Indonesia, Norway and Sudan, the Code enables health stakeholders to engage in ongoing dialogue with other sectors that otherwise may not be possible.

28. In light of the changing global context, longstanding health workforce challenges, and escalating interest across sectors and stakeholders, as described above, the EAG finds the Code to be highly relevant. The Code holds significant potential to advance core elements of the 2030 Agenda for Sustainable Development: e.g. universal health coverage; safe, orderly and regular migration; the human capital development agenda; and international trade. The EAG emphasizes with urgency the need to make full use of the Code's potential.

29. The EAG highlights one element that is hindering the Code's high relevance and legitimacy: the list of countries with critical health workforce shortages. The list has at times been misinterpreted and led to suboptimal application of Code principles in the context of relevant policy dialogue within and between countries. Regularly updating this list and the provision of associated guidance by the WHO Secretariat is required to ensure the Code's relevance and full application.

(a) Through its objectives, principles and articles, the Code emphasizes, with varying use of terms, the need to support and safeguard the health workforce and health systems of "developing countries", "developing countries, economies in transition and small island States", and "countries particularly vulnerable to health workforce shortages and/or countries with limited capacity to implement the recommendations".¹ In the specific context of discouraging active recruitment from the most vulnerable health systems (Article 5.1 final sentence), specific focus is placed on "*developing countries facing critical shortages of health workers*".

(b) Notably, the Code does not identify "countries with critical health workforce shortages", nor references an associated list. The *World health report 2006* did, however, identify 57 countries with critical shortages of health workers based on earlier available data. This list of countries has been used, modified and expanded by several destination countries² to limit their active recruitment activities.

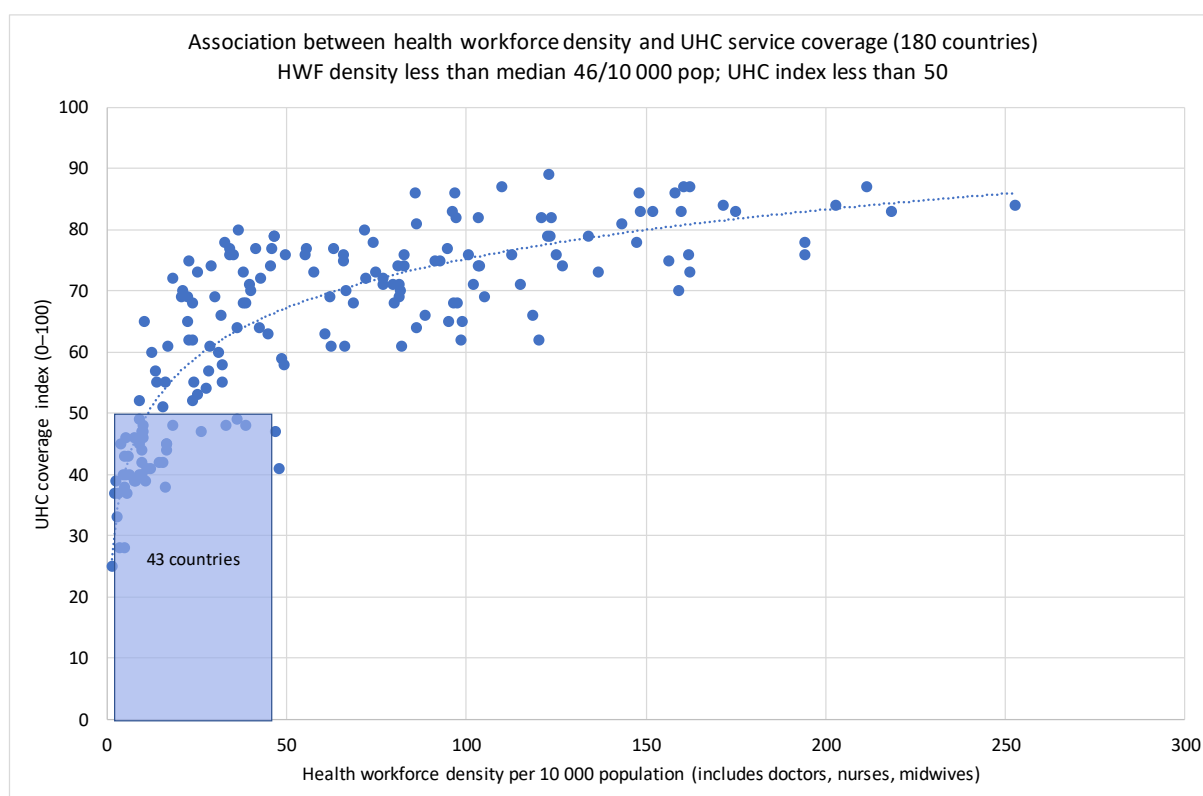
(c) The 2006 list of countries with critical health workforce shortages, in the context of low coverage of services relating to the Millennium Development Goals (MDGs), was developed for research, policy dialogue and advocacy purposes. It is not currently suitable for fulfilling the purpose of identifying countries which should be prioritized for health personnel development support and for which safeguards related to active recruitment are required. The EAG finds important value, as clearly articulated by the Code, in both providing health workforce related support and including recruitment-related safeguards for countries that are particularly vulnerable to health workforce shortages. However, the EAG finds the existing list, and its underlying methodology, to be MDG-focused, outdated, and static.

¹ See Code Articles 1.4, 2.3, 3.2, 3.3, 5.2 and 8.7.

² As examples, Germany, United Kingdom of Great Britain and Northern Ireland and South Africa.

(d) Following a presentation of a variety of options and extensive deliberation,¹ the EAG finds that the UHC service coverage index (UHC SCI),² the official indicator for SDG 3.8.1, and health workforce density, the official indicator for SDG 3.C.1, should be used to identify countries with the most pressing health workforce challenges in relation to UHC and where special caution in terms of active international recruitment is warranted. Based upon this analysis, to be regularly updated alongside Code progress reports, the EAG suggests that countries which both score in the first quartile of the UHC SCI and have less than the median density of doctors, nurses and midwives should be prioritized for intensified health workforce related support and active recruitment-related safeguards.³ Forty-three countries fall in the lowest quartile of the UHC SCI and have less than the median density of doctors, nurses and midwives (see Fig. 1 below with further methodological details to be available on WHO's website).

Fig. 1. Countries with low UHC SCI and low health workforce density⁴



¹ See Working Group 1 paper.

² UHC SCI scores are based on **tracer interventions** that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases, as well as service capacity and access.

³ Use of the identified benchmarks for both UHC SCI and for doctor, nurse and midwife density can together help account for countries where other cadres of health workers, as increasingly prominent across countries, play an important role in providing UHC-related services: e.g. accelerated medically trained clinicians, including clinical officers, assistant medical officers and physicians' assistants.

⁴ Latest data between 2010–2019, as available on the National Health Workforce Accounts (NHWA) Platform on 20 January 2020, was used for this analysis.

(e) The EAG recommends that the 43 countries identified in the above analysis should first and foremost be prioritized for health personnel development and health systems related support, as called for by the Code. As also called for by the Code, active recruitment related safeguards should be provided for these countries. With respect to the latter, the EAG suggests an approach that does not restrict government to government agreements or limit the individual right to freedom of movement, but rather incorporates additional safeguards in the process of negotiating relevant bilateral agreements. These steps should include: (1) Performance of a health labour market analysis to ensure there is an adequate domestic supply in source countries, taking into account models of care and scopes of practice for various health worker occupations. (2) Explicit engagement with health sector stakeholders, including ministries of health. (3) Notification of the associated health labour market analyses and negotiated agreements through the Code and National Health Workforce Account (NHWA) reporting process. Germany and WHO are currently piloting this approach. The list of countries, methodology and associated guidance should be published on WHO's website, with regular updates consistent with Secretariat progress reports.

(f) The EAG additionally recognizes strengthening health workforce data with improved reporting through the system of NHWA. As evidence on dentists, pharmacists, allied health professionals and other qualified providers is becoming increasingly quantifiable across all nations, calculations for health workforce density (Sustainable Development Goal 3.C.1) along with the UHC SCI should consider the maximum number of uniformly available data sets for health professionals, when updating the list of vulnerable countries in the future.¹ In the medium-term, analysis should also be possible that maximizes data availability to better capture the full dynamic of the health labour market² in the classification of health workforce vulnerability across all countries.

Effectiveness

The extent to which implementation of the Code's objectives, principles and articles have influenced actions and policies concerning health workforce strengthening at country, regional, and global levels.

30. The EAG unanimously finds that both Code effectiveness, and the underlying availability of information to assess its effectiveness, have strengthened considerably since the first Code review in 2015. However, the EAG also finds that the current level of Code implementation is insufficient to realize its full potential in the context of current global, regional, and national challenges.

31. The EAG reviewed both the legal and behavioural effectiveness of the Code. Legal effectiveness can be assessed by measuring the extent to which Member State and non-State actor actions conform with Code principles and recommendations, with national reporting utilized as a key indicator of Code compliance. Behavioural effectiveness, in turn, is more difficult to assess, as it seeks to identify the

¹ Analysis was also conducted with health workforce density based on five occupations: doctors, nurses, midwives, dentists and pharmacists. Recent stock for all five occupations was available for 154 countries with the UHC SCI as compared to 180 countries for the three occupations (doctors, nurses and midwives). Member States are encouraged to increase the availability of data on more occupations through progressive implementation of National Health Workforce Accounts.

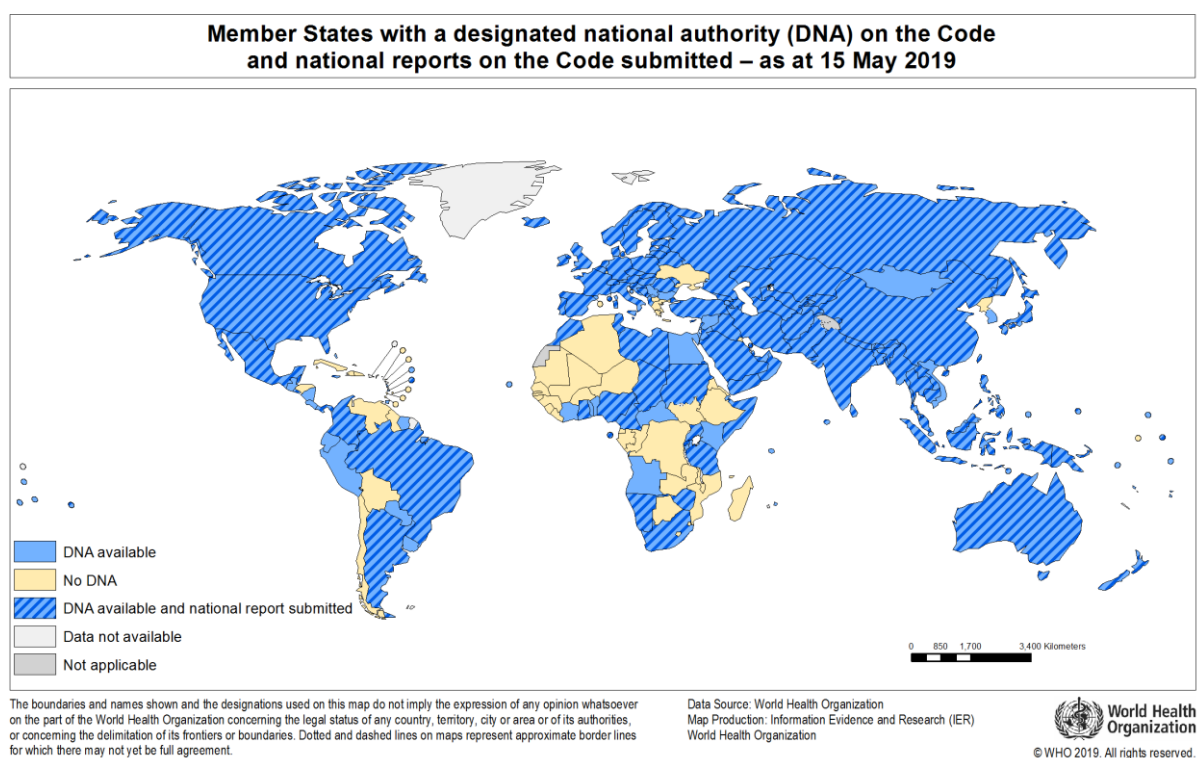
² E.g. NHWA indicators related to production, density across multiple occupations, direction and rate of change in density, distribution, health workforce demographics, employment and migration.

extent to which the Code has resulted in the called for behaviour change across key stakeholders to meet the “spirit of the Code”.¹

Legal effectiveness

32. The EAG notes a substantial increase in Member States’ awareness and engagement with the Code over the last few years. Currently, **three-quarters** of all WHO Member States (146/194) have designated a national authority to support Code implementation. Moreover, **110 Member States**, reflecting over 80% of the world population, have submitted a national report on Code implementation to the Secretariat (See Fig. 1). At the time of the first Code review (2015), Member State reports had only been received from 56 countries, primarily from the European Region. The diversity of reporting has also improved substantially with strong reporting across Member States of the Eastern Mediterranean, European and South-East Asia Regions (See Fig. 2). However, reporting and engagement with the Code remains limited for several countries that the Code was intended to protect, particularly in the African Region.

Fig. 2



¹ See RANGONE, N. (2018). Making Law Effective: Behavioural Insights into Compliance. *European Journal of Risk Regulation*, 9(3), 483–501.

33. The EAG recognizes that, while Code reporting figures are still lower than for the highly successful and significantly better-resourced Framework Convention on Tobacco Control, they are considerably higher than for the set of multilateral environment agreements identified earlier, most of which achieve less than 50% reporting from State Parties.¹

34. In addition to quantity and diversity, the quality of national reporting on Code implementation has also strengthened. Improving data and information on health worker mobility is a core substantive (Article 6) and procedural element (Articles 7 and 9) of the Code. More robust data reporting via the Code, NHWA, and the OECD/Eurostat/WHO European Region Joint Questionnaire has for the first time allowed for a global picture of international health worker mobility. Data on share of migrant health workers is now available through the NHWA portal for over 80 countries across five occupations: dentists, doctors, midwives, nurses and pharmacists.

35. Alongside improvements in data, information on bilateral agreements has also strengthened: 120 bilateral agreements were notified to the Secretariat during the second and third rounds of national reporting, with texts of 30 agreements provided. The WHO Secretariat, with partners from ILO and OECD, is in the process of analysing and preparing guidance with respect to these bilateral agreements, aimed at maximizing use of the Code in future agreements.

36. The evidence presented to the EAG confirms legal effectiveness of the Code in a large proportion of the 110 WHO Member States that have submitted Code implementation related national reports to the Secretariat. The EAG notes that assessment of Code-related legal effectiveness responds partly to the question of Code effectiveness, with the proviso that some Member States may be mechanically reporting Code compliance without having actually implemented the required governance and management mechanisms.

Behavioural effectiveness

37. The assessment of behavioural effectiveness for international agreements is more challenging than for legal effectiveness. The Code's robust implementation and monitoring arrangements have supported the EAG's attempt to assess the Code's behavioural effectiveness. Code Article 8, Implementation of the Code, is particularly useful as it identifies practical measures to translate Code recommendations into the desired behaviour expected by the Code (see Box 1).

¹ See Raustiala, Kal, Reporting and Review Institutions in 10 Multilateral Environmental Agreements, United Nations Environment Programme, 2001, available at <https://www.peacepalacelibrary.nl/ebooks/files/C08-0025-Raustiala-Reporting.pdf>. Multilateral Environmental Agreements analysed include in the 1971 Ramsar Convention on Wetlands, the 1972 World Heritage Convention, the 1973 Convention on International Trade in Endangered Species of Wild Fauna and Flora, the 1979 Convention on Migratory Species, the 1982 Law of the Sea Convention, the 1987 Montreal Protocol, the 1989 Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and their Disposal, the 1992 Framework Convention on Climate Change and the 1997 Kyoto Protocol, the 1992 Convention on Biological Diversity, and the 1994 Convention to Combat Desertification.

Box 1. Implementation of the Code (Article 8)

Member States are encouraged to:

8.1: Publicize the Code

8.2: Incorporate the Code into law and policy

8.3: Consult all relevant stakeholders

8.4: All relevant stakeholder (non-State actors) to work individually and collectively to achieve the objectives of the Code

8.5: Maintain a record of all recruiters authorized to operate within jurisdiction

8.6: Encourage good practice by only using recruitment agencies that comply with Code guiding principles

8.7: Observe and assess magnitude of active international recruitment of health personnel from countries facing critical shortages

38. Member States report evidence of significant improvement across many of the identified measures:

(a) Article 8.1: Over thirty countries have reported publicizing the Code across each of the three rounds for reporting. In addition to the six United Nations languages, the Code has now been translated into Catalan, Dutch, Farsi, Finnish, German, Hungarian, Indonesian, Italian, Japanese, Norwegian, Polish, Romanian and Thai.

(b) Article 8.2: Forty Member States identified incorporating the Code into national law and policy, with the process ongoing in four additional WHO Member States.

(i) Measures adopted include: incorporation of Code recommendations into national law¹ and national strategic plans;² in the development of, and/or incorporation into recruitment and migration policies;³ and the creation of new administration and coordination functions.⁴

(1) Notably, following the June 2019 EAG meeting, Jamaica's Permanent Secretary, Ministry of Health created a health workforce related post mandated to better monitor and support inflows and outflows of health workers.

¹ E.g. Bahrain, El Salvador, Germany and Indonesia.

² E.g. Bangladesh, Cameroon, Dominican Republic, Eswatini, Ireland, Jordan, Myanmar, Sierra Leone and South Africa.

³ E.g. Canada-Saskatchewan Code, Finland, Sudan, South Africa, Switzerland, Trinidad and Tobago, United Kingdom of Great Britain and Northern Ireland and Scotland Codes.

⁴ E.g. Germany, Nigeria, Norway, South Africa, Sudan and United States of America.

(ii) Forty-four countries additionally identified that Code recommendations were incorporated in their government-to-government agreements.¹

(c) Articles 8.3 (Stakeholder engagement), 8.5 (Record of recruiters), and 8.6 (Utilization of Code compliant recruitment agencies): as reported by Member States, the EAG noted consistent improvement across subsequent rounds of national reporting for each of these implementation measures.

39. Based on evidence presented, the EAG also notes that Code principles and articles are reflected in regional policies (e.g. European Union Global Approach for Managing Migration, the South-East Asia Region Decade of Health Workforce Strengthening (2015–2024), and the forthcoming Southern African Development Community (SADC) human resources for health plan) and in related Non-State Actor Codes (e.g. the European Hospital and Healthcare Employers' Association/ European Federation of Public Service Unions (HOSPEEM/EPSU) Code of Practice and the Commission on Graduates of Foreign Nursing Schools (CGFNS) Alliance Code for Ethical International Recruitment).

40. The EAG also notes growing recognition of the Code across different sectors of government, international agencies and civil society. The establishment of the ILO/OECD/WHO International Platform on Health Worker Mobility has expanded the WHO Secretariat's partnership with other international agencies (e.g. IOM, World Bank and WTO) and relevant non-State actors. The EAG also notes that over 4000 academic articles have explicitly referenced the Code, a figure similar to the 1981 WHO/UNICEF Code on the Marketing of Breast Milk Substitutes adopted decades earlier.² Examples were also provided to the EAG of the role of the Code in empowering ministries of health to engage in ongoing discussions with other sectors, and in raising health system concerns.

41. Despite clear and substantial improvements since the 2015 review, critical gaps in Code implementation (and thus effectiveness) remain. The EAG notes with concern the limited Code engagement from several Member States and regions that are particularly challenged by international health worker mobility.³ The EAG emphasizes the need to provide improved global guidance and technical support to Member States in support of effective Code implementation: 64 Member States requested such support during the third round of Code reporting. Similarly, there is an opportunity to engage more strategically with and support regional bodies and institutional mechanisms in Code implementation.

42. The EAG notes that there are gaps in the Code's engagement with non-State actors. There is a pressing need to substantially raise awareness and Code engagement among health workers, public and private employers, regulatory bodies, public and private sector recruitment agencies, academia and civil society to further drive Code implementation and effectiveness. There is also a clear opportunity to strengthen the synergies and coherence between the Code, a largely Member State led process, and ethical processes that are led by other actors: employers, health workers and recruiters. Strengthened engagement with and improved reporting processes for non-State actors can also help ensure the accountability of governments.

¹ See Evidence Brief Number 2, WHO Global Code of Practice on the International Recruitment of Health Personnel: Reliance, Compliance and Effect (2010–2019), WHO.

² *Id.*

³ Eighty-four Member States have not participated in national reporting across three consecutive rounds of national reporting.

43. Most crucially, the EAG stresses the need to engage further with destination countries and donor and financial institutions to ensure that health workforce related technical and financial support called for by the Code, and as required for UHC, is indeed made available.

Conclusions and recommendations

44. Following its review, the EAG unanimously confirms that the relevance of the Code is high and growing. The EAG also notes improved evidence of Code awareness and effectiveness. However, critical gaps are prominent in relation to Code implementation. A concerted focus on Code implementation by WHO, Member States, and relevant stakeholders is needed to achieve its full potential. Today more than ever, the Code is indispensable to advancing the Sustainable Development Agenda, including the realization of UHC.

45. Ten years have passed since the Code's historic adoption. The EAG finds that the Code has matured as an international legal and normative instrument. The Code is increasingly well recognized within and outside the health sector. In several cases, it has also been used to strengthen coherence, international cooperation and health system improvements as envisioned by its objectives and guiding principles.

46. The EAG notes that incorporation of Code recommendations into national law, policy and agreement, regional policies, and associated implementation has largely been on an ad hoc basis and based on country leadership rather than achieved through targeted financial resources. As such, and of concern, several countries and regions particularly in need remain to benefit from the Code's potential.

47. The EAG notes that limited financial and technical assistance for its implementation has accompanied the Code since its adoption. A year after its adoption, Member States, through resolution WHA64.6 (2011), called for additional technical, financial and political support to be targeted towards Code implementation. Similar calls have been repeated by various World Health Assembly resolutions, Secretariat progress reports, and the first EAG review report to the World Health Assembly.¹ The experience of other successful international legal instruments under WHO's stewardship indicates that maximizing their impact requires implementation-related financial support.² This poses the question of what could have been expected with adequate resourcing of the Code.

48. The Code stands as the leading UHC-related normative instrument under WHO's stewardship. Investment towards a strengthened WHO Secretariat, a more robust, inclusive and responsive process of Member State engagement and reporting, and an enhanced role for non-State actors will accelerate progress towards UHC and the broader Sustainable Development Agenda.

49. The EAG recognizes the Code's information sharing, monitoring and institutional mechanisms to be major contributors to its success. They must be maintained and strengthened during the forthcoming rounds of Member State and non-State actor reporting.

¹ To list all references in World Health Assembly resolutions and Secretariat progress reports.

² The Framework Convention on Tobacco Control serves as a leading example, with its implementation benefiting from an annual budget of US\$ 20 million.

50. To bridge existing gaps and to leverage fully the Code's high potential, the EAG recommends the following measures:

- (a) The EAG recommends that WHO strengthen technical cooperation with Member States, the capacity of the WHO Secretariat, and engagement with relevant non-State actors to accelerate implementation of the Code through actions on the following activities over the next two biennia (see Box 2):

Box 2. Code implementation activities 2020–2023

Priority activities in support of Code implementation (2020–2023):

1. Provide requested technical assistance to Member States: 64 Member States requested support during the third round of Code reporting.
2. Strengthen institutional governance for the health workforce, including management of health worker mobility, across WHO Member States. Targeted support should also be provided to Member States who have not yet designated a national authority or participated in Code reporting.
3. Develop Global Guidance and Tools: Code User and Implementation Guide, Repository and Best Practices on Bilateral Agreements, Global Data Report on International Health Worker Mobility, Estimation of education costs and remittances, and Approaches to better understand and improve the lived experience of migrant health workers.
4. Strengthen the Member State reporting processes related to the fourth round of national reporting, including improved synergy with NHWA.
5. Revise the Independent Stakeholder Instrument and strengthen the reporting process to better capture input from non-State actors.
6. Engage with and support regional economic bodies and harmonization processes.
7. Strengthen engagement with private sector actors, including complementary hospital, trade union and recruiter codes.
8. Regularly update the list of countries with critical health workforce shortages, with the Secretariat encouraged to explore analysis that considers the full dynamic of the health labour market in determining health workforce vulnerability.
9. Strengthen Code advocacy efforts, including partnership with destination countries and donor and financial institutions, to drive health workforce related support to countries with greatest UHC-related health workforce vulnerability.
10. Ensure knowledge production, dissemination and lateral linkages with efforts in other sectors and with non-State actors through regular convenings and outputs of the ILO/OECD/WHO International Platform on Health Worker Mobility.

- (b) As called for by the Code, the EAG urges all WHO Member States to mobilize the necessary investments in the education, recruitment and retention of health workers to effectively deliver UHC. The EAG further calls on leading destination countries and development partners, as well as others interested in providing health workforce related support and safeguards, to commit multi-year flexible funds towards Code implementation as a global public good.

(c) Emphasizing the central importance of health workforce education and employment to the UHC agenda, the EAG encourages the Director-General to allocate sufficient non-earmarked funds to support the Secretariat's health workforce activities.

(d) The EAG recommends a further assessment of the Code's relevance and effectiveness to be considered following the fifth round of national reporting in 2023–2024 and to be presented to the Seventy-ninth World Health Assembly.

Appendix

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3. El-Sheikh Badr, Federal Ministry of Health, **Sudan**
4. Dunstan Bryan, Ministry of Health, **Jamaica**
5. Charles Darr, Health Resources and Services Administration, **United States of America**
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2. Barbara Lubben, Federal Ministry of Health, **Germany**

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