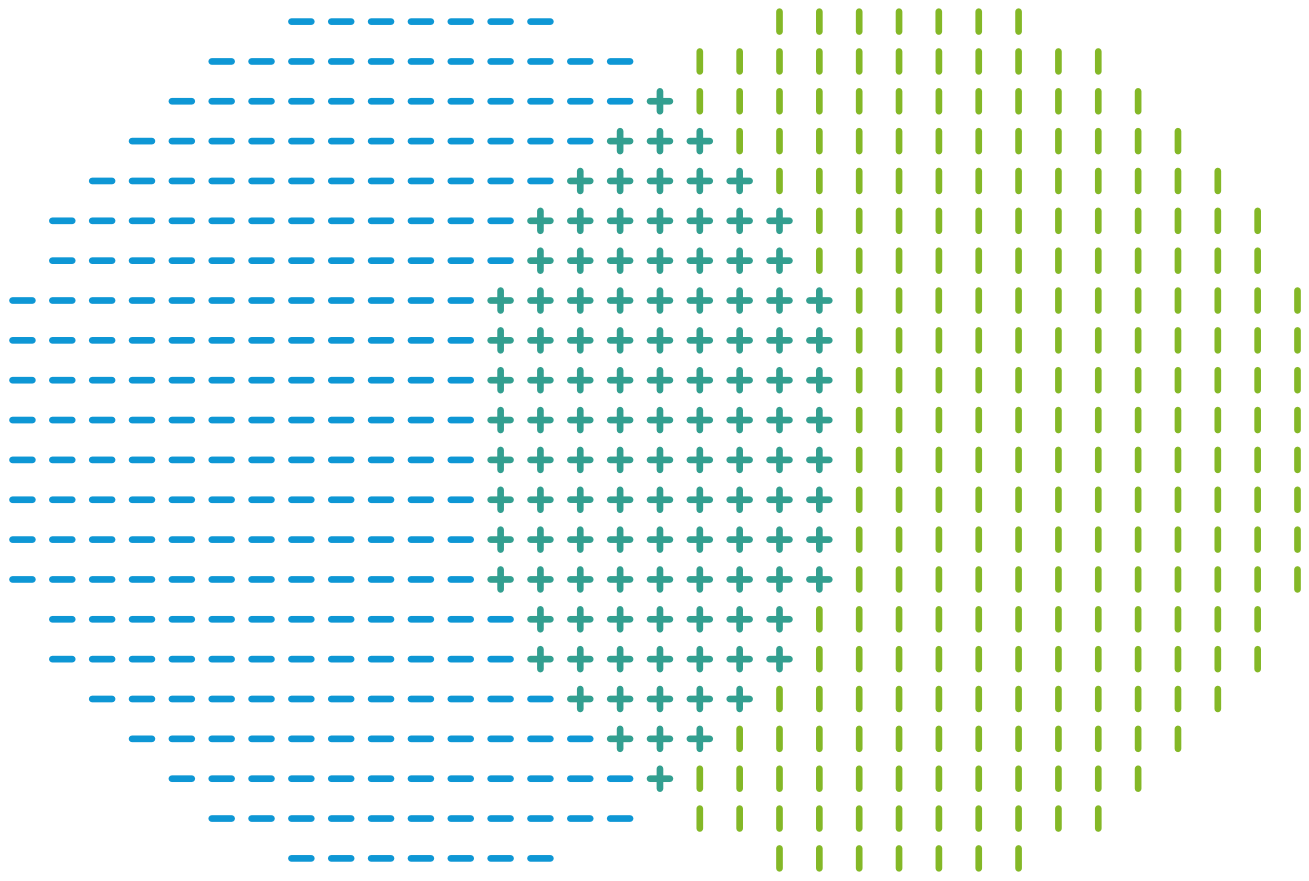
Bilateral agreements on health worker migration and mobility

Maximizing health system benefits and safeguarding health workforce rights and welfare through fair and ethical international recruitment



World Health Organization

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Page 42, Table A.1, column 3, row 3

Delete: Indonesia
Insert: Philippines

Page 42, Table A.1, column 3, row 4

Delete: Indonesia
Insert: Philippines

These corrections have been incorporated into the electronic file.

Contents

Foreword

At the mid-point to the 2030 Sustainable Development Goal on universal health coverage, more than half of the world's population still lacks access to essential health services and 2 billion people face financial hardship due to health costs. Central to addressing these inequities is tackling gaps in the number and distribution of health and care workers globally. All countries experienced major health workforce challenges even before the coronavirus disease 2019 (COVID-19) pandemic, with an estimated global shortfall of 10 million health and care workers projected by 2030, predominately in low- and middle- income countries.

The COVID-19 pandemic exposed and magnified the health systems' weaknesses and health inequalities that have arisen from decades of underinvestment. An acceleration in the international migration of health and care workers since the pandemic risks exacerbating health workforce shortages in the source countries and stripping back their hard-won health gains, unless international recruitments are ethically managed and the production of workers is increased everywhere. The WHO Global Code of Practice on the International Recruitment of Health Personnel ("the Code") aims to do just that: link the ethical recruitment of health workers with investments in the health systems.

The significant surge in the demand for health workers and in their international migration globally has increased the use of bilateral agreements between destination and source countries to facilitate international health worker recruitment.

This document on "Bilateral agreements on health worker migration and mobility" has been developed by the World Health Organization (WHO) and Organisation for Economic Co-operation and Development (OECD) with the International Labour Organization (ILO) as part of the Working for Health programme. It addresses critical gaps in guidance for developing mutually beneficial bilateral agreements on both health worker mobility and on the investments needed to strengthen health systems in low- and middle-income countries. It provides practical guidance on the preparation, negotiation, implementation and evaluation of a new generation of such bilateral agreements.

We encourage national authorities to make use of this guidance when developing policies and bilateral agreements that cover health workforce mobility and migration. By harnessing the potential of the Code, we can accelerate progress towards universal health coverage, health security and broader development targets for health, education, gender equality and economic growth.

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Assistant Director-General, Universal Health Coverage and Life Course

World Health Organization

Mr Stefano Scarpetta

Director, Employment, Labour and Social Affairs

Organisation for Economic Co-operation and Development

Preface

The WHO Global Code of Practice on the International Recruitment of Health Personnel, adopted by the World Health Assembly in 2010, provides an overarching global framework to improve global governance and minimize the negative consequences of health worker migration, particularly from developing countries.

Thirteen years since the Code's adoption – with its explicit provisions on information exchange and monitoring – WHO has consolidated more data on the global trends and patterns in the international migration of health workers than ever before. This evidence base confirms that the ethical management of international recruitment practices continues to be a major challenge for governments worldwide, raising concerns about health workforce sustainability and health equity.

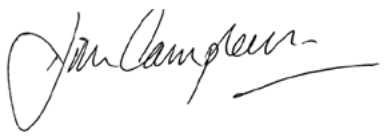
The COVID-19 pandemic served as a stark reminder that global health security and the global economy are inextricably linked. The pre-pandemic health worker shortages in virtually every health setting, coupled with the increased demand for health workers during the pandemic, has stepped up further the pace of international migration of health workers.

Against this backdrop, both source and destination countries are taxed by the implications, challenges, and opportunities of international health worker mobility on their health systems and the wider economy, including in relation to the policy provisions enshrined in global policy instruments and the role for international diplomacy and multilateral engagement.

The development, implementation, monitoring and evaluation of government-to-government agreements that specifically address health systems strengthening presents untapped potential. For example, when such agreements harness the mutual benefits of international health worker migration in both countries of origin and destination, as well as for health workers themselves.

This new guidance explores such untapped opportunities in depth. It aims to promote good practice in the design and dissemination of bilateral agreements on international mobility and migration, as well as to highlight the importance of evidence-based implementation and open access publishing. It complements the United Nations Global Compact for Safe, Orderly and Regular Migration and provides a practical step-by-step guidance to countries on how to develop fair and ethical bilateral agreements.

Member States and other stakeholders are encouraged to make the best use possible of this guidance when negotiating such agreements. Together we can work towards a better approach to health worker migration based on fairness and ethics that benefits us all.



James Campbell

Director, Health Workforce Department

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Acknowledgements

The conceptualization and development of the contents of the guidance were led by Agya Mahat, Giorgio Cometto and Ibadat Dhillon, under the oversight of James Campbell (WHO Health Workforce Department). The WHO Health Workforce Department is part of the Universal Health Coverage and Health System Cluster.

The product development was also supported by Maren Hofpe, Natalia Popova and Christiane Wiskow (ILO); and Jean-Christophe Dumont (OECD) through the Working for Health programme.

The WHO Secretariat led the conceptualization of the guidance, identified members of the Technical Expert Group, facilitated Technical Expert Group meetings, and led the drafting of the guidance document and subsequent rounds of revision. The WHO Secretariat included the following WHO staff members: Giorgio Cometto and Agya Mahat (WHO headquarters); Adam Ahmat (WHO Regional Office for Africa); Jose Garcia Gutierrez (Pan American Health Organization); Ibadat Dhillon (WHO Regional Office for South-East Asia); Cris Scotter and Tomas Zapata (WHO Regional Office for Europe); Gulin Gedik Fethye (WHO Regional Office for the Eastern Mediterranean); and Masahiro Zakoji (WHO Regional Office for the Western Pacific). Jean-Christophe Dumont (OECD); and Maren Hofpe and Natalia Popova (ILO) also contributed to the drafting of specific sections of the document. Teena Kunjumen and Tapas Sadasivan Nair (WHO headquarters) provided the latest health worker data from the National Health Workforce Accounts. Members of the Working for Health Secretariat also included Ayat Abu-Agla and Paul Marsden (WHO headquarters). Onyema Ajuebor, Khassoum Diallo, Siobhan Fitzpatrick, Catherine Kane, Michelle McIsaac, Tapas Sadasivan Nair, Amani Siyam and Pascal Zurn (WHO headquarters) provided input to the drafts of the guidance.

The Technical Expert Group refined the scope of the guidance, reviewed the evidence and developed the policy considerations. The members included: Elsheikh Badr (formerly Sudan Medical Specialization Board, Sudan); Mukul Bakhshi (CGFNS International and Alliance for Ethical International Recruitment Practices, United States of America); Howard Catton (International Council of Nurses); Rupa Chanda (Indian Institute of Management Bangalore, India and United Nations Economic and Social Commission for Asia and the Pacific [UNESCAP]); Sarah Cliff and Dave Howarth (Department of Health and Social Care, United Kingdom of Great Britain and Northern Ireland); Helen Dempster (Center for Global Development, United States of America); Ulrich Dietz and Alexandra Shale (German Federal Ministry of Health, Germany); Enrico Fos (Department of Foreign Affairs, the Philippines); André Gariépy (Office des professions, Québec, Canada); Genevieve Gencianos (Public Services International); Percy Mahlathi (Department of Health, South Africa); Moeketsi Modisenyane (Department of Health, South Africa); Ali Sani (West African Health Organization); Pretchell P Tolentino (Department of Health, the Philippines); and Carlos Van der Laat and Vassily Yuzhanin (International Organization for Migration [IOM]). Declarations of interest were collected from Technical Expert Group members and managed according to WHO policy.

Research to inform the contents of the guidance was contracted to Innovation Insights. Jennifer Brant, Skylar Furley and Caitlain Wright (Innovation Insights) conducted a rapid review of literature (Annex 1); Jennifer Brant and Eduardo Escobedo (Innovation Insights) and Ibadat Dhillon (WHO) conducted the textual analysis of the agreements (Annex 2); and Jennifer Brant (Innovation Insights) conducted the key stakeholder interviews (Annex 3). James Buchan (Health Foundation, United Kingdom; University of Technology Sydney, Australia); and Antonia Carzaniga and Joscelyn Magdeleine (World Trade Organization [WTO]) reviewed drafts of the guidance.

Financial support for the development and dissemination of the guidance was received from the Working for Health Multi-Partner Trust Fund and the UHC Partnership (Belgium, Canada, European Union, France, Germany, Ireland, Japan, Luxembourg, United Kingdom and WHO).

Abbreviations

ASEAN	Association of Southeast Asian Nations
COVID-19	coronavirus disease
ENT	economic needs test
EPA	economic partnership agreement
EU	European Union
FTA	free trade agreement
GATS	General Agreement on Trade in Services
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
IJEPA	Indonesia-Japan Economic Partnership Agreement
ILO	International Labour Organization
IOM	International Organization for Migration
I-TIP	Integrated Trade Intelligence Portal
MFN	most favoured nation
MOU	memorandum of understanding
MRA	mutual recognition agreement
OECD	Organisation for Economic Co-operation and Development
RTA	regional trade agreement
UHC	universal health coverage
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization
ZAV	International Placement Service of Federal Employment Agency (Germany)

Executive summary

Background

International migration and mobility of health workers has increased in volume and complexity in recent decades. Regional bodies play a growing role in facilitating the cross-border delivery of health services. Among various pathways for movement of health workers, government-to-government agreements hold important potential to ensure that health workers and the health systems of participating countries benefit from health worker migration and mobility.

Objectives

The objectives of the guidance are:

- to describe the diversity of government agreements on health workforce migration and mobility that already exist;
- to identify promising practices; and
- to articulate policy considerations to inform the design, implementation, monitoring and evaluation of migration and mobility agreements, consistent with the objectives and principles of the WHO Global Code of Practice on the International Recruitment of Health Personnel ("the Code") and other relevant international instruments.

The guidance is a tool for improving the capacity of state actors involved in the development, negotiation, implementation, monitoring and evaluation of agreements related to international health worker migration and mobility, in alignment with the provisions of the Code.

Scope

This document presents policy and operational considerations for countries negotiating health worker migration and mobility agreements. It outlines fundamental principles, policy considerations and promising practices for the negotiation, implementation, monitoring and evaluation of bilateral and regional migration and mobility agreements, keeping health system priorities at the fore. It addresses the range of issues typically covered in such agreements, including governance, protection, patient safety, recognition of qualifications, access to language and other training, financial and other support for countries of origin, and programmes to help arriving health workers integrate in the host country. The policy considerations in this document apply to all government-to-government agreements that are focused on, have a component on, or could have an impact on, health worker migration and mobility.

Process and methods

WHO developed this guidance in response to specific requests from WHO Member States. The document stems from the recommendations of the Expert Advisory Group on the 10-year review of the Code, and it represents a tool to support the operationalization of some of its aspects. It also aligns with the UN Global Compact for Safe, Orderly and Regular Migration and ILO international labour standards. This tool is consistent with and complementary to the UN Network on Migration's *Guidance on bilateral labour migration agreements.*[1] The guidance was produced as part of the ILO-OECD-WHO Working for Health programme and its international mobility platform, an initiative co-led by WHO, OECD and ILO.

Primary evidence to inform the contents of this guidance was gathered through a rapid review of literature, textual analysis of 37 agreements and 22 stakeholder interviews.

Findings

The evidence identified a variety of government-to-government agreements that influence health worker migration and mobility. The agreements are aimed at advancing economy and trade; education and health; labour migration and mobility; and humanitarian and philanthropic support. Bilateral agreements on health worker migration and mobility tend to be driven by the health sector needs of the destination countries and, in some cases, with limited meaningful engagement by the ministries of health of the countries of origin. Notably, 59% of agreements focus on labour migration, or economic and trade priorities, rather than advancing health policy objectives. Accordingly, the development and implementation of these agreements are led by different entities.

Irrespective of the area of focus of the agreements, all health workers belonging to regulated professions are required to meet the regulatory requirements of the destination country to be eligible to practise and meet patient safety standards. Assessment of qualifications attained in another country is an important component of the requirements for entry to practise in the host

1 See https://migrationnetwork.un.org/resources/global-guidance-bilateral-labour-migration-agreements.

country and any significant differences in qualifications need to be addressed through established measures. While some countries have signed agreements specifically for recognition of qualifications, this does not equate to permission to enter practice as there may be additional requirements set by the regulator as deemed necessary to advance patient safety (e.g. language requirements, licensing exam).

In some cases, bilateral health worker migration and mobility agreements have allowed the governments of countries of origin to contribute to safer and more orderly migration and mobility for their health personnel. Available evidence suggests that elements of health workers' rights and welfare are increasingly incorporated across most agreements. At the same time, gender considerations are typically absent in the agreement texts, despite health being a heavily gendered area of service provision. Provisions for circular migration is also a feature or an objective of some agreements but evidence of this outcome is scarce, particularly when the purpose of the mobility is securing employment in another country.

The potential of government health worker migration and mobility agreements to strengthen the health systems of countries of origin has yet to be realized, despite it being central to the objectives of the Code. The negotiation capacity, socioeconomic inequalities and power dynamics between countries participating in the agreements place high-income destination countries, which have little incentive to support health systems in countries of origin, at an inherently more advantageous position during the negotiation and implementation of agreements. On the other hand, the position of countries of origin is further weakened by push and pull factors and the reality that concurrent health worker movement will continue to take place through alternative pathways in different directions.

While bilateral agreements have allowed countries of origin to limit the negative consequences of health worker migration and mobility to a certain extent, they have not yielded investments in health system strengthening. The limited engagement of ministries of health in the development and implementation of these agreements could also have contributed to this. Further, it is difficult to estimate the potential impact on health systems through the aggregate number of health workers leaving a country alone, without information on the competencies, experience and specialty of the health workers. The findings suggest that even if the destination country makes a financial contribution to the education in the country of origin, it does not compensate for the loss of health personnel with several years' experience in specialized technical areas because of the additional time it takes for senior health workers to gain such experience. Some countries of origin could face an endless cycle of continued investment in enhancing the competencies of health workers who are then internationally recruited, leaving their population to be served largely by junior health workers.

Evidence gaps

Data on implementation and evaluation of the agreements are sparse or non-existent. The lack of dedicated monitoring and evaluation mechanisms does not allow for a comprehensive assessment of the effectiveness and impact of the agreements on health system strengthening, on health workers' welfare or even to determine if the agreements were implemented and to what extent the objectives were met.

Key policy considerations and good practices

The move towards the creation of a new generation of fair and ethical bilateral agreements, or revision and update of existing ones, that are balanced in terms of benefits to all parties, should prioritize the right to the highest attainable standard of health of populations in both countries of origin and destination. This will require signatories to explicitly define the types and amounts of investments and support, as well as other essential safeguards, that will benefit the health system of the country of origin.

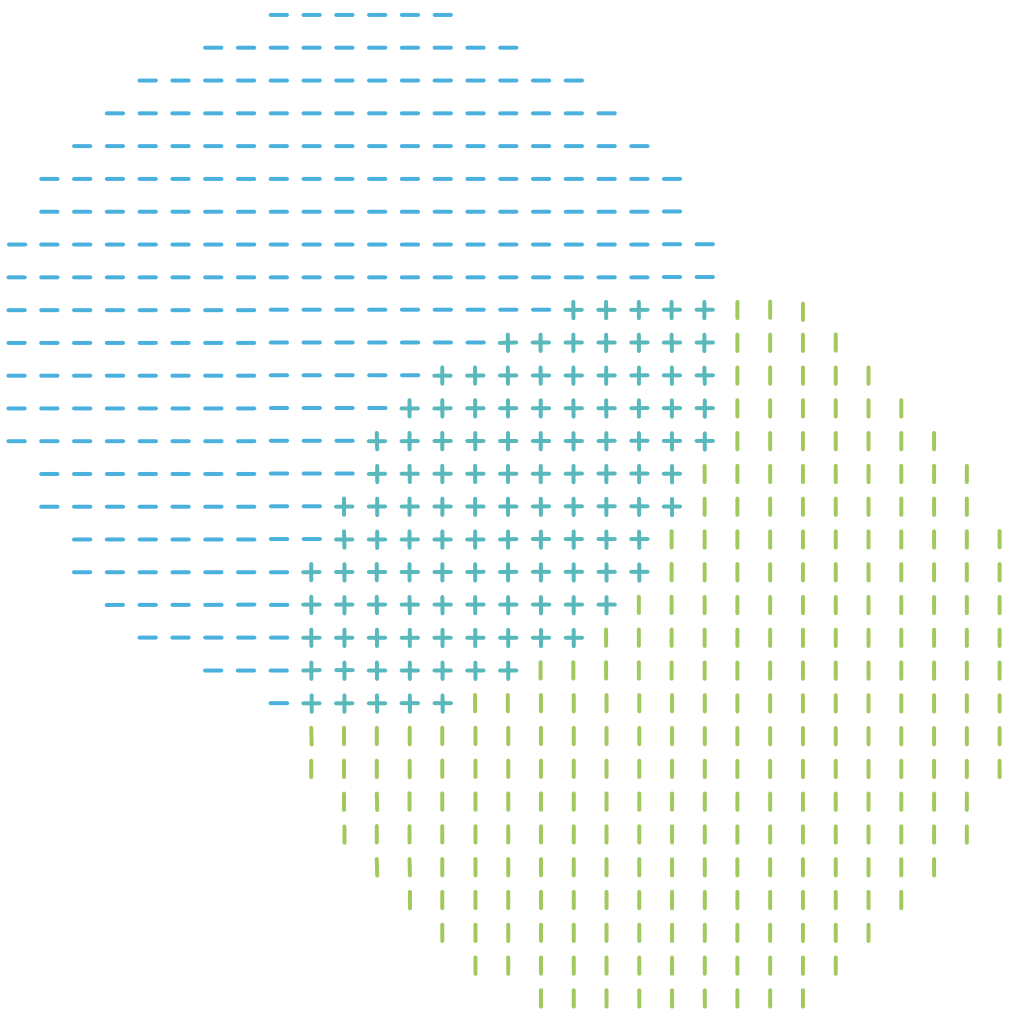
To this end, an intersectoral approach, with substantial involvement by the ministry of health, in the development, negotiation and implementation of these agreements is recommended. A health system needs assessment that includes a health labour market analysis is required to inform the objectives and policy options in the agreements, as well as the broader strategies to achieve health and socioeconomic goals. Engagement of all relevant stakeholders, including government (e.g. health, education, foreign affairs, migration, labour, trade and commerce ministries) and nongovernmental entities (health workers' and employers' representatives, unions, regulators, diaspora associations or migrant groups, professional associations, private sector actors, etc.) at every stage of an agreement's development, implementation and evaluation is required to ensure coherence, recognize priorities, generate synergies and address concerns. Data collection on the implementation of agreements, along with greater transparency, can support assessment and evaluation as to whether agreements' objectives were met, the impact on the health systems of the countries involved, and on the rights and welfare of health workers. This is crucial to contribute to the growing body of knowledge about innovations and emerging best practices to maximize benefits from health worker migration and mobility for all parties. The triennial reporting by Member States on the implementation of the Code is an appropriate mechanism to capture and share such information.

This guidance provides key policy considerations and good practices to inform the conceptualization and content of government health worker migration and mobility agreements (Fig. ES1) along with implementation considerations during the different phases of developing and executing these agreement.

Fig. ES1. Bilateral agreements – policy considerations

All bilateral agreements should:

- Contribute to **workforce sustainability, universal health coverage and health security** in countries of origin and destination.
- Specify how the partnership will **strengthen health systems** of both countries.
- Include additional **safeguards and support** to countries with workforce vulnerabilities.
- Ensure **equal treatment** of domestic and foreign-trained health workers.
- Plan and address **gender needs** of health workers.
- Include **monitoring and evaluation** mechanism with **operational feedback** loop.
- **Report** on the agreement arrangements and implementation to WHO.



1. Background

International mobility and migration affect all economic sectors. Migrant workers comprise 169 million of the 272 million international migrants globally *(1)*, making labour migration the primary driver of international migration.

ILO standards on labour migration define "migrant for employment" or "migrant worker" as "a person who migrates from one country to another with a view to being employed" *(2,3)*. While not all internationally mobile health workers qualify for the definition of "migrant for employment" (e.g. in cases where the main purpose of movement is education, technical support, humanitarian assistance or trade), for the purpose of simplicity and considering that employment is the main objective of most internationally mobile health workers, this document refers routinely to "migrant" health workers.

For the purpose of this document, "mobility" encompasses any movement (physical or virtual) of health workers and students in health sciences from one country to another irrespective of status, purpose, direction or duration of movement. Migration refers to physical movement to another country irrespective of the reason or legal status for a duration of 3–12 months (temporary or short-term migration), or to a change of country of residence for a duration of 1 year or more (long-term or permanent migration).

International migration and mobility of the health workforce is increasing in volume and growing in complexity. For example, based on the latest available data from National Health Workforce Accounts,[2] more than one in five doctors in 37 countries, areas and territories and more than one in five nurses in 30 countries, areas and territories are foreign-trained *(4)*; and in OECD countries approximately a quarter of doctors and 16% of nurses are foreign-born *(5)*. The pattern of migration and mobility of health workers is not limited to movement from low- and middle-income countries to high-income countries, but also includes movement from high-income countries to low- and middle-income countries and substantial movement within both high-income and low- and middle-income countries *(6)*.

High demand for health workers in high-income countries has been triggered by changing health service needs, ageing populations and health workforce shortages. This has resulted in rising international migration and mobility of health workers since the start of the 21st century, as evidenced by the 60% increase in international migration of health workers to OECD countries in the decade to 2016 *(7)*. The increasing needs and shifting patterns of demand related to the pandemic response (2020–2022) have further accelerated the international recruitment of health workers *(8,9)*.

Several pathways for international migration and mobility for health workers exist according to the purpose of the movement. These include education, fleeing from conflicts or other forms of displacement, humanitarian missions, short-term volunteerism, temporary or long-term employment and trade. The movement may take the form of direct enrolment in education programmes or direct recruitment for employment; or through private or public agencies and intermediaries for education, recruitment and employment; it can also be part of free movement within regional economic communities or in the context of government agreements on health, education, trade or labour. The process and criteria for evaluating competencies and qualifications through recognition of credentials and/or licensing of health workers is one important factor in the decision to move across borders.

Health worker migration and mobility result from individual choices that health workers are free to make, and from which they can benefit – through improvements in working and living conditions, income, as well as educational and career development opportunities. However, labour migration can also have implications on the health system of the country the health workers leave (the "country of origin") and the country where they choose to work (the "destination country"). The investment made by the governments and societies in countries of origin, in terms of educating and training health workers, will have limited impact in the country of origin itself if a substantial share of skilled and experienced health workers leaves the country. Conversely, populations in destination countries reap a larger share of the benefits as health workers become available without their governments having to invest in their education and professional development. The consequence of excessive, unplanned and unmanaged health worker migration and mobility from countries

2 As of April 2022, 76 countries, areas and territories had reported data on place of training for doctors and 105 countries for nurses. High-income countries accounted for 21/37 countries where more than 20% of doctors were foreign trained and 12/30 countries where more than 20% of nurses were foreign trained.

facing pre-existing workforce vulnerabilities can be devastating. In such cases, it can exacerbate workforce shortages for the most vulnerable populations, thus worsening health inequities.

Concerns about the negative impact of health workforce migration in countries of origin led to the adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel by the 63rd World Health Assembly (WHA) in 2010 (referred to as "the Code") *(10)*. The Code, with the associated Health Workforce Support and Safeguards List *(11)*, promotes fair and ethical management of international recruitment, including through bilateral agreements,[3] to safeguard the rights and welfare of migrant health workers. Further, it seeks to mitigate the negative impact of migration on the health systems of countries of origin through technical assistance and financial support for health workforce development and health systems strengthening. The Code also encourages countries to develop adequate internal capacity to manage and monitor such agreements.

In addition to the Code, a number of international instruments contribute to shaping the international policy environment for international migration and mobility across different sectors. Such instruments can also influence the development and implementation of government agreements on health worker migration and mobility. These include the General Agreement on Trade in Services (GATS) *(12)*, the Global Compact for Safe, Orderly and Regular Migration *(13)*, the Global Convention on the Recognition of Qualifications concerning Higher Education *(14)*, ILO international labour standards, in particular the ILO fundamental Conventions, but also other relevant Conventions, Recommendations and Protocols, such as the Migration for Employment Convention (Revised) 1949 (No. 97) *(2)* and the Migrant Workers (Supplementary Provisions) Convention 1975 (No. 143) *(3)*, as well as UN human rights instruments such as the International Convention on the Protection of Rights of All Migrant Workers and Members of Their Families *(15)*. During emergencies, international humanitarian laws also apply.

Bilateral agreements hold the potential to contribute to orderly migration and mobility that can benefit health workers as well as the health systems of the countries that they move across. The agreements can take several forms. They can be customized to be meet the specific needs and priorities of each country. When appropriately formulated, such agreements can contribute to other Sustainable Development Goals, including decent work and economic growth, gender equality and reduced inequalities.

The potential gains for destination countries that derive from health worker migration and mobility relate to their contribution to addressing unmet health service needs, thus playing a crucial role in advancing the human right to health and socioeconomic growth. At the individual level, migrant health workers can increase their income (when wage differentials exist across countries of origin and destination) and/or advance their education, training and career development.

Some estimates indicate that trade in services through the movement of health workers represents over US$ 3 billion annually.[4] In some cases, remittances from migrants contribute significantly to the economy of their country of origin *(16)*, although the lack of remittance data that are disaggregated by employment sector makes it difficult to ascertain the specific contribution of migrant health workers.

The effect of health worker migration and mobility on the health systems of countries of origin appears to be, at best, mixed. There is evidence that, international migration and mobility can contribute to increasing in the total stock of nurses, while negatively affecting quality *(17)*. The increase in stock, however, was not enough to increase the national density of nurses *(18)*. The indirect theoretical benefits that may accrue from health worker migration and mobility to the health systems of the countries of origin include: contribution of the diaspora network regarding skills; knowledge and technology transfer; and capacity building initiatives. However, evidence of these positive effects actually materializing is very limited *(19,20)*. Although international development assistance for the health workforce has increased in recent years, it has largely concentrated on short-term activities rather than interventions for workforce sustainability *(21)*. On the other hand, arguments against increasing international health worker migration and mobility include reducing the skills and capacity base in the countries of origin *(22,23)*.

1.1 Rationale

As the overarching framework linking international recruitment of health workers with health systems strengthening *(24)*, the Code remains the principal instrument that informs the development of health worker migration and mobility agreements so as to strengthen the health systems of all participating countries, consistent with international labour standards and human rights.

3 For the purpose of this guidance tool, bilateral health worker migration and mobility agreements are any agreement between government agencies of two or more countries that affect health worker migration and mobility. Since certain agreements could involve more than two countries (e.g. regional or multilateral agreements), we use the term "government agreements" interchangeably with "bilateral agreements" throughout this document.

4 Estimates on trade in health services by mode of supply are produced using the WTO Trade in Services Data by Mode of Supply (TISMOS) methodology (2019, based on the recommendations of UN DESA 2012), further improved in 2021. A new TISMOS dataset is forthcoming. For more information, see WTO, "Statistics on Trade in Commercial Services" https://www .wto.org/english/res_e/statis_e/tradeserv_stat_e.htm

Interest in the use of bilateral, multilateral and regional agreements on health worker migration and mobility is increasing *(24)*. At the same time, it appears unlikely that all countries have been able to reap adequate benefits from them, for various reasons. Socioeconomic inequities have deep historical roots *(25)*, and they continue to influence the power dynamics between countries *(26,27)*. This may contribute to the difficulty that countries of origin face in securing investments and other benefits for their health systems as part of their health worker migration and mobility agreements. At the same time, destination countries have little direct incentive to contribute to strengthening the health systems of countries of origin.

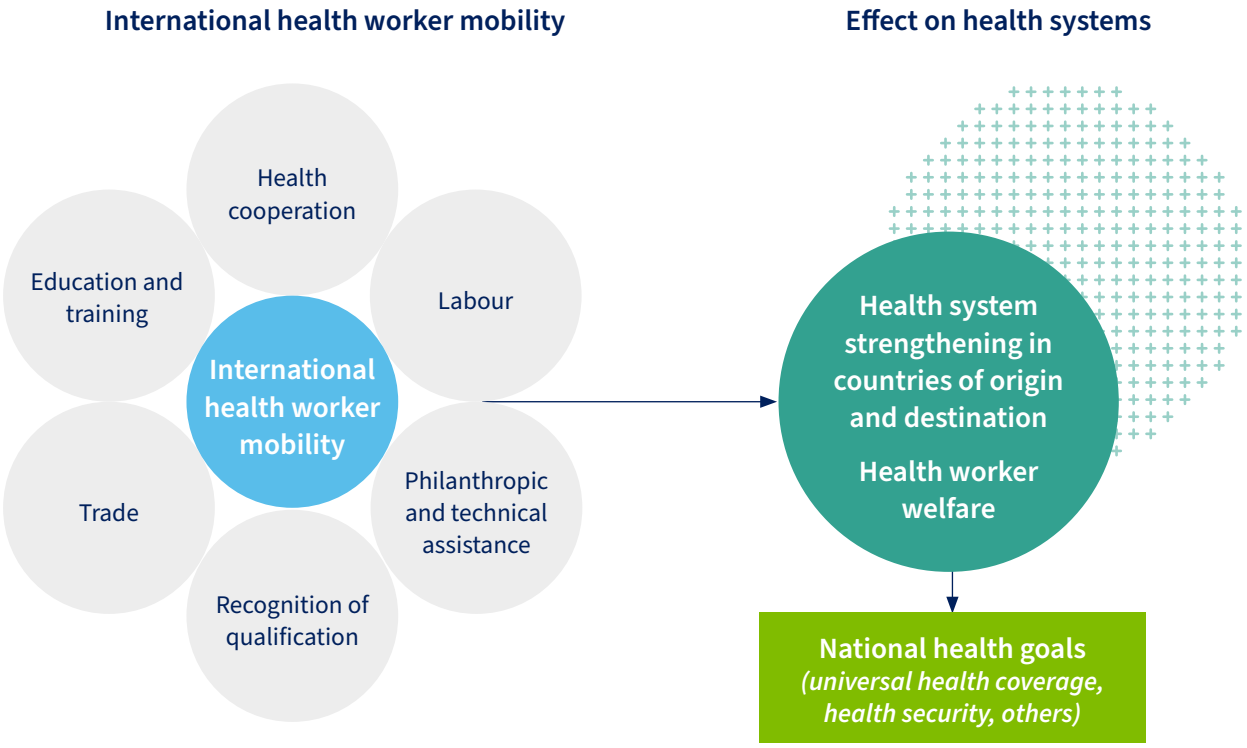
It is, however, in the interest of every country to ensure that health worker migration and mobility agreements do not undermine public health and health system goals in the participating countries. Health workers play a vital role in the progress towards the Sustainable Development Goals on health, gender equality, employment and economic growth, and safe, orderly and regular migration. They are fundamental in ensuring the right to health and are one of the major contributors to economic growth *(28)*. In today's globalized world, the effects of diseases, climate change, conflicts and increased human migration and mobility are felt across countries, continents and economies. A weak health system anywhere in the world can threaten international health security, with grave repercussions for economies and societies globally.

Furthermore, given that many countries rely on migrant health workers to meet domestic demand, there is a risk of international supply constraints during emergencies and pandemics. This became clear during the COVID-19 pandemic when some countries introduced export restrictions on essential resources to meet domestic requirements *(29)*. Strengthening the health systems of countries of origin is not just an ethical and moral responsibility, it is also in the interest of health workforce sustainability of destination countries, global health security and economic growth.

Moreover, the right to health is a fundamental human right irrespective of colour, ethnicity, geography, gender, nationality, religion and social or economic status *(30–32)*. The progress towards advancing this basic human right can be compromised if broader economic or political agendas overlook health system implications and requirements. While economic growth is essential to advance public health, it is not enough to secure good health and well-being of the population and needs to be accompanied by adequate investments in health systems and the health workforce. Conversely, a healthy population is vital to economic growth.

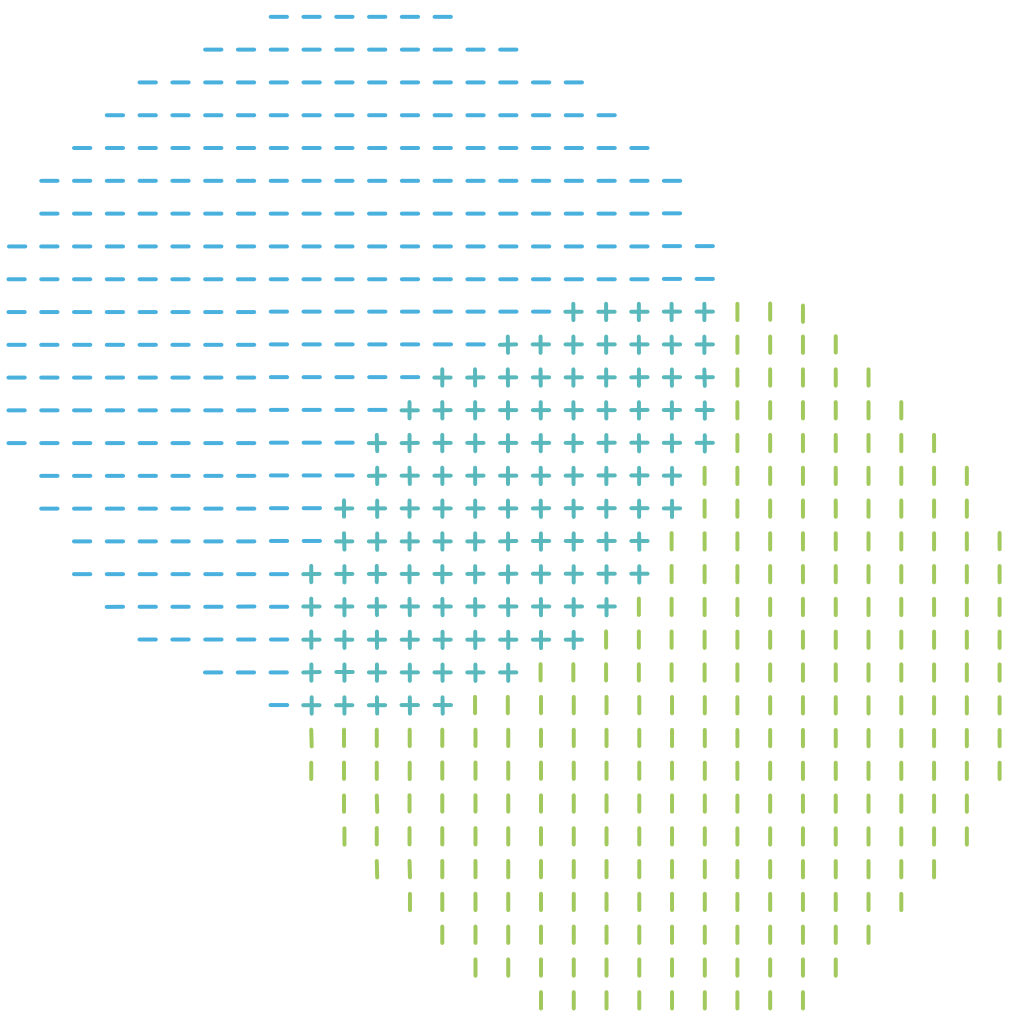
The conceptual premise underpinning this document is that bilateral agreements hold the potential to promote holistic, fair and ethical recruitment of health workers, which can be mutually beneficial to the health systems of countries of origin and destination and health workers themselves, thereby minimizing the unintended negative consequences of migration and mobility and contributing to national health goals (Fig. 1).

Fig. 1. Scope and potential benefits of government-to-government agreements



Health worker migration and mobility agreements between governments hold the potential to improve the management of international movement of health workers and ensure convergence of interests between the participating countries. Such agreements need not be limited to the issue of personnel migration and mobility. They can also be utilized for cooperation in relation to other aspects of health systems, and be tailored to meet the specific requirements of each country, in order to:

- Enable a more predictable supply of international health migrant workers in destination countries, to fill skills gaps, and service or labour gaps.
- Minimize the adverse effects of health worker migration and mobility on the country of origin by determining the quantity, type and duration of migration and mobility, so as to not harm the health system (this benefit, however, may materialize only if the bilateral agreement is the main mode of recruitment).
- Strengthen the health system of the country of origin by addressing gaps in training, education and technology, and by securing financial or technical support from the destination country in priority areas.
- Assure health workers of safe and orderly migration and mobility and of their rights and welfare in the destination countries.



2. Objectives

The goal of this guidance is to support the development of bilateral agreements that advance national health goals for both countries of origin and destination, and to safeguard the welfare and rights of health workers, while harnessing opportunities for gains across other sectors such as education, trade, economy, etc.

The intention of this guidance is neither to promote nor discourage the international movement of health workers. The Code recognizes the right of health workers to move across borders under applicable laws. Acknowledging that human migration and mobility are a reality, and that multiple pathways for health worker movement exist, this document focuses on improving the government agreements that govern international health worker migration and mobility. It does so by identifying approaches that can help to ensure that such agreements are ethical, fair, gender responsive, health system strengthening, inclusive, people centred and rights based, and that they support health workforce sustainability.

This guidance was developed in response to specific requests from WHO Member States for technical assistance in the development of bilateral agreements on health workforce migration and mobility, and in alignment with the recommendations of the Member States' led review of the relevance and effectiveness of the Code. It is meant to be an instrument for improving the capacity of state actors involved in the development, negotiation, implementation, governance, and monitoring and evaluation of agreements related to international health worker migration and mobility, keeping health system priorities at the fore, and consistent with ILO international labour standards and other relevant instruments.

This guidance is consistent with the UN system-wide guidance on bilateral labour migration agreements *(33)*, which seeks to support Member States in designing, negotiating, implementing, and monitoring and evaluating rights-based, gender-responsive bilateral labour migration agreements across sectors. Among its provisions, the UN guidance recognizes that health workforce shortages in origin countries have a negative impact on delivery of health services to their populations, and emphasizes the importance of equal treatment of migrant health workers with national health workers. This document complements the UN system-wide guidance through additional information specific to the health sector *(33)*.

This guidance represents an implementation tool to operationalize the provisions and recommendations of the Code, consistently with international labour standards and human rights instruments. In particular, it focuses on the implications of health worker migration and mobility agreements for the health systems of countries of origin; preservation of the health system in countries of origin is a central tenet of the Code. It also represents an implementation tool to support the operationalization of the provisions and recommendations of the Code, the Global Compact for Safe, Orderly and Regular Migration *(13)*, the High-Level Commission on Health Employment and Economic Growth *(28)* and the ILO-OECD-WHO Working for Health Programme[5] and promotes international labour standards and human rights instruments.

5 The Working for Health Programme is a joint partnership between the WHO, ILO and OECD to expand and transform the health and social workforce to drive inclusive economic growth and achieve the Sustainable Development Goals. For more information, see https://www.who.int/health-topics/health-workforce#tab=tab_3.

Objectives of the guidance

1

Identify and describe the variety of bilateral and regional agreements on international health worker migration and mobility.

2

Identify challenges and promising practices to advance the principles of the Code, consistent with international labour standards and human rights instruments.

3

Provide policy considerations for the preparation, design, negotiation, implementation, and monitoring and evaluation of bilateral agreements, as consistent with the Code.

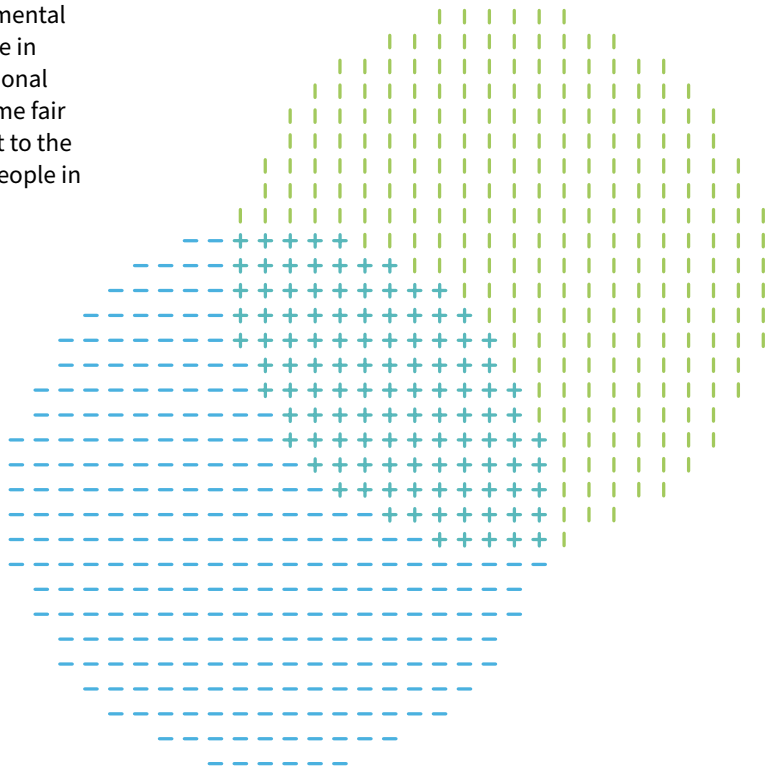
2.1 Target audience, scope, applicability

This guidance is meant to inform policy-makers and other officials in ministries of health and other sectors (such as labour and foreign affairs) who have the responsibility to design, negotiate, develop, implement, and monitor and evaluate government agreements regarding the international migration and mobility of health personnel. Secondary target audiences are nongovernmental entities (including public or private employers, trade unions, health worker representatives, regulators, professional associations, education institutions, recruiters and others) and representatives from other ministries and sectors (such as education, trade and migration), which may be involved through different roles and capacities in the preparation and drafting, negotiation, implementation, and monitoring and evaluation of agreements involving health worker migration and mobility.

The guidance is global in scope. It is expected to inform and empower officials as well as nongovernmental stakeholders in all regions that play a key role in government agreements that affect international health worker migration and mobility, to frame fair and ethical agreements that uphold the right to the highest attainable standard of health of all people in all countries.

For clarity, when referring to migration and mobility flows, this guidance uses the terms “country of origin” and “country of destination”. This is in recognition of the predominant direction of movement of health personnel between two countries, typically driven by wage differentials, income opportunities, and education and career advancement prospects. This distinction is not rigid, and the guidance does not exclude the possibility that countries may be at the same time a country of origin for health workers moving abroad, as well as a destination country for health workers entering from other countries.

While the guidance is meant for bilateral agreements on health worker migration and mobility, many of its elements are applicable to other regional or multilateral agreements. Governments and other stakeholders can use this document when considering and negotiating agreements with a health worker migration and mobility component, and/or when assessing the impact of such agreements.



3. Methods

The process to formulate the contents of this guidance included extensive research, based on the following steps:

- **A rapid scoping review of health worker mobility agreements (Annex 1).**
- **Textual analysis of bilateral (and regional) health worker mobility agreements (Annex 2).**
- **Key stakeholder interviews (Annex 3).**
- **Technical Expert Group peer review and validation.**

There is a scarcity of published evidence regarding the implementation and impact of government agreements that affect health worker migration and mobility. In particular, there is little evidence about the impact of such agreements on the health systems of the countries involved and health workers themselves. This is true also in relation to the 37 agreements for which the text is available to WHO through the first three rounds of reporting on the implementation of the Code (2012, 2015 and 2018) since its adoption in 2010 and through the notification of regional trade agreements (RTAs) containing health services commitments to the WTO (Annex 2).

For these agreements, a textual analysis was carried out in relation to implications on:

- orderly movement of health workers;
- welfare of health workers crossing borders, in terms of their rights and working conditions; and
- health systems of the countries involved.

It is challenging to fully understand the processes that generate health worker migration and mobility agreements, and their impacts, by looking at the text only. By way of example, the texts of the agreements do not provide information about the background, modalities and negotiation process leading to the agreements, about their monitoring and evaluation, or about the results and outcomes once implemented. The details might be in the implementation plans (typically developed as next steps) but reports on implementation and/or completion of the agreements are normally not available as supplementary material; therefore, it is difficult to understand if and how agreements were implemented.

For these reasons, it was necessary to complement the textual analysis through in-depth interviews with key stakeholders with direct experience in the preparation and drafting, negotiation, implementation, monitoring and/or evaluation of government agreements on health worker migration and mobility. The number of stakeholders interviewed was 22. The individuals were identified initially through a starter convenience sample, followed by snowball sampling. The group of interviewees consisted of experts from government entities from countries of origin and countries of destination, trade union representatives, advisory bodies and migrant health workers (Annex 3).

Private sector actors (e.g. employers, recruiters) were not represented among the interviewees because the focus was on the government agreement pathway for migration and mobility; further, the snowball sampling approach did not identify any stakeholders from the private sector that met the inclusion criteria in the timeframe in which the interviews were conducted. The interviews explored how and why the agreements were developed and negotiated, alignment of the content of the agreements with subsequent implementation, and the successes, challenges and lessons learned.

The Technical Expert Group was convened by WHO to contribute to the identification and prioritization of topics to address as part of the research and development of the guidance, the interpretation of the evidence gathered, and the validation of findings and policy considerations. The Technical Expert Group comprised representatives from countries of origin and destination, thematic experts and officials from agencies involved in the health worker migration and mobility agreements.

4. Key findings

4.1 Findings from the literature review

The rapid review found that bilateral agreements involving health worker migration and mobility vary significantly in their form, objectives, content and scope. Different types of bilateral and regional agreements have been used to facilitate the recruitment of migrant health workers to address labour shortages and unemployment *(34)*, address maldistribution *(35)*, as a component of trade in health services agreements *(36)*, to promote the education and training of health workers *(37)*, to facilitate intraregional migration and mobility of health professionals *(38)*, to advance health cooperation *(39)*, to facilitate safe migration and mobility especially for women *(40)*, and to respond to emergencies and support service delivery in underserved areas *(41,42)*.

Several international instruments provide principles and recommendations on different elements of such agreements (see Annex 4). The UN Global Compact for Safe, Orderly and Regular Migration (2018) lays down a cooperative framework with objectives, commitments and actions to improve governance of worker migration and mobility. It encourages the development of government agreements that promote skills development, career mobility and professional exchange programmes. It endorses pro-development outcomes for the countries of origin through investments in human capital *(13)*.

The ILO standards (Conventions, Recommendations and Protocols) include standards of general application, instruments containing specific provisions on migrant workers, dedicated instruments on migrant workers, and social security instruments that are applicable to migrant workers *(2,3,43,44)*. International labour standards apply to all workers, including migrant (health) workers, unless otherwise stated *(45)*. A wide range of ILO standards therefore apply to migrant health workers, but there are two dedicated instruments, notably the Nursing Personnel Convention 1977 (No. 149) and Nursing Personnel Recommendation 1977 (No. 157).

Moreover, Recommendation No. 157 specifically refers to international cooperation, including bilateral or multilateral arrangements, and refers to a number of relevant issues such as education and training abroad, recognition of qualifications, recruitment, repatriation and social security *(46,47)*. In addition, the ILO Declaration on Fundamental Principles and Rights at Work, as amended in 2022, requires ILO Member States to promote, respect and realize the principles and rights at work that are set out in the Declaration and that are covered by the 10 Conventions that have been identified as fundamental *(48)*. These fundamental principles and rights apply to all workers, including migrant health workers. Further, ILO General Principles and Operational Guidelines for Fair Recruitment, and the Definition of Recruitment Fees and Related Costs (2019), ILO Multilateral Framework on Labour Migration along with *Guidance on bilateral labour migration agreements,* have also been developed to support fair recruitment *(33,49)*.

The United Nations Educational, Scientific and Cultural Organization (UNESCO) Global Convention on the Recognition of Qualifications concerning Higher Education ensures the right of individuals to have their higher education qualifications evaluated through fair, transparent and non-discriminatory mechanisms *(14)*.

Moreover, WTO Members may have commitments6 under GATS related to the temporary presence of foreign individuals supplying health-related professional services and health and social services. To the extent that health worker migration and mobility is covered by mode 4 of GATS – which relates to the movement of natural persons to supply services abroad (foreign individuals who work for foreign-owned health service providers or are self-employed and temporarily present in the host jurisdiction) – then WTO Members are required to respect the most favoured nation (MFN) obligation,[7] whether they have made sector-specific commitments or not.[8] GATS allows regional or bilateral trade agreements between two or more economies to deviate from the MFN principle under certain conditions *(12)*.[9]

6 If health is not excluded by the coverage of the agreement, and there is no reservation for possible future measures, then they are commitments by default.

7 The MFN principle of GATS, which is part of all WTO agreements, reflects the obligation to treat foreign and domestic suppliers of like services in the same way.

8 At the time they became WTO Members, economies were, however, allowed to retain some MFN inconsistent measures if they listed them in what are known as “MFN exemptions”.

9 For example, the agreement has to have a substantial coverage, i.e. a priori cover of all four modes of services supply, and provide for the absence or substantial elimination of all discrimination between the Parties. There is also an obligation to notify the agreement to the WTO Council for Trade in Services.

Countries are using government agreements on international recruitment of health workers to provide for the orderly migration and mobility of health workers through formal channels and to ensure their welfare. They are innovating through approaches for managing health worker migration and mobility to ensure both countries benefit; one example is skills partnerships, which blend health workers' training with migration and mobility *(50)*. Regional economic bodies such as the Association of Southeast Asian Nations (ASEAN) and the European Union (EU) are encouraging free migration and mobility within their regions *(38,51)*. For third-country nationals, the EU Talent Partnerships initiative (2021) seeks to strengthen legal pathways for movement and international partnerships in priority areas such as health and medical care *(52)*. The updated United Kingdom Code of Practice for the International Recruitment of Health and Social Care Personnel, in alignment with the Code, aims to foster mutually beneficial government agreements that strengthen health systems in countries of origin *(53)*.

Alongside the increasing use of bilateral agreements, evidence points to numerous challenges in terms of their negotiation and execution, including an absence of adequate monitoring and evaluation mechanisms. Challenges include uneven power and negotiation capacity, non-binding governance mechanisms on migration and mobility, and relationships between countries that place the richer destination countries at an advantage to secure more benefits from the agreements, whereas countries of origin lose skilled workers *(51,54–57)*. In certain cases, it appears the governments of countries of origin were able to secure commitments for resources in exchange for the departure of health personnel, depending on the capacity and willingness of the destination country *(42)*.

A notable challenge pertains to situations where government agencies that lead in negotiating and executing government agreements that affect health services do not adequately consult with the ministry of health. When there is no proper input from the ministry of health, this may result in political and economic agendas taking precedence over health *(58)*.

Challenges in the implementation of the agreements include: variations in the education, training systems and regulatory systems of the countries negotiating the agreement, along with language and cultural differences; resistance by local health workers in destination countries to the arrival of foreign health workers; health workers' preferences in terms of where to move and their migration and mobility pathway; limited engagement of stakeholders, including non-state actors, in the development and implementation of agreements; the cost of implementing and enforcing agreements, and the possible lack of incentives for the destination country to implement all provisions; and lack of mechanisms to monitor the impact of agreements *(38,42,54,55,57,59)*.

4.2 Findings from the textual analysis and key stakeholder interviews

The textual analysis of the bilateral agreements and the key stakeholder interviews provided rich descriptive evidence about the diversity of bilateral agreements and about the processes involved in their negotiation, development and implementation. The following section summarizes the evidence from the analysis and the interviews.

Diversity of agreements

Government health worker migration and mobility agreements differ widely in terms of their objectives, level of detail of the provisions, approach to managing migration and mobility, dispute resolution and administration mechanisms, and the occupational groups covered. The stated purposes of these agreements range from filling workforce gaps to meeting innovation needs, and from the deployment of new technologies to provision of philanthropic support, to the creation of new health care infrastructure with the help of expertise from abroad – and a combination of the above objectives. Consequently, there is no one standard format or prevalent template for these agreements. This reflects the fact that each country's health worker migration and mobility situation is unique in objective, scope and content. At the same time, certain commonalities and positive elements can be identified across the different agreements that can be potentially replicated elsewhere.

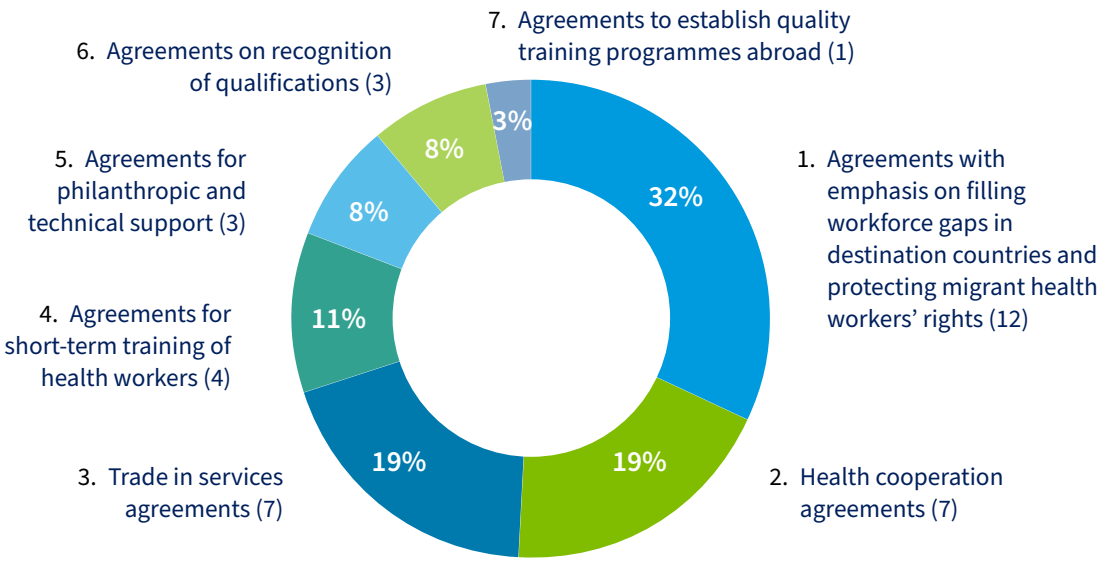
Based on the review of 37 agreement texts, bilateral government agreements on health worker migration and mobility can be broadly classified into seven categories according to their predominant area of focus (see Fig. 2 and Annex 2).

1. **Agreements with emphasis on filling workforce gaps in destination countries and protecting migrant health workers' rights:** These labour migration agreements are aimed at addressing shortages in destination countries' health systems, while also attempting to safeguard the welfare of migrant health workers, including fair treatment for workers and transparent recruitment practices. Although agreements may envision circular migration, this is not a requirement as some agreements explicitly mention the provisions for permanent residency in the destination country.
2. **Health cooperation agreements:** Agreements under the category of health cooperation for mutual benefit are typically framework agreements that establish the general objectives for cooperation between the countries. The areas for cooperation can encompass training and temporary work opportunities, hospital sector

reform, cooperation between hospitals, research and development, emergency interventions, procurement of drugs and equipment, etc.

3. **Trade in services agreements:** These agreements are negotiated among two or more economies and can include commitments, and in certain instances provisions, for the temporary international migration and mobility of health workers. Countries have used RTAs to deepen commitments on health services compared with those in GATS, including by allowing greater access to migrant health workers. Both in GATS and in RTAs, destination countries can place quantitative limits on the entry of migrant health workers, for instance by conditioning access on the existence of a demonstrated need for their services. Such agreements include commitments to treat foreign workers no less favourably than domestic workers performing the same service are treated, the so-called MFN provision generally found in trade agreements.
4. **Agreements for short-term training of health workers:** These involve health education institutions in destination countries providing education and training to health workers from the countries of origin. The agreements are often negotiated in the context of a broader health strategy for the country of origin and circular migration is one of the envisaged provisions of the agreements. Health workers from the countries of origin receive training beyond what they would have received in their home country, and the destination countries benefit from these health workers temporarily providing services in their health system.
5. **Agreements for philanthropic and technical support:** These agreements include temporary migration and mobility provisions in which one party provides specific support to fill the gaps in health services, sometimes in the context of emergencies. In some cases, they may also include elements of cooperation for mutual benefits.[10] The general objectives of these agreements include enhancing the destination country health personnel's education and training to strengthening service delivery. Some agreements include provisions for the health workers' conditions of employment in the destination country after completing the terms and duration of the technical assistance.
6. **Agreements on recognition of qualifications:** These agreements are aimed largely at encouraging the delivery of health services from internationally mobile health workers and migrant workers through facilitating recognition of workers' qualifications. The requirements for different occupations can vary. Regulators of individual countries retain the authority to override the provisions in the harmonization agreement to protect the public. These agreements are typically limited to qualifications' recognition of specific categories of health occupations and do not actually create channels for international recruitment.
7. **Agreements to establish quality training programmes abroad:** This type of agreement aims to enhance health worker education in the country of origin in alignment with the standards in the destination country and provide employment opportunities to the country of origin's graduates in the destination country. Such agreements are intended to facilitate collaboration between experts, academic institutions, faculties and hospitals, including faculty exchanges between the countries of origin and destination. There can be several options for employment in the destination country, with or without a return to the country of origin clause.

Fig. 2. Agreements on health worker migration and mobility categories (*n* = 37)



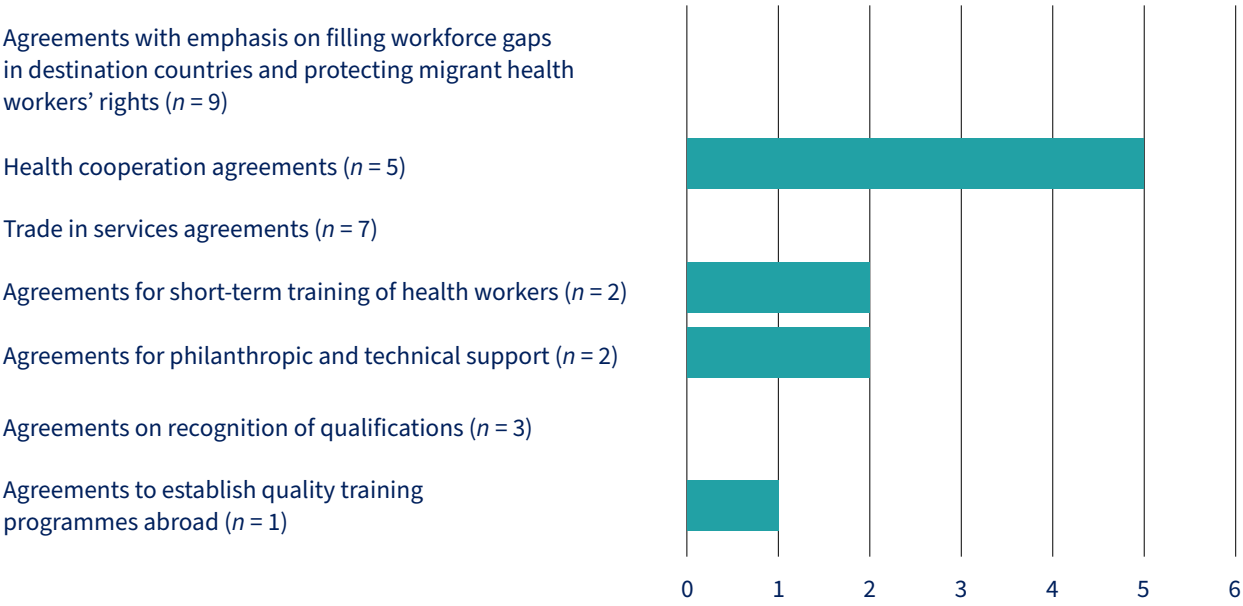
10 "Mutual benefit" was considered to exist if gain could be identified for both the countries of origin and destination.

Institutional arrangements

Countries with significant experience in bilateral migration agreements on health workers tend to have a well-established framework for negotiation and implementation of the agreements, including identification of responsible agencies. These engage relevant stakeholders within and beyond various government agencies (e.g. regulators, academic institutions, professional associations, recruitment agencies, employers, trade unions, etc.). Countries of origin, particularly those that are new to using government agreements for health worker migration and mobility, may lack such organizational infrastructure. They may also have limited dedicated resources and institutional mechanisms available to negotiate and implement agreements.

The agencies responsible for international agreements on health worker migration and mobility vary, depending on the country and in relation to the category of agreement. As an illustration, the agreements with emphasis on addressing health workforce shortages and protecting migrant health worker rights appear to be mostly led by employment-focused government entities and sometimes by ministries of foreign affairs, economy or the interior, while those focusing on education, health cooperation and philanthropic and technical support are more frequently led by ministries of health (see Fig. 3 and Annex 2).

Fig. 3. Number of agreements with ministry of health as signatory



Based on the category of the agreement and factors specific to the negotiating countries, the signatories of government agreements may be the relevant departments or agencies within the ministry of economic development, foreign affairs, health, interior or immigration, industry, commerce or trade, labour, etc. The signatories from the countries of origin and destination are not necessarily the technical counterparts from the same ministries but may instead represent other government agencies. In two-thirds of the texts reviewed,[11] the ministry of health was not a signatory of the agreement (Annex 2). The agreements focusing on recognition of qualifications, filling workforce gaps and protecting health workers' rights and trade were all signed by non-health ministries including, for instance, government entities dedicated to commerce, economic development, foreign affairs, interior, labour and trade etc.

Stakeholder interviews revealed that the development of government agreements can be triggered by a variety of factors including health sector strategy, economic reasons, unemployment, education, international relations, trade and political gestures. Agreements are often not preceded by and/or based on a health system needs assessment, health labour market analysis, or even careful preparation of the institutional structure and regulatory processes for operationalizing agreements in both the countries of origin and destination.

The areas of focus in the agreements often reflect different goals of different government agencies and stakeholder groups, which can be complicated to manage, monitor and evaluate over time. Some countries have an inter-agency coordination mechanism, where focal persons from each relevant

11 Information on the signatories were available in 29 of the 37 agreements analysed. Only 10 of the 29 agreements were signed by the ministry of health.

government agency or other entities come together for discussions related to government health worker migration and mobility agreements. In some cases, the ministries of health of countries of origin are co-leads or have equal voice in government agreements on health worker migration and mobility, even though the negotiation process is led by another government agency. In others, consultations with the ministry of health may be limited, or their inputs may not be taken into account, as the final authority on the terms of the agreement remains with other parts of the government.

Health system benefit

Most agreements are explicitly aimed at addressing health worker shortages in health systems of destination countries. It is often unclear in these agreements, however, how health service delivery in countries of origin will be maintained, and or what the expected benefits migration can generate for the country of origin's health system. The text of health cooperation agreements appears to advance the health agenda in some specific areas, but these agreements are fewer in number than trade or labour agreements (Annex 2). Notably, most countries had limited data on implementation of the agreements and no evaluation of their impact. This makes it difficult to know whether agreements were beneficial to the health systems of both countries.

Most agreements are explicitly aimed at addressing health worker shortages in health systems of destination countries.

Many low-and middle-income countries suffer from needs-based workforce shortages together with health worker unemployment due to limited ability to create adequate and attractive work opportunities *(60)*. In some of these contexts, stakeholders reported that agreements for employment of health workers are perceived as a means to mitigate workforce unemployment, which is a priority for the government. However, although this mechanism supports individual families, public funding or investment required to increase domestic recruitment of health workers could remain unaddressed.

Although many agreements include provisions for circular/temporary migration, and may even cite this as an objective, this may not always be feasible or likely. Evidence of this outcome actually materializing is not generally available, particularly when the purpose of migration and mobility is securing employment abroad. Even in agreements with an explicit return clause the status and contribution of the health workers after return was unclear, lacking specificity on absorption capacity, entry levels and remuneration.

Countries of origin appear to have few leverage points to negotiate a mutually beneficial agreement from the health system strengthening perspective. Stakeholders reported that the substantial difference in health worker remuneration between countries, which is the main pull factor for health workers, along with the non-binding nature of the Code, may place the source countries in a position of disadvantage.

The position of the countries of origin can be further weakened by the reality that health worker movement will continue to take place through alternative routes, in parallel to movement under bilateral agreements. Due to all the above, it can be difficult to secure commitments from destination countries to compensate countries of origin for the loss of health workers – and it is difficult to enforce such commitments. Box 1 summarizes some of the reasons why source countries have used bilateral agreements on health worker migration and mobility.

The need for investment in health systems of countries of origin to offset the loss of health workers was mentioned by several stakeholders. Specific modalities and financing arrangements would need to be spelled out explicitly in the agreements, with benefits commensurate to the costs in relative value to the health systems of the countries of origin.

Stakeholder interviews revealed that some of the specifications for international recruitment placed by destination countries – for instance, the requirement that health workers have a certain number of years of practice – can come at the cost of access to skilled workforce in the country of origin and cause increased inequities.

For instance, the recruitment of experienced health workers in certain specialties, who sometimes also have teaching or training responsibilities, can result in the population of the country of origin being served by comparatively inexperienced health workers and by faculty depletion. It can provoke an endless cycle of public investment in training and specialized practice to compensate for the loss through migration. Stakeholders also pointed out that the loss of health personnel with several years' experience in specialized technical areas will not be adequately nor equivalently compensated with financial support by the destination country in the health education system of the country of origin because of the additional time it takes

for senior health workers to acquire the necessary experience. Pre-service education of new health workers is comparatively easier to accomplish than the years-long process of acquiring experience and skills by holding a job.

Agreements with a focus on education and technical support may benefit countries of origin in terms of capacity development. At the same time, it is important to maintain realistic expectations about the practical impact on delivery of health services in these countries.

The number of such agreements and the number of health workers having access to specialized training opportunities through these arrangements can be extremely limited compared with hundreds or even thousands of health workers moving to the destination country through different pathways. When the root causes of mobility and migration persist, retention of essential health workers may continue to represent a challenge for many countries of origin.

Box 1. Evidence of health system benefits to countries of origin were not identified in most cases despite this being central to the Code

Stakeholder interviews revealed that countries of origin appear to sign agreements on health worker migration and mobility for a variety of reasons. These include: to address unemployment challenges; enable access to international markets; ensure welfare of their people abroad; to build capacity of their health system; and in some cases, to advance their international cooperation and development assistance agenda, and obtain benefits in other sectors.

While some agreements identify strengthening longer term collaboration and a few agreements commit to support capacity building in the source countries, this is usually limited to generic best endeavour statements (Annex 2). In one such agreement, the commitment by the destination country to support an initiative to build capacity of the health system in the country of origin could not be implemented reportedly due to funding challenges.

International migration and mobility of health workers is often expected to bring new knowledge and skills to the source country of origin health system through circular migration. However, it was observed that it may be hard to apply some of those skills in the country of origin because of contextual differences, and fewer resources and technologies.

Conversely, bilateral agreements allow governments of countries of origin to ensure workforce sustainability to some extent. Governments can decide on the quantity and category of health workers moving to another country without harming their health system. While some countries have placed an annual ceiling on health workers leaving the country under employment visas to address domestic shortage or have established a requirement for public service for a certain number of years following completion of training, others have limited health worker eligibility for movement under migration and mobility agreements for medium- to long-term employment to unemployed health workers and occupational groups that are not in high demand in the domestic market. Some countries have undertaken additional agreements with the same destination country to build capacity in priority areas.

The recruitment of experienced and senior health workers can provoke an endless cycle of public investment in training and specialized practice to compensate for the loss through migration.

Health worker welfare

Provisions safeguarding the welfare of migrant health workers is a prominent feature of most bilateral agreements (Annex 2). Stakeholders pointed out that the challenges health workers faced with private recruiters or while moving across countries individually for employment (in terms of cost, safety and transparency) have the potential to be addressed through or benefit from government agreements. In most of the agreements, the cost of health worker recruitment is covered by entities in the destination countries, not by the individual health workers, and this is one of the major advantages leading individual health workers to opt for the bilateral agreement pathway for migration and mobility.

The health worker safeguards in the agreements generally focus on the right to receive a contract in advance, fair working conditions, including appropriate remuneration, support to understand the conditions in the contract, support to prepare for living and working in the destination country, access to health care and social protection benefits, training opportunities, and transparent migration and mobility and recruitment processes, among others. Some agreements also include provisions for dispute resolution, provide support with the immigration process, and allow health workers' families to join them in the destination country. Trade unions play a crucial role in ensuring agreements adequately take into account health worker rights and welfare.

Countries with experience in international health worker migration and mobility have specific procedures and leading agencies that are in charge of the implementation and management of the different types of health worker migration and mobility agreements. In the case of agreements for employment, the migration process may be managed by a designated government agency and the terms of the agreement may apply also to private recruiters, requiring them to respect the terms of the agreement alongside public sector entities. Regulation of private recruitment in the countries of origin and destination can take place through national legislation and policy provisions informed by the Code, or be enforced through conditioning their licences on compliance with terms of the government agreements.

In the case of agreements on philanthropic support and technical assistance, countries of origin are generally responsible for the cost of the health workers' travel and remuneration, but the destination countries may provide additional and supplemental allowances (Annex 2).

Some agreements provide detailed provisions for professional and personal integration in the destination country. The establishment of worker welfare funds was included in certain agreements to support migrant workers in need. However, stakeholders reported the need to inform communities in the destination countries about the professional qualifications of international workers, as local peers and colleagues or community members may require reassurance on their official, professional or academic status.

Although health service delivery is a heavily gendered area *(61)*, no gender-specific lens appears to have been considered in any of the agreements analysed: for example, none of the agreements mention entitlement to maternity leave, de facto leaving the provision of such benefits to implementation of national legislation and policies in the destination countries.

Qualification recognition

Qualification recognition is an important feature of health worker migration and mobility agreements, across the different categories (Annex 2). While the qualification of the health worker gained in the country of origin may be recognized, it does not necessarily translate into equivalency or give rise to a licence to practise in the destination country.

Assessment of how training in workers' countries of origin aligns with the requirements in destination countries is a crucial factor for health worker migration and mobility. Countries of origin thus negotiate bilateral and regional agreements that govern the recognition of qualifications by destination countries. These (mutual) recognition agreements (MRA) benefit health workers moving under bilateral and regional health worker migration and mobility agreements, as well as those moving between these countries via other pathways. These agreements can help to manage concerns about differential treatment for qualified health workers based on their country of origin and the training programme at home.

Qualification recognition agreements result from a process whereby authorities in the countries of origin are expected to certify that the health workers possess the required qualifications for their jurisdiction, and regulators in the destination countries closely review and compare the health worker education and training in both countries to identify similarities and any significant differences and gaps, and then define ways to account for those gaps when granting permission to practise. This is an exercise in identifying, offsetting and otherwise managing differences in training and preparation, for instance through additional or bridging training or by providing partial licensure.

The ultimate responsibility to accept workers based on their expertise, experience and qualifications rests with destination countries. In the case of regulated health professions, the health practitioner regulatory requirements of destination countries must be satisfied, which can include, for instance, demonstration of competence for the intended areas of practice, familiarity with the local language, having the minimum number of years' work experience, presenting a recently issued certificate of good standing, etc. Migrant health workers may also be required to go through additional training (on specific technical areas that are public health priorities or local requirements of the destination countries), and/or acquire work experience in a junior role or limited/supervised practice in the destination country before being considered eligible for a role corresponding to their competencies and qualifications.

Most countries have specific and transparent requirements for entry into regulated health professions. Because training programmes differ across countries, special provisions for applying them to workers coming

from abroad are typically required. Sometimes these provisions may be applied differently depending on the country of origin of the health worker. In some cases, there is a lack of clarity as to the requirements for entry into specific domains, for instance postgraduate specialists, for workers coming from certain countries or regions.

Certain agreements offer training opportunities, language training and support to prepare for the qualifying and/ or licensing exam, when required, in destination countries or in the country of origin prior to departure.

The majority of agreements do not include any data collection mechanisms that would facilitate monitoring the implementation and evaluation of the impact.

Monitoring and evaluation

The signed agreements between countries are framework agreements that set rules to govern the recruitment, education, migration and mobility arrangements of health workers. The details of the implementation plans include the specific technical areas and terms and conditions of health workers eligible for migration and mobility (e.g. specialty, experience, employment status, number of health workers determined by the technical teams of both countries) and typically are not publicly available. The majority of agreements do not include any data collection mechanisms that would facilitate monitoring the implementation and evaluation of the impact. Few agreements explicitly mention data collection and information exchange on health worker migration and mobility between countries, despite this being an explicit provision of the Code. Creation of a specific body, often called a "committee", to oversee the execution of the agreements, monitor impact, propose amendments and take other necessary actions during implementation was envisaged in only a small minority of the agreements analysed. In the agreements that have established "joint bilateral committees", "joint working groups" or "joint consultative committees", the activities, deliberations or decisions of these bodies are not public.

In general, the evaluation of agreements appears inadequate. Although the stakeholders interviewed reported that the terms of the agreements were largely implemented in good faith, they could not point to information on the outcomes of these agreements, the status of migrant health workers after the agreements expired, or the agreements' impact on the health system of the countries of origin. In the absence of a dedicated monitoring and evaluation mechanism, it is uncertain how the arrangements can be adjusted or taken to scale for maximum impact.

Limitations

The research methods and findings have several limitations. The literature review did not identify quantitative evidence on the results of implementation or evaluation of bilateral agreements. The agreements analysed were the ones that were available to WHO or publicly available via the WTO portal. The texts of these agreements did not include implementation details or reports on completion or evaluation. The stakeholders interviewed were initially identified based on the agreements reviewed, followed by snowball sampling within the timeframe of the research. Therefore, the findings may not have fully captured the diversity of agreements, negotiation and implementation challenges and promising practices and perspectives of all stakeholders. Although the private sector provides a significant share of health services in many countries, the stakeholder interviews did not include representatives from the private sector because most of the agreements reviewed related to the public sector. Finally, with increasing use of information technology and cross-border delivery of health services, especially following the COVID-19 pandemic, more recent government agreements may also have focused on international digital health services, telemedicine and distance education, which include utilization of expertise and/or services of health workers with minimal or no physical movement across borders; these emerging dimensions were not identified in the agreements reviewed.

5. Key policy considerations and good practices

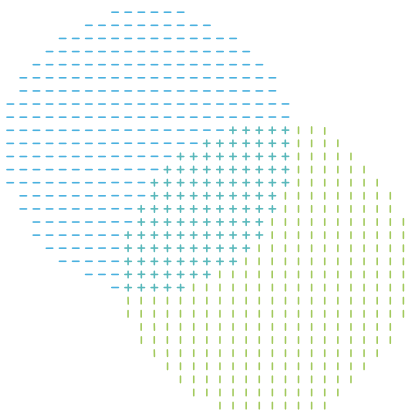
The contents of this chapter are informed by evidence that, as the previous section illustrates, is largely descriptive and explorative in nature. The evidence and research findings have therefore been supplemented by inputs from the WHO Technical Expert Group on bilateral agreements. The adoption of the good practices and policy considerations that are described in this document, along with the related implementation considerations, depend on contextual adaptation, acceptability and feasibility elements, and the implementation capacity of the participating countries.

Renewing the call for partnerships, technical collaboration and financial support as outlined in the Code, and based on the specific needs and special circumstances of countries, the focus of government agreements on health worker migration and mobility could include: filling workforce gaps and ensuring migrant health workers' rights; health cooperation; health workforce mobility in relation to trade in services; health workforce education and training; health workforce migration and mobility for technical assistance and philanthropic support; and harmonization of requirements for and/or recognition of qualifications.

Irrespective of the specific topic(s) or primary goal of the agreement, government agreements related to health systems and workforce (including professionals, associate professionals, auxiliaries and care workers in the health sector) should be in alignment with the objectives and principles of the Code in order to be considered fair and ethical. The principles and rights enshrined in relevant ILO Conventions, Recommendations and Protocols, as well as those set out in ILO declarations (in particular the ILO Declaration on Fundamental Principles and Rights at Work, as amended in 2022), ILO resolutions, and other guidance, such as the ILO *General principles and operational guidelines for fair recruitment and definition of recruitment fees and related costs (49)* and the ILO Multilateral Framework on Labour Migration, are equally relevant.

Global declarations such as the UN Global Compact for Safe, Orderly and Regular Migration, and commitments under UNESCO Recognition Conventions and under the WTO GATS are complementary to and can reinforce the implementation of the Code.

The key policy considerations and good practices to inform the conceptualization and content of government health worker migration are presented below. While the policy considerations and good practice statements relate to any type of health worker migration and mobility agreement, not all considerations will be applicable in all cases. For instance, where movement occurs from a country with a comparatively stronger health system and economy to a weaker one or under an agreement for philanthropic or technical support, there would be no need to provide for investment in the countries of origin by destination countries.



Workforce sustainability

Bilateral agreements should ensure that international health personnel recruitment or migration and mobility contribute to workforce sustainability, health security and progress towards universal health coverage in both country of origin and country of destination without exacerbating workforce challenges.

A commitment to respect and promote the right to the highest standard of health of all people in both countries of origin and destination should inform the development of agreements to contribute to health workforce sustainability *(62)*. When a destination country advances the right to health of their population through recruitment of migrant health workers, the same right should be secured for the populations in countries of origin for progress towards universal health coverage *(24)*, health security and other related sustainable development goals.

Agreements should be informed by analysis of health sector and labour market needs in both countries of origin and destination. Examining the short-term and long-term effect of international migration and mobility in countries of origin and destination includes consideration of possible consequences on: the availability, distribution and quality of different categories of the health workforce; the health labour market; health service delivery; alignment of health education and training with population health needs; cost for health services; and, ultimately, population health outcomes.

Recognizing that international migration and mobility of health workers can take place through multiple pathways in large volumes, existing or anticipated negative consequences of the migration and mobility patterns could be countered through international cooperation. Countries of origin could consider appropriate investments in education, regulation, incentives and support for health workers *(63)*, and appropriate regulation of the different pathways of international migration and mobility. Destination countries could provide support through existing international development channels, increasing or repurposing existing aid, without prejudice to the overall development needs of the country of origin; as well as prioritize recruitment through the provisions of the bilateral agreement.

Health system benefit

The agreement should specify the benefits of the partnership to the health systems of participating countries, in alignment with the respective national health-related goals.

When significant numbers of migrant health workers enter a country through various pathways, destination countries could appear to have little reason to engage in a government agreement, apart from securing a more stable supply of health workers. However, strengthening health systems in countries of origin is in the direct interest of destination countries for their economy, health system sustainability and health security.

Recognizing structural factors that place certain countries at a disadvantage in the negotiation of mutually beneficial agreements, the contribution of the migration and mobility agreement to strengthening health systems in countries of origin needs to be explicit in the agreement. Specific examples of benefits to the health system of country of origin can include:

- Investment of financial resources in the country of origin. These resources can originate, as applicable under country laws and international commitments, from a variety of sources from the destination country, including, for example, official overseas development assistance, health, education or other budgets; recruitment fees charged to destination countries or employers; and ring-fenced taxation of migrant health workers' income gained in the destination country.
- Institutional capacity development that could include but is not limited to education and employment opportunities for health workers in countries of origin, as relevant to nationally identified needs.
- Additional technical or financial assistance to other areas of the health system, such as service delivery infrastructure and technology, leadership and information, medicines and health products, health financing, as per contextual need.
- It is critical that, irrespective of the assistance modality and channel chosen, the benefits that accrue to the health system in the country of origin are:
  - Proportionate and commensurate to the contribution of health workers in the destination country.
  - Determined by national authorities in the country of origin in alignment with nationally defined policy and strategic priorities.
  - Associated with binding commitments to finance and/or support such activities.

Safeguards for vulnerable countries

Additional safeguards against active recruitment and health systems related support should be provided to countries facing workforce vulnerabilities.

For international recruitment to be considered fair and ethical, it should be linked with equitable strengthening of health systems in countries of origin and destination, also taking into consideration the additional needs of countries facing workforce vulnerabilities or weak capacity to implement the Code. Remittances do not qualify as support for health systems strengthening, as these are individual earnings of migrant health workers that they may choose to send to their families in the country of origin and therefore cannot be used as a proxy for "mutual benefit".

The countries facing the most pressing health workforce challenges are included in the WHO health workforce support and safeguards list *(11)*, which is periodically updated. These countries need to be prioritized for health systems and health workforce development support.

The countries with workforce vulnerabilities require additional safeguards against active international recruitment of health workers. The Code advises destination countries and recruitment agencies to refrain from active recruitment in these countries, except within the framework of government-to-government agreements. Such agreements, when negotiated with participation from health stakeholders and ensuring that the domestic supply of health workers being negotiated for is adequate, should provide necessary investment in countries of origin to improve their health outcomes. When economic demand and absorption capacity for health workers are insufficient to adequately address population health needs, measures to increase fiscal space to recruit specific types of health workers should also be considered.

These practices could also be extended, according to a precautionary principle, to countries not included in the WHO health workforce support and safeguards list.

Health worker rights and welfare

Migrant health personnel should enjoy the same rights, benefits and opportunities as health workers in the destination countries.

Health worker migration and mobility agreements should be informed by a rights-based and gender-responsive approach, protecting migrant health workers and helping them to contribute to and benefit from socioeconomic development of both countries in a fair and equitable manner. This includes informing health personnel of their rights and obligations and upholding those rights, including to leave any country in accordance with applicable laws, and managing international recruitment with transparency, fairness, and promotion of health systems sustainability in developing countries.

All health workers should have the opportunity to assess the benefits and risks associated with migration and mobility in order to make informed decisions about their choices. Transparent communication about the migration and mobility agreement, such as the immigration process, regulatory and licensure requirements, qualification recognition, contract details, language and culture, scope of work, working conditions and remuneration, estimated living expenses and taxation, and information on labour and social protection rights and benefits, including health care and the portability of social security benefits, dispute resolution, options for education, career or service expansion, migration and mobility, residency status, and return pathway, is therefore an essential component of orderly migration and mobility.

Once in the destination country, migrant health workers should enjoy equal treatment with domestic health workers with respect to relevant labour and/or broader rights, professional rights and opportunities (including by promoting a lifelong learning approach), social benefits (including access to health services) and social protection, occupational safety and health (including in case of emergencies), in line with relevant ILO standards *(2,3,47,64,65)* as well as the ten conventions on fundamental rights at work and those on violence and harassment, wages and conditions of work. WTO Member States also have a legal obligation to grant non-discriminatory treatment to foreign health workers if they have included health and health-related services in their trade commitments without specifying relevant limitations to such treatment.

Wherever possible, health workers should have access to dedicated services to help them integrate and succeed personally and professionally in the destination country. The participation of social partners in all stages of bilateral agreements can help to facilitate inclusion of these components on health workers rights and welfare component.

Gender considerations

Government agreements should incorporate a gender-responsive approach to meet gender-specific needs and address vulnerabilities of migrant health workers.

Mechanisms of migration and mobility and the provision of rights and benefits for health worker welfare can affect genders in different ways. Since women can be particularly vulnerable in the different steps of the migration and mobility process, and because the health sector is a heavily gendered area, government agreements should include relevant provisions to safeguard them and promote their empowerment.

Health worker migration and mobility agreements should consider, address and monitor (through gender-disaggregated metrics) the possible negative effects of the migration and mobility arrangement on different genders, including in relation to: health insurance coverage of gender-specific diseases and conditions that are specific to each gender; maternity leave provisions to preserve women's equal opportunities for education, training, promotion or career progression; equal remuneration across genders for work of equal value; safeguards against possibilities of sexual exploitation, harassment, violence and abuse; access to justice, including to the legal system free of charge; and full recognition of broader rights.

Monitoring and evaluation

All government agreements should include a monitoring and evaluation mechanism with an operational feedback loop.

Monitoring and evaluation allow assessment of the success and shortcomings of the agreements and their value added to the health system of countries of origin and destination as well as impacts on health worker welfare. Indicators to measure success, depending on the objective and contents of the agreement, will help the countries to assess whether operations proceed as intended, take appropriate measures to address emerging issues, monitor the health system in countries of origin and evaluate the effectiveness and impact of the agreement including the gender-disaggregated impact.

Agreements need to factor in a review mechanism that could take the form of, for instance, a joint committee with representation from relevant government agencies, social partners (employers' and workers' organizations) and key stakeholders, with regular scheduled meetings and dedicated resources to inform the progress in implementation and facilitate discussion between the different parties. Importantly, agreements should include a revision clause to allow adaptations of the indicators or provisions in the agreement based on the monitoring data, changing needs or any evolution in the political situations of either country. Provisions for a temporary suspension of the agreement could also be considered in exceptional circumstances.

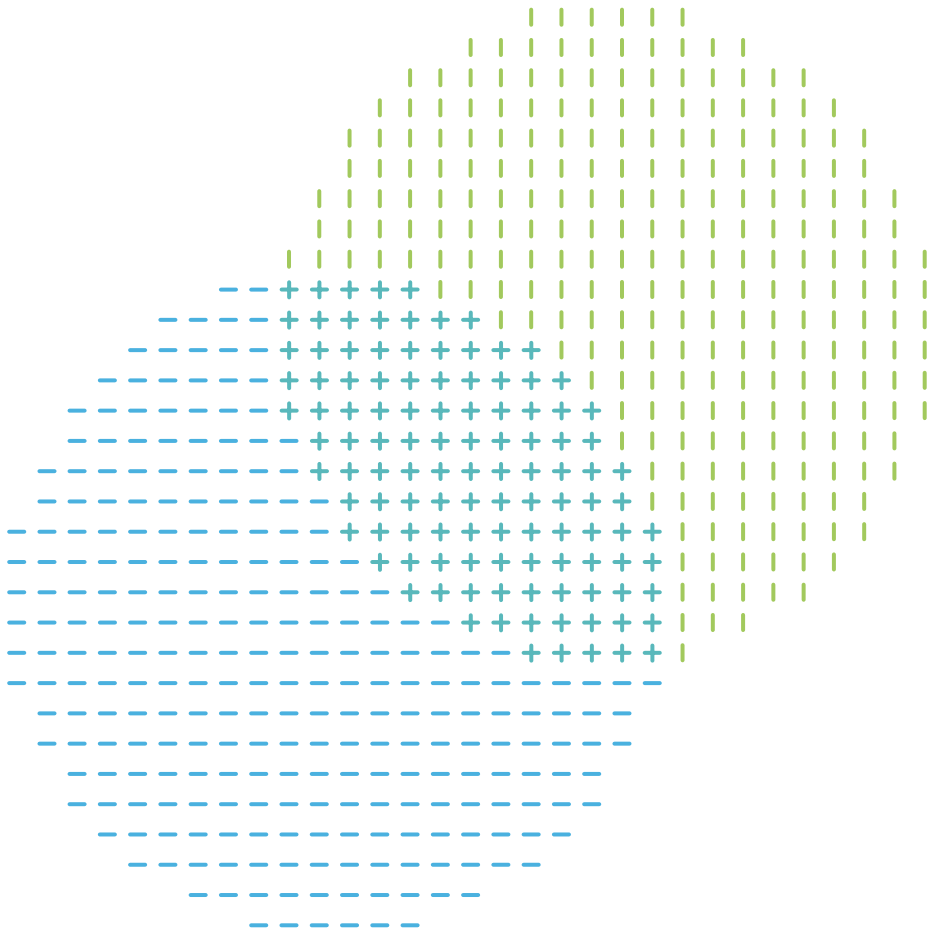
The findings from the monitoring and evaluation activities will be crucial to determine the strengths, limitations and opportunities of the different agreements, which can then be used to improve future agreements and to inform health workforce strategies in both countries. They will also provide evidence for countries to compare the trade-offs between fiscal and economic gains in the short to medium term and building a more sustainable supply of health workforce to address health security and equity. Public availability of these reports will help other countries strengthen their workforce strategies and bilateral agreements.

Transparency and information sharing

Information on the agreements and respective implementation data should be shared domestically and internationally, including through notification to the WHO Secretariat.

Transparency in data and information sharing are key elements of effective global health governance, which also applies to health workforce international migration and mobility. WHO Member States are required to report on the implementation of the Code every 3 years, and the participation of Member States has been increasing over the subsequent rounds of reporting. Increasing numbers of agreements are being notified and the full text of agreements are being shared with WHO. This reporting can be extended to include information and data on implementation, monitoring and evaluation of health worker migration and mobility agreements.

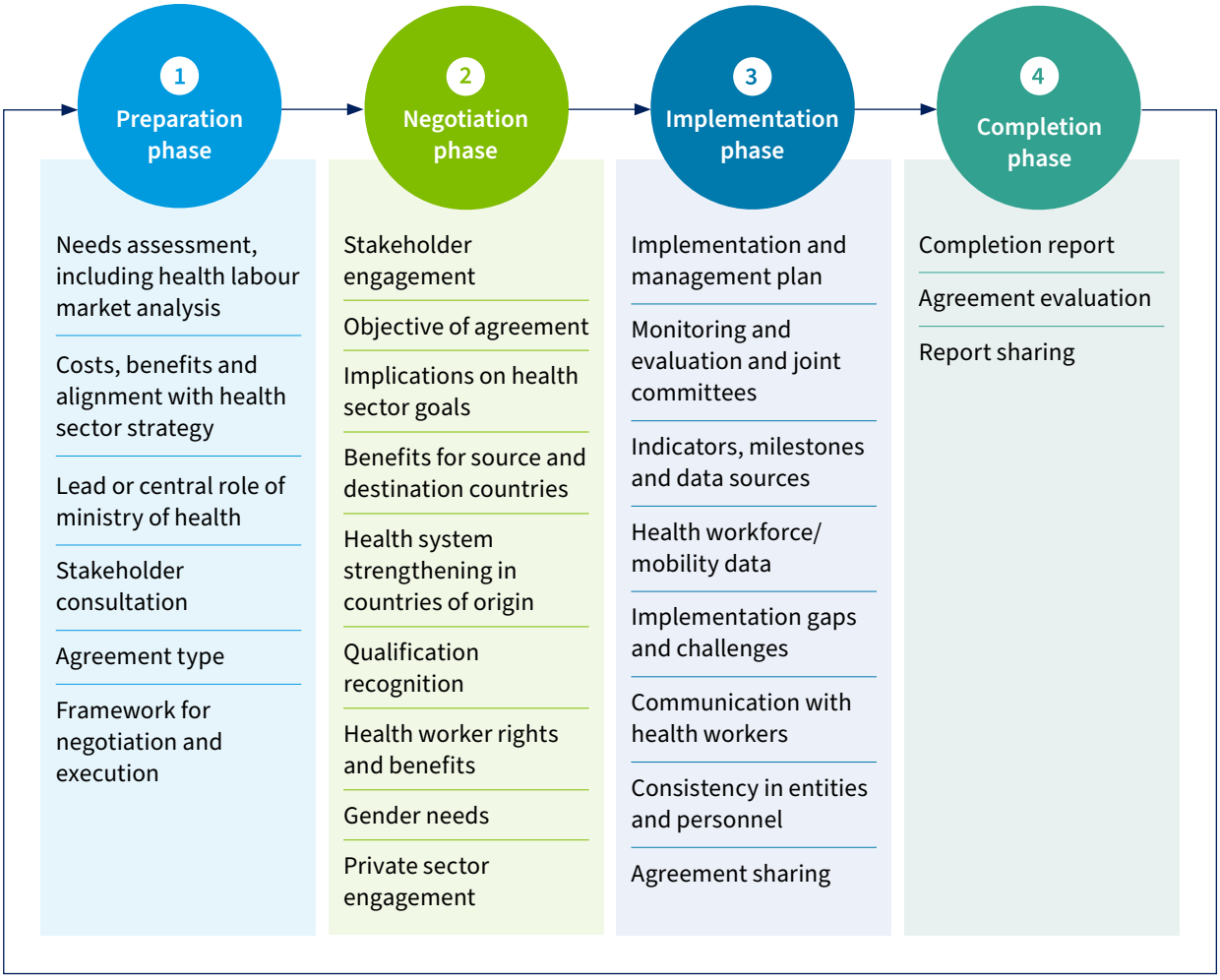
A centralized repository of evidence gathered through the reporting process, which includes information on the existence and implementation of the health worker migration and mobility agreements, would help to inform the global community on assessing the successes, challenges and lessons learned in their implementation across different contexts. This would contribute to a growing body of knowledge that can inform policy decisions in the countries of origin and destination as well as to improve conceptualization and design of future agreements that can maximize health system benefits for participating countries, safeguard health workers' rights, and inform health workforce policy and planning in both countries of origin and destination.



6. Implementation considerations

This chapter summarizes key considerations of relevance to the typical phases of preparation, negotiation, implementation and completion of the agreement. While they are presented for simplicity according to a standard chronological order (Fig. 4), different elements can overlap and intersect at different points in time, for instance when new evidence, or the results from monitoring of the agreement itself, may inform the need to develop and negotiate additional or different elements of the agreement. All stakeholders, including social partners, should be able to participate in all these instances through effective social dialogue structures.

Fig. 4. Bilateral agreements – implementation considerations



1 Preparation phase

Needs assessment

Ministries of health in both countries of origin and destination should undertake a health system and health workforce needs assessment which includes a health labour market analysis *(66)* and forecasting, in consultation with other sectors and key stakeholders, to identify the health system needs, labour market supply, demand and trends and priority health workforce policy interventions in each country. Health labour market analysis is particularly necessary for:

- the destination country to understand the drivers of dependency on foreign-trained health workers, and identify policy options to adopt corrective measures;
- the country of origin to assess whether there is an oversupply or undersupply compared with economic demand, absorption capacity of health workers and estimate the effects of international migration and mobility; and
- both countries to identify the level of international migration and mobility (entry and exit).

The analyses should be disaggregated by occupations, specialties/experiences and subnational distribution, as oversupply of some health workers and in some regions often coexists with undersupply of others. In the case of trade agreements, this could also help to define the labour market needs and bring more transparency and predictability for service suppliers in countries of origin.

Alignment with health sector strategy and other sectoral strategies

The mechanisms to address the identified gaps and challenges in health systems and the health workforce need to be aligned with the respective sectoral strategies, priorities and long-term goals – in health, as well as education, labour, migration and other relevant sectors. Over-reliance on migrant health workers needs to be progressively overcome with measures to increase domestic production and retention of workforce in destination countries through appropriate education policy and investment decisions. In parallel, exit of health workers from the labour market in countries of origin should be compensated by the creation of appropriate education, employment and career advancement opportunities, which requires coordination and synergy among health, education and labour policies. Consideration of the costs and benefits of the different approaches to meet health workforce or health system needs, including various pathways of migration and mobility, is important before deciding on bilateral agreements between prospective countries and the probability of health workers choosing this pathway over others.

Lead entity

High-level political support will help to facilitate the development, adoption and implementation of the agreement. Also, the identification of a single government entity to coordinate the development of government health worker migration and mobility agreements in each country can be instrumental to ensuring consistency and efficiency. Although the lead agency may vary across countries and the type of agreement (e.g. foreign affairs, health, labour, trade and industry etc.), the ministry of health should be part of the leading team (if not the lead) or at the minimum consulted on any agreement that: is related to health worker migration and mobility; has a health sector component; or has a broader scope which could have a potential impact on the health sector. A focal point from the ministry of health or a subunit within it responsible for human resources for health or health systems could be designated to participate in any issue related to education, employment, trade in health services or international migration and mobility of health workers with counterparts from different government entities (e.g. from education, foreign affairs, labour, industry, etc.) through an inter-agency consultation process for continuous discussion, information exchange and inputs. To ensure that inputs from ministries of health (particularly from countries of origin) carry sufficient weight for consideration, they could also be included as a co-signatory in agreements that include health sector involvement and continue participating in implementation, feedback and evaluation.

Consultation with government and nongovernment stakeholders

Consultation with priority stakeholders within countries is required to consider inputs from different perspectives in order to adopt an all-of-government and all-of-country approach on the prospective agreements prior to negotiation. These include relevant government entities across education, foreign affairs, health, immigration, labour and trade sectors, as well as diaspora groups, educational institutions, employers, migrant rights associations, professional associations, trade unions, private sector actors, regulators, etc. Collaboration between different sectors will ensure alignment of policies across sectors; mutual understanding of priorities; contribution of resources; identification of limitations; and areas for synergy. Ministries of health should share the rationale and priority strategies to advance the health agenda in the agreements and highlight its importance in the progress towards broader socioeconomic goals.

Type of agreement

The choice of focus area(s) and scope of the agreement will depend on the negotiating countries' priorities and context. Each category of agreement has its advantages, limitations and disadvantages, and the right choice will depend on the participating countries' objectives. The terms of the agreement need to be tailored to meet the specific requirements of both countries and be in alignment with the respective national health policies and (depending the type and content of the agreement) other relevant policies on education, immigration, international relations, labour, professional regulation and trade, and be coherent with the principles and recommendations of the relevant international instruments. Trade agreements should be leveraged to advance health system objectives and health worker welfare to the greatest extent possible.

The terms of the agreement need to be tailored to meet the specific requirements of both countries and be in alignment with the respective national health policies.

Framework for negotiation and execution

A framework of procedures and methodology for managing negotiation and execution of the agreements in each country can contribute to consistency and efficiency of the process as opposed to ad hoc arrangements. Based on country contexts, this framework could clarify explicitly the distribution of roles, specify the lead agency for the specific type of agreement, steps to follow in the different stages of the agreement including an inter-agency consultation process, the role of different government entities in the various aspects of implementation and how to resolve any differences. It could also recognize and make provisions for a more detailed implementation agreement, and the required financial and human resources and/or dedicated staff time of the responsible entities.

2 Negotiation phase

Stakeholder engagement

Depending on the type of governance structure, national or federal governments could lead the negotiations on the agreement, if permitted under national laws and policy frameworks. Subnational level government entities (e.g. provincial or state governments in countries with a federal structure) may also negotiate agreements whose scope relates to their specific jurisdiction. Engagement of key stakeholders (in addition to employers, health sector representatives and experts, government entities across relevant ministries, regulators, migrant associations and diaspora groups, professional associations, private sector actors, trade unions, others as applicable) is of paramount importance. Furthermore, anticipation and management of concerns from groups or stakeholders that are potentially impacted by the agreement is also warranted. For example, health workers in the destination country may have reservations on the competence or quality of migrant health workers, or on reliance on migrant health workers instead of promoting the domestic workforce.

Objective of the agreement

The text of any agreement with a health worker migration and mobility component should clearly identify the objective and the intended contribution and benefits to the health system (and health workforce) of each country. An explicit commitment in the agreement to uphold the Code can help to ensure that agreements contribute to health system strengthening, health personnel welfare, ensure transparency and be mutually re-enforcing with other relevant international instruments. In the case of entry of significant numbers of migrant health workers through various pathways, destination countries could initiate bilateral agreements taking into account the overall movement of health workers from a country when considering the degree of financial or other support provided to that country of origin.

Implications on health system goals

It is important to consider the implications of the migration and mobility arrangement on the broader health sector goals of each country, including the impact on workforce availability and sustainability on equitable provision of health services. Regardless of the category of agreement, countries can specify the quantity and eligibility criteria based on their domestic supply and demand for different categories of health workers, in the context of monitoring, planning and forecasting of workforce availability in relation to health system needs. In cases of medium- or long-term migration and mobility arrangements, clauses in the agreement that limit international recruitment to

recent graduates of the country of origin or to skills and occupations that are not in high demand can avert the loss of experienced and/or essential health workers. An approach of hiring only recent graduates in turn would require destination countries to subsequently invest in any additional training and work experience to ensure migrant health workers acquire the requisite competencies after arrival in their destination countries. At the same time, any regulatory measure on international movement (such as ceilings or limits to include migration of certain groups only) should not incentivize health workers into unregulated channels of migration and mobility. When governments decide to encourage supply of health workers for the international market, investment in building the regulatory system capacity should occur in parallel to maintain quality.

Any regulatory measure on international movement should not incentivize health workers into unregulated channels of migration and mobility.

Mutual benefits

The migration and mobility of health workers should benefit the health systems of both parties. Countries of origin should have tangible and realistic benefits for their health systems, proportionate to the benefits for the destination country. What may constitute proportionate benefits depends on individual country contexts, but in agreements on medium- to long-term migration and mobility could include: technical and financial support in priority areas of public health; support to the public investment in pre-service education of health workers; or general budgetary support for health systems; this could be of an equivalent value to the costs saved by destination countries in education and training of health workers or the loss experienced by countries of origin through the departure of qualified health workers. Specifying the areas of assistance or investment based on nationally determined priority areas should be a central element of the negotiation process for the agreement. In many countries the movement of health workers through alternative pathways substantially outnumbers those moving within government agreements. In such cases, agreements may also be developed not only to provide a formal framework to the de facto situation, but also to introduce specific benefits for health systems of countries of origin.

Health system strengthening investments

Specific interventions for health system strengthening in countries of origin include support for implementation of components of the health sector strategy or health workforce strategy. For instance: expanding education/training programmes and employment opportunities; supporting schemes and policies to address inequities in workforce distribution; ensuring quality of education and practice in health services; development or expansion of health infrastructure, information systems, technology, medicines and health products; and supporting health financing, leadership and good governance to improve health service delivery and quality of care. Destination countries need to identify resources to ensure the arrangements in the agreement will be implemented and yield positive health outcomes in both countries, which should also be part of the evaluation of the agreements.

Qualification recognition

Qualification recognition mechanisms should be transparent, fair, objective, impartial, non-discriminatory and not more burdensome than necessary. Qualification assessment identifies similarities and differences in the training/learning programmes or competence requirements between countries for the respective type of health worker; the differences should be addressed by appropriate compensatory mechanisms for qualification requirements in a jurisdiction to avoid underutilization of health workers, de-skilling and differences in remuneration. The entity responsible for this process may be part of the regulatory body or an independent agency set up for this purpose. However, recognition of qualifications may not be sufficient on its own to enter into practice of regulated health occupations.

Regulatory requirements

The criteria for entry into regulated health occupations and scopes of practice of a profession are determined by the regulators based on health worker competence and probity to provide the services that are relevant to patient safety, population needs and health goals of the jurisdiction. It is important to consider that differences in occupational regulation across jurisdictions and occupations could prevent entry into a health occupation or limit the scope of practice unless the requirements are met. When countries enter into qualification recognition agreements or consider updating of the regulatory standards and processes to meet international standards or requirements, where they exist, these should also remain relevant to meet domestic needs.

Health worker rights and welfare

For government agreements to be scalable, they should be more attractive to health workers compared with alternative pathways for migration and mobility. Consideration of health workers' rights and welfare, in alignment with international labour standards, should include, among others, provisions for: access to training and education opportunities free of cost through the government agreement; equal opportunity and treatment of national and migrant health workers including during emergencies; freedom of association and collective bargaining, equivalent to the domestic health workers; health workers to avoid bearing the cost of recruitment and placement; support for professional and social integration in destination countries; dependents' visas and visits for family reunification; clarity and support in navigating the immigration system and regulatory process; access to dispute resolution systems; insurance coverage; mechanisms to report and seek legal assistance on workplace issues, such as exploitation or abuse; relevant social protection benefits, such as access to health services; ensuring the portability of social security benefits through the conclusion of bilateral or multilateral social security agreements; protection from falling into irregularity in case of loss of employment and flexibility in terms of change of employment; pathways for safe and dignified return and approaches to facilitate sustainable reintegration of health workers in countries of origin, where applicable, including during emergencies.[12] While migrants workers may be trained and oriented in the language, culture and lifestyle of the destination countries prior to departure, it can also be beneficial to inform their potential employers and colleagues on the education or training background and culture of the migrant health workers to ease integration in the workplace.

Provisions aimed at protection of women should advance their empowerment rather than restrict migration, mobility and integration.

Gender and equity considerations

Gender-specific considerations should be embedded in a broader equity lens that addresses other elements of vulnerability, which may be relevant to the scope of the agreement and geographic, population and sociocultural characteristics and differences between countries of origin and destination. This may include specific attention to health workers from groups that may be at risk of discrimination and unfair treatment on account of their ethnicity, religion, disability, sexual orientation, among others. As part of this broader equity-oriented approach, application of a gender-specific lens in agreements is necessary to anticipate and appropriately manage the potential gender impact. Provisions aimed at protection of women during the migration and mobility process should advance their empowerment, and provide support rather than restrict migration, mobility and integration.

Private sector

Subject to country specificities, movement of health workers may also occur through private recruitment agencies and education or immigration consultancies, whether health workers are subsequently employed in the public or private sector. In many cases, the movement through these channels may be the primary source of migration and mobility, with movement in much larger volume compared with the bilateral agreement pathway (if it exists). Governments should strive to ensure that recruitment agencies apply the same provisions as those existing under the government agreement on health worker migration and mobility, including the involvement of ministries of health, the inclusion of proportionate benefits for countries of origin, respect for migrant health workers' rights and welfare, including not charging recruitment fees to health workers *(49)*. For this to be effective, adequate regulation of and oversight capacity from a government agency on recruitment agencies, education and immigration consultants, and private sector employers operating within a jurisdiction are essential to transfer to them relevant elements of the government agreements signed by the respective governmental authorities.

12 The UN Network on Migration *Guidance on bilateral labour migration agreements (33)* provides more specific information to help countries develop rights-based and gender-responsive agreements that are based on a cooperative and multistakeholder approach.

3 Implementation phase

Execution and management plan

The agreement itself may not always include a detailed implementation plan. In such cases, one may be developed by the technical teams after the agreement is signed specifying the details of the agreement, activities, the roles of different government entities and other stakeholders, expected timeframes, processes, implementation modalities, resource requirements, funding sources and a monitoring and evaluation framework. The execution plan needs to be reflective of the content of the agreement and the actual situation to ensure the implementation aligns realistically with the intended objectives. Adequate infrastructure, resources and political will are important requisites for successful implementation.

Monitoring

A monitoring body, such as a joint committee that may include representatives from participating countries and relevant stakeholders, can be set up as agreed by the participating countries. The task of the joint committee is to ensure the smooth implementation of the agreement through the correct interpretation of clauses, resolution of disputes between the parties to the agreement, monitoring and evaluation of the effectiveness of provisions and suggesting amendments for improvements. This body can identify SMART[13] indicators and collect relevant gender-disaggregated data to track progress on the implementation of the agreements. Any gaps or challenges identified in the monitoring should be addressed by the respective entities. The UN Network on Migration *Guidance on bilateral labour migration agreements* provides model terms of reference for a joint monitoring committee *(33)*.

Selection of indicators

The indicators, milestones and data sources to monitor the implementation and evaluate the effects of the agreement depend on the objectives, scope and content of the individual agreement. Ideally, data should be collected, before and after the implementation of the agreement.

Examples of indicators (Table 1) for the migrant health workers' welfare component may include number of health workers moving under the migration and mobility agreement compared with other routes; remuneration, working hours, rights and opportunities compared with domestic health workers; and access to and utilization of dispute resolution mechanisms, social benefits and legal services, etc.

Indicators for the health system component of the migration and mobility arrangement could include, but are not limited to, the proportion and distribution of migrant health workers disaggregated by sex, occupation and mechanism of recruitment compared with domestic workforce disaggregated by sector and level of health service delivery; proportion of vacant positions, unemployment and attrition of health workers; the rate of entry, exit and return of health workers to the labour market; the average period of employment overseas; the level of qualification and years of service or experience of the workforce; the duration of stay; financial and technical investments in other areas of the health system; national and subnational density of relevant categories of health workers, etc.

Ad hoc surveys of the beneficiaries, both employers, migrant health workers and governments of source and destination countries, could be conducted to collect more detailed information, including on the impact of migration and mobility, evidence of knowledge transfer and diaspora contribution to countries of origin as well as intention of future migration and mobility.

Sources of human resources for health data

The health workforce data (including information related to migration and mobility such as entry, exit, country of birth, training and nationality) required for monitoring and evaluation and the data sources should be mapped to identify viable sources as well gaps in obtaining the necessary information. While administrative records of specific agreements track the number of health workers entering or exiting a country through the agreements during the agreement period, it is also important to compare the data with health workforce movement through other pathways. Wherever feasible, the use of existing national or subnational health information systems and data sources to capture the total stock of the health workforce, including migrant health workers, will avoid duplication of efforts and ensure consistency and reliability of data, but requires that the information system is functional and accurate, or strengthened to become so. Where private recruitment agencies, immigration consultancies and private employers are regulated, periodic information on health worker recruitment through these channels could be obtained from the entity responsible for monitoring their performance or providing oversight. Qualitative data can be captured through stakeholder interviews.

13 Specific, measurable, achievable, relevant and time-bound.

Table 1. Selected examples of monitoring and evaluation domains and indicators

Example of monitoring and evaluation domain	Example of selected indicators (not an exhaustive list)	Possible data sources
Health system strengthening	Number of health workers leaving origin country through different migration/ mobility routes, including students [a,b,c,d,e]	• National Health Workforce Accounts/human resource information systems • Health labour market analysis • OECD database on migrant (foreign born) and foreign-trained health workers (by country of origin) in OECD and non-OECD destinations • Certificate of good standing, migration certificates from regulators or other entities in countries of origin if applicable • Private recruitment agencies
	Proportion and distribution of migrant health workers in destination country [b,c,f]	• National Health Workforce Accounts/human resources for health information system • OECD database on migrant (foreign born) and foreign-trained health workers (by country of origin) in OECD and non-OECD destinations
	Investment in source country health system (technical or financial support provided by the destination country for workforce development or employment, service delivery, health financing)	• National Health Accounts • Progress report/completion report of the agreement
Health worker welfare	Migrant pay gaps using monthly earning [b,c]	• Terms of the contract • Ministry of labour
	Number of health workers recruited under a specific agreement [a,b,c,d,e]	• Ministry of labour
	Number of migrant health workers that moved through a bilateral agreement that pays contributions into the national social security scheme of the country of destination [b,c]	• Social security institutions
Orderly mobility	Engagement of ministry of health and other relevant government and nongovernmental entities in the negotiation, implementation or monitoring of agreement	• Agreement document and progress reports
	Establishment of joint monitoring committees	• Agreement document.
	Number and proportion of health workers recruited through a bilateral agreement who signed their employment contract before departure [a,b,c]	• Ministry of labour • Public employment services • Private employment agencies
	Proportion of health workers, recruited through a bilateral agreement, who have returned to their origin country [b,c,d,e]	• Ministry of health, labour, health and interior • Immigration and border authorities • Agreement progress report/completion report • Statistical services

Notes:
OECD Organization for Economic Cooperation and Development
[a] Disaggregation by age.
[b] Disaggregation by sex.
[c] Disaggregation by occupation.
[d] Disaggregation by specialty.
[e] Disaggregation by years of practice.
[f] Disaggregation by mechanism of recruitment (if applicable).

Collaboration for migration and mobility data

Capturing data on international migration and mobility of health workers can be a challenge as they can occur under different categories of visa such as business, education, employment, permanent migration or tourism. It can be even more difficult to track international movement that does not require a visa. While access to information on entry of migrant health workers to regulated health occupations and those employed in the public sector can be done through the professional registries if these capture active workforce data, it can be more difficult to capture information on those who are not engaged in a regulated profession, employed in the private sector, or have exited the labour market. Moreover, aggregate data on the broad categories of health workers can mask the data on skill mix within professions and in specialty areas (e.g. critical care, mental health). While the Code reporting requirements and National Health Workforce Accounts provide a platform to share data on health worker stock and migration and mobility, strengthening data availability and quality for data analysis and use requires collaboration between countries of origin and destination.

Addressing gaps and challenges

There should be flexibility to include updates and additions to the original provisions to address issues that emerge during implementation. The achievements, gaps and challenges identified during the implementation and monitoring can be presented during regular joint review meetings to inform the need for updates and adjustments. For example, in the context of an agreement on education, should absences due to emergencies, maternity leave or unexpected health conditions compromise the timely completion of the training, provisions on extension of the stay could be mutually agreed; the number of health workers or specialty area of training could be updated based on the needs and priorities of participating countries, etc.

Communication with health workers

Provision for regular communication between migrant health workers and the relevant entity responsible for operationalizing the agreement can provide support and enable smooth transition into the destination country's health system, and/or return of workers. These mechanisms can also channel relevant information, such as updates on the agreement, and facilitate access to support to address challenges encountered by health workers, including dispute resolution mechanisms when required.

Operationalizing government entities

Consistency in terms of the officials and the government entities responsible for operationalizing the health worker migration and mobility agreement or its monitoring will help to strengthen relationships between countries and build ownership of the programme. This will also build the capacity of the agencies and personnel to support scalability of implementation of such agreements. High turnover of responsible personnel can conversely result in loss of institutional memory, potentially causing incomplete implementation, delays and inefficiencies.

Reporting

All agreements on health worker migration and mobility should be shared with the WHO Secretariat by the designated national authority of each country as part of the triennial reporting on the implementation of the Code. Active participation of the ministry of health in the development and implementation of the agreements could facilitate the reporting.

4 Completion phase

Completion report

The results of the agreement at the end of its implementation period should be documented through a completion report by the government entities responsible for implementation or the monitoring bodies set up at the start of the agreement; and also in the case of automatic renewal. The report could include information on the background, scope and content of the agreement, implementation evidence and data, modalities of implementation, progress realized, challenges encountered, mitigation strategies adopted, data on results according to the agreed indicators, role of key stakeholders, etc. to help countries decide on the continuation, modification or scale up of the migration and mobility pathway.

Evaluation

The evaluation of the impact of the agreement may be undertaken by an independent body (other than the joint committee) to also assess the role of each stakeholder participating in the agreement. Evaluation of the agreement after its completion can identify the extent to which the objectives of the agreement were met and its contribution to broader health system goals; assess the costs and benefits of the agreement to both countries; the gaps and challenges encountered; and to apply the innovations and lessons learned in future agreements. The impact of the agreement on the health systems of participating countries could be evaluated even when health is not the primary goal of the agreement. An impact evaluation of health

worker migration and mobility on health systems could also be an important periodic exercise, covering multiple agreements over time if feasible. Such evaluations could provide evidence on positive and negative issues to inform the health workforce strategy of both countries of origin and destination and to strengthen future agreements.

Sharing of evidence and learning

The existing reporting mechanisms of the Code provide a viable mechanism that could be extended to include information and data on the implementation and results of health worker migration and mobility agreements, so as to share best practices and lessons learned globally. Making the information public will not only improve transparency, but also help countries who are initiating migration and mobility agreements for the first time to identify and adopt promising practices.

A checklist of elements to consider during the different phases in the development and implementation of bilateral agreements is presented in Table 2.

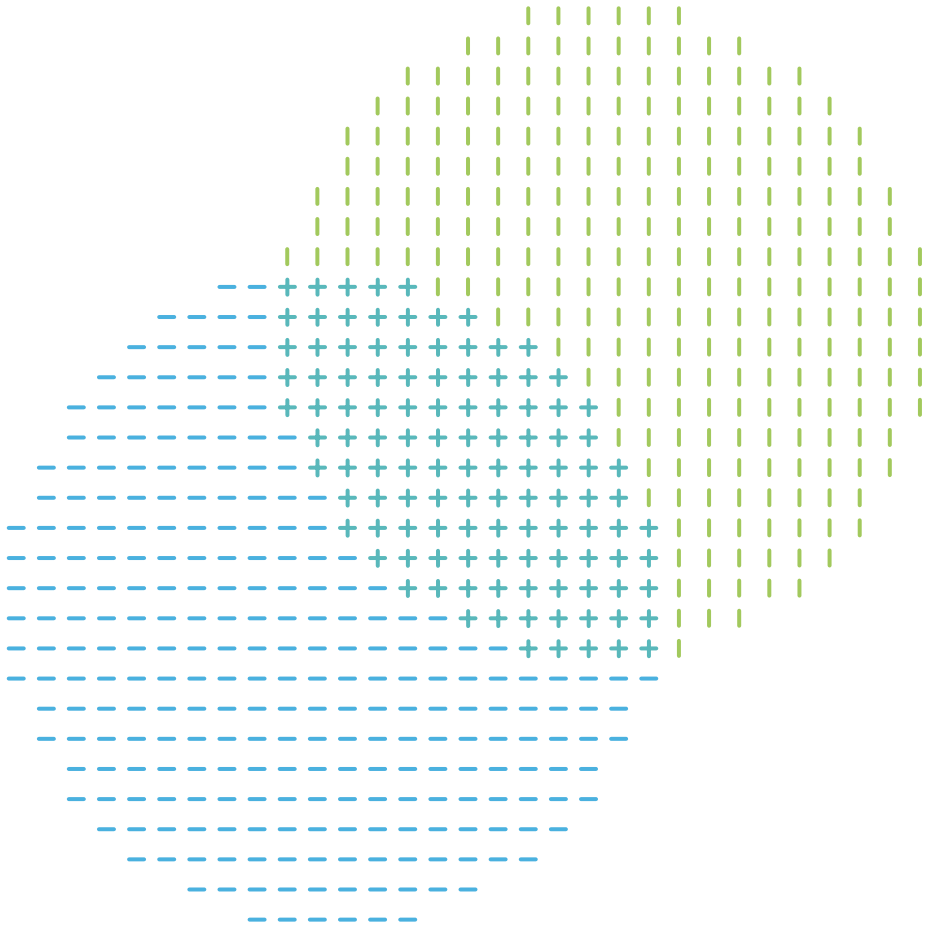


Table 2. Checklist for development and implementation of bilateral agreements in alignment with the WHO Code of Practice on the International Recruitment of Health Personnel

1 Preparation phase	2 Negotiation phase
☐ Conduct a health sector/health workforce needs assessment including health labour market analysis (in countries of origin and destination).	☐ Engage all relevant stakeholders including ministries of health of both parties (countries of origin and destination) and identify an approach for addressing the concerns of different groups.
☐ Consider different approaches to address workforce needs and challenges including entering into agreements with a health workforce component. If such an agreement is pursued, take into account findings from the workforce need assessment.	☐ Identify objectives and the intended benefits of the agreement for both parties, in alignment with the Code.
☐ Consider costs and benefits of government health worker migration and mobility agreements against alternative and parallel interventions to address workforce issues in alignment with health sector strategy.	☐ Depending on the type of agreement, ensure alignment with international labour standards and other international instruments on migration and mobility.
☐ Select appropriate government coordination mechanism, such as an ongoing inter-agency consultation process, for the development of agreements with a central or lead role by the ministry of health.	☐ Consider possible effects of the agreement on the health systems of each country and enact countermeasures to mitigate any negative impacts.
☐ Consult with other relevant sectors, and workers', employers' and recruiters' representatives as part of developing coherent negotiating objectives and positions across government and nongovernment entities.	☐ Consider if the arrangement in the agreement is ethical, fair and balanced in terms of providing health system benefits for both parties, taking into account the migration and mobility occurring in parallel through alternative pathways.
☐ Deliberate on the most appropriate type of government agreement to meet the broader national goals in alignment with national policies.	☐ Identify specific interventions for health system strengthening in countries of origin that can improve service delivery and health outcomes, which should also be part of the evaluation of the agreement.
☐ Establish a framework for negotiation and execution of the agreement, specifying the role of different government entities.	☐ Ensure recognition of qualifications is transparent, fair, objective, impartial, non-discriminatory, and not more burdensome than necessary; after assessing differences in training in the participating countries, identify legitimate additional requirements for entry into practice; and ensure compensatory mechanisms are accessible.
	☐ Apply a gender lens to anticipate and appropriately manage the gender impact of the arrangement, ensuring promotion of empowerment rather than restricting migration and mobility.
	☐ Identify mechanisms for ensuring that private sector actors, such as recruitment agencies, immigration consultants and employers, follow the terms of the agreement.

Table 2. (continued) Checklist for development and implementation of bilateral agreements in alignment with the WHO Code of Practice on the International Recruitment of Health Personnel

3 Implementation phase	4 Completion phase
☐ Develop a detailed execution and management plan for the agreement that also includes monitoring and evaluation, resource requirements, and funding sources.	☐ Ensure the completion report includes information on the background and objective of the agreement, qualitative and quantitative data on implementation, information on the process, targets achieved, challenges, innovations and lessons learned; and use findings to determine continuation, update or scale up of the agreement.
☐ Create a platform for regular communication and meetings between the two parties (e.g. joint committee) to track progress, share information on implementation and identify gaps and challenges to be addressed.	☐ Evaluate if the agreement met its intended objectives; using available data, assess its impact on the health system of the countries of origin and destination and on health workers, and use the findings to inform workforce strategies and the development of future agreements.
☐ Identify appropriate indicators, milestones, data sources and frequency of data collection about health system components and health worker welfare components, to be used when monitoring implementation and for future evaluation of the agreement.	☐ Share completion report, along with information on the implementation and evaluation of the agreement, with WHO.
☐ Identify mechanisms, including international collaboration, to address the challenges in health workforce data including migration and mobility disaggregated data.	
☐ Update the agreement to address relevant issues, as necessary, during regular meetings between the two parties.	
☐ Create a system for regular communication between international personnel and the government agency responsible for operationalizing the agreement to support smooth transition and/or return.	
☐ Ensure consistency in terms of the government agency(ies) and personnel responsible for operationalizing the agreement, to enable capacity building over time and support scalability of implementation.	
☐ Share the migration and mobility agreement with WHO.	

7. Role of the WHO Secretariat

While health worker migration and mobility agreements represent a direct collaboration mechanism between participating countries, the WHO Secretariat can play a range of supporting roles, as needed and as may be requested by Member States, involving, as relevant, other UN agencies through the UN Network on Migration.

The WHO Secretariat will provide, when requested by Member States, specific support in relation to bilateral agreements, including:

- **Technical assistance to Member States:** This can include facilitating the implementation of the Code; and providing technical support in the different stages of the preparation, development and implementation of the agreements (see Chapter 6); capacity building based on specific country needs and demands; operational support in conducting health labour market analyses; linking with experts from different sectors (e.g. education, labour, migration, occupational regulation, trade, etc.) in collaboration with other relevant UN agencies (e.g. ILO, IOM, UNESCO, WTO); development of methodologies for evaluating the impact of health worker migration and mobility agreements on health care systems and health workers' welfare. As requested by Member States, WHO will also provide a confidential assessment of draft agreements on alignment with the Code principles of fair and ethical international recruitment. Such assessment will be based on the criteria and elements outlined in this document, so as to identify opportunities to refine and strengthen its contents to improve adherence to the Code provisions.
- **Sharing of information and good practice:** Development of a repository on health worker migration and mobility, national and international policies and regulation on health worker migration and mobility could serve Member States in gaining a global perspective for planning and designing evidence-based policies, regulatory frameworks and agreements on health worker migration and mobility. A repository of government agreements, including their texts; information on the background, negotiation and operation, and evidence on their implementation and outcomes would help promote transparency and increase the global knowledge base, thereby providing an additional reference for Member States who are initiating such agreements for the first time. In addition to analysis of data from Member States through the report on implementation of the Code, developing a methodology and conducting case studies that analyse the different health worker migration and mobility agreements, how they performed over time, and their impact could inform Member States' decisions and allow them to incorporate positive practices relevant to their contexts.
- **Implementation of the agreements in the context of the Code:** Governments and relevant stakeholders across sectors could be convened in countries and informed about the Code with a specific focus on recommended elements and operational features of the health worker migration and mobility agreements, and to encourage Member States to incorporate elements of health systems strengthening, health worker welfare and workforce sustainability in their education, foreign affairs, trade, immigration, occupational regulation, labour and migration policies to achieve socioeconomic development outcomes.

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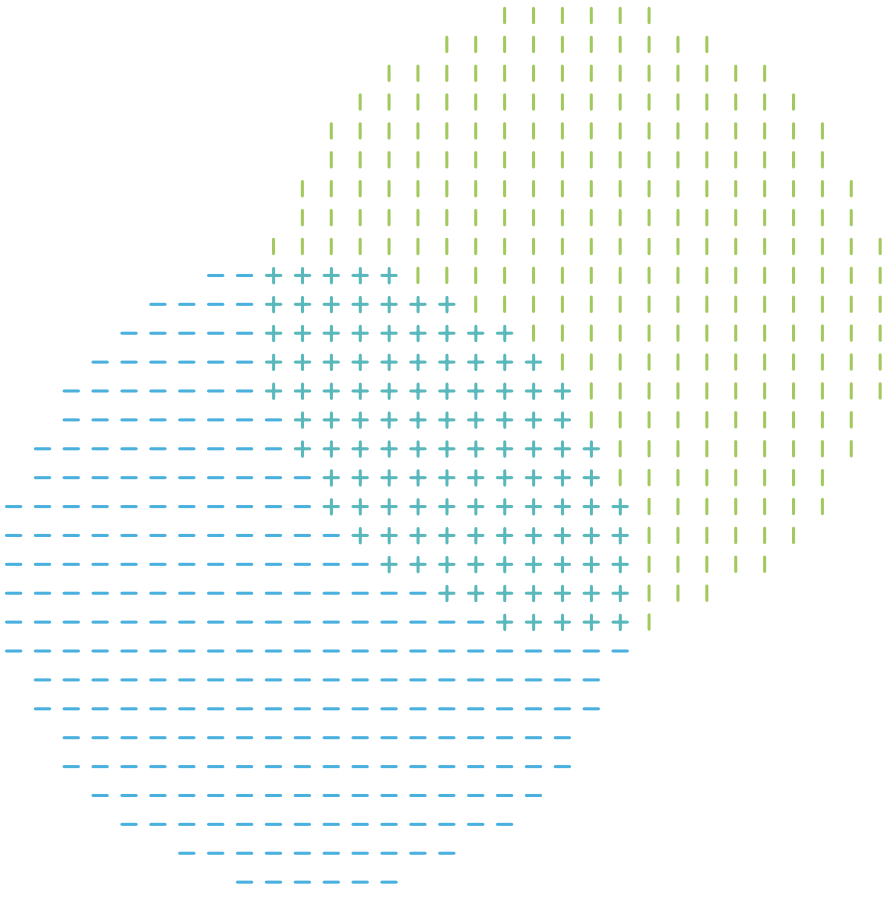

Annex 1. Rapid literature review – health worker mobility agreements

Background

Globally, addressing shortages of health workers has been a priority for governments for many years. This challenge took on new urgency following the COVID-19 pandemic, which resulted in widespread disruptions to essential health services and reports of increasing reliance on the recruitment of international health and care personnel to fill employment vacancies, especially in upper middle- and high-income countries *(1)*.

In recent years, governments have shown increasing interest in managing health worker mobility. In many places, efforts are under way to better understand, and to shape, the channels, drivers and conditions of such movement. By way of example, the United Kingdom has instituted a Code of Practice for the International Recruitment of Health and Social Personnel, which aims to promote high standards of ethical practice in the international recruitment of health workers *(2)*.

WHO Member States have put different types of international agreements in place to facilitate he movement of health workers, address shortages, provide training and education for health workers, deliver development assistance, advance health cooperation and improve conditions for health workers as they move across borders. The relevant bilateral and regional agreements reflect many different formats and content related to health worker mobility. They address a range of issues including recruitment practices, recognition of qualifications, integration in the destination country, access to training, immigration rules and dispute settlement *(3)*.

While in most cases, health worker mobility agreements are bilateral (between two governments), countries have also concluded regional agreements, for instance within ASEAN and the EU. In addition to health worker mobility agreements, trade agreements can affect the movement of health workers internationally; certain trade agreements include commitments to open markets for the delivery of health services by individuals crossing borders (so-called "mode 4") *(4)*. The international architecture surrounding ethical recruitment and mobility of health workers also includes national and regional policies *(3)*.

Health workers move in many directions: North-South, South-North, North-North and South-South. It appears that agreements have most often been put in place to address health workforce shortages in destination countries, often higher income nations, and skilled health workers' unemployment in source countries. Formal health worker mobility agreements have also been agreed by countries for other purposes, for instance to provide for bilateral or regional "mutual recognition" of professional qualifications *(5)*.

Adopted in 2010, the WHO Global Code of Practice on the International Recruitment of Health Personnel ("the Code") seeks to establish and promote voluntary principles and practices for the ethical international recruitment of health personnel, considering the rights, obligations and expectations of source countries, destination countries and health workers.

In addition to the Code, a range of international standards, guidelines and instruments apply to the movement of workers, including health workers. Certain international instruments govern general aspects of migration, such as the UN Global Compact for Safe, Orderly and Regular Migration, which is designed to support international cooperation on the governance of international migration, provide policy options to countries on some of the most pressing issues, and give countries the space and flexibility to pursue implementation in line with their contexts and capacities *(6)*. More specifically, ILO provides several tools for governments, workers and employers on the subject of labour mobility; for instance, ILO standards govern the treatment of migrant workers and set forth general principles and operational guidelines for their ethical recruitment *(7–11)*. In relation to health care, ILO has promulgated standards for the ethical international recruitment of nursing personnel *(12,13)*. In addition, the UNESCO Global Convention on the Recognition of Qualifications concerning Higher Education helps to ensure that individuals' qualifications are assessed based on fair, transparent and non-discriminatory criteria *(14)*.

Under the WTO GATS, WTO members can make commitments to open their markets to allow the delivery of health services by foreign individuals. As noted, service delivery based on the movement of individuals across borders – foreign individuals who work for foreign-owned health service providers or are self-employed, and temporarily present in the host jurisdiction – is referred to as mode 4 service provision. To the extent that health worker mobility is covered by GATS mode 4 commitments, WTO members are required to respect the most favoured nation (MFN) obligation; this means they must grant all WTO members treatment no less favourable than that granted to other WTO members. This applies regardless of whether they have made sector-specific commitments. GATS allows regional or bilateral free trade agreements (FTAs) between two or more economies to deviate from the MFN principle under certain conditions.

The use by governments of bilateral agreements to manage international health worker mobility has increased over time, as evidenced by WHO Member States' reporting on the implementation of the Code *(15,16)*. Such agreements also appear to have enabled international surge support during the COVID-19 pandemic *(17)*. The EU Talent Partnerships initiative (2021) aims to expand the legal pathways for health workers' movement and to put in place new international partnerships for health care delivery *(18)*. The updated United Kingdom Code of Practice, endorses the conclusion of mutually beneficial bilateral agreements for recruitment of health workers *(2)*.

Objective

The primary objective of this annex is to identify evidence on the impact of bilateral and regional agreements on health worker mobility, on the health systems of the participating countries, and on the welfare of health workers.

Methodology

A rapid literature review was conducted to identify evidence through a search in PubMed, SSRN and ScienceDirect using the keywords (Box A1.1) presented below. Manual searches were also undertaken on Google to identify additional literature about the impact of known health worker mobility agreements based on the reporting on the Code. Websites of specific organizations (Center for Global Development) and governments of countries (ministries of health, ministries of labour and ministries of trade) known to have signed bilateral agreements on health worker mobility were also searched to identify grey literature.

The inclusion criteria for the review included publications in English on health worker mobility agreements, published between January 2010 and October 2022, that included information on the implementation or impact analysis of the agreement. Prospective agreements that included the expected or theoretical impact were also included.

The exclusion criteria included publications containing a general or conceptual analysis of health worker mobility in general but not specifically about health worker mobility agreements, publications that mention health worker mobility agreements in passing or focus on existing health mobility agreements but without information on the implementation or (actual or expected) impact, and newspaper articles or blogs.

Relevant publications, both peer reviewed and grey literature, were screened based on the title, abstract and keywords used to describe the publication. JB and SF independently screened the titles and abstracts, to offset possible bias from just one person reviewing them. Both researchers read the full text of the shortlisted publications and confirmed inclusion or exclusion (Fig. A1.1) of the shortlisted publications through discussion.

Data were analysed and synthesized using qualitative content analysis. JB and SF read the full text of the selected publications and coded data under seven categories: the specific agreement; the geographic region covered by the agreement; the opportunities and challenges of the agreement implementation; quantitative data on implementation and/or impact; overall assessment of the agreement; the focus area of the research; and recommendations. The notes of both researchers were compared and discussed to ensure agreement and consistency. CW read the full text of the articles to verify the key messages.

Box A1.1 Search strategy – keywords

"bilateral agreements" AND "health worker mobility", "health worker mobility agreements", "mobility and health systems", "health worker shortages", "international health worker migration", "international recruitment of medical personnel", "health worker policies", "doctors migration", "nurses migration", "medical brain drain", "medical brain gain", "migration policy for skilled workers", "recognition of qualifications for health workers", "standards for mutual recognition of qualifications", "health worker mobility impact", "global movement of doctors", and "global movement of nurses", alone and in combination with the names of the countries participating in the agreements.

Results

A total of 24 publications (peer reviewed and grey literature) that address the impact of bilateral and regional agreements on health worker mobility, health systems and health workers were identified for review (see Table A1.21). Of these, 15 were peer-reviewed literature and nine were grey literature. Most of these were descriptive and provided qualitative analysis of the agreements' impacts rather than implementation data and quantitative evaluation.

The primary themes of the papers are reflected in Fig. A1.2, with some addressing more than one topic. The design of the bilateral agreements was the most common theme (83%). Challenges on the implementation of the agreement were also highlighted in most publications (58%), while others referred to good practices (21%) and health worker experience (13%).

A vast majority of publications (87.5%) referred to a specific agreement between two countries or several agreements involving a specific country or region, and a few had a global focus (12.5%).

Fig. A1.1 PRISMA diagram showing the literature search and selection process

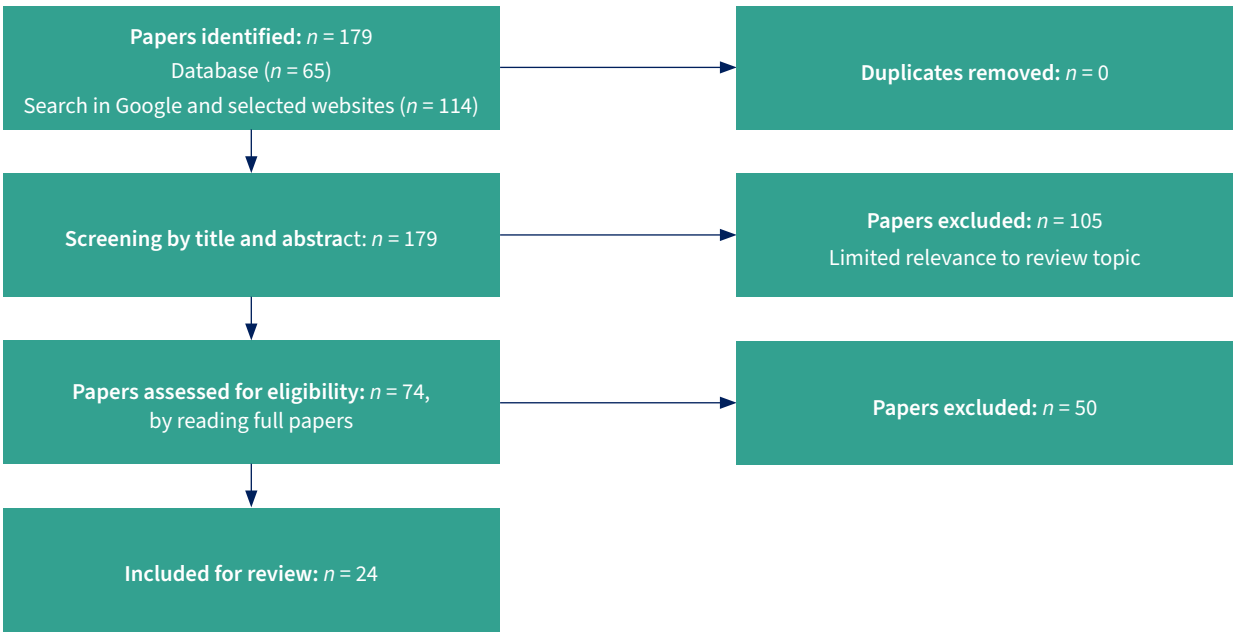

Fig. A1.2 Primary themes of papers

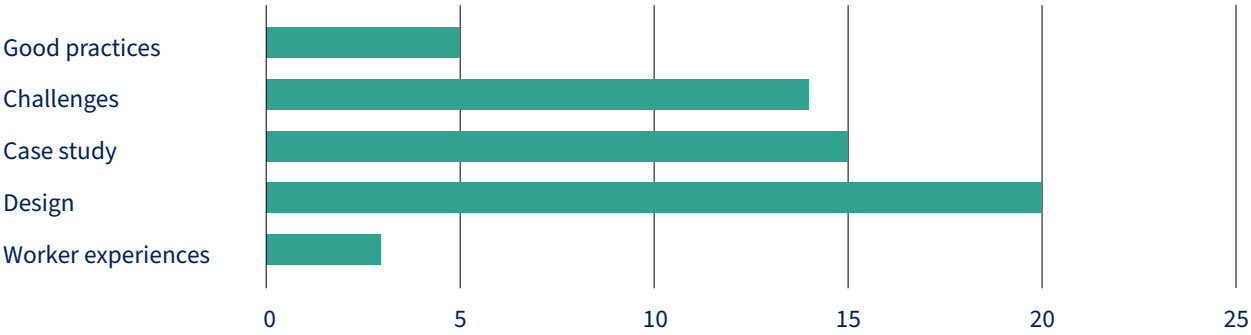

Table A1.1 Overview of papers on health worker mobility agreements

Lead author	Year	Geographic focus	Focus of article	Key findings	Type of study[a]
Fernandez KR *(1)*	2022	Global	Bilateral labour agreements and health worker mobility during the pandemic	• COVID-19 highlighted the reliance on migrant health workers to fill workforce gaps. • Not clear how these agreements benefit health workers and source countries, in addition to destination countries.	Qualitative study
Yakubu K et al. *(5)*	2022	Global	Examination of literature about the impact of bilateral health worker mobility agreements	• Currently, bilateral agreements appear to benefit destination countries disproportionately. • Health services in source countries require more attention. • Important to account for all channels for worker movement. • Need better implementation and monitoring of agreements.	Review
European Commission *(18)*	2020	European Union-third countries	EU Talent Partnerships and health worker mobility	• Positive evaluation of the EU Talent Partnerships in relation to health worker mobility and migration generally. • Matching labour needs within the EU with skills of foreign health workers can generate positive outcomes for workers and health systems.	Qualitative descriptive case study
Clemens M and Dempster H *(19)*	2021	Global	Potential good practices when designing health worker mobility partnerships	• Properly designed health worker mobility agreements can achieve the goals of all parties. • Using the same methodology as WHO used in 2006 to identify countries with a "critical shortage" of health workers would reduce the number of countries from 57 countries to 43. The 47 countries in the WHO health workforce support and safeguards list, 2020, have been identified using a different method. • Destination countries should do more to address health worker shortages within their health systems; not realistic to rely on mobility.	Mixed methods study
Abuagla A and Badr E *(20)*	2016	Sudan-multiple countries	Sudan's implementation of the Code and bilateral agreements	• The Code improved Sudan's management of health worker mobility. • Limited incorporation of ethical recruitment in agreements unless the country designs and implements a robust national policy. • Lack of regional framework or mediator to support Sudan's efforts in signing bilateral agreements with destination countries. • Limited impact of Code because it is non-binding.	Qualitative case study

Lead author	Year	Geographic focus	Focus of article	Key findings	Type of study[a]
Adhikari S et al. *(21)*	2021	United Kingdom-Nigeria	Global Skill Partnership model for health worker mobility	• As of 2018, Nigeria has a shortage of over 400 000 nurses and the United Kingdom requires over 100 000 new nurses by 2028–2029. • The Global Skill Partnership model ensures training for health workers, both staying and migrating. • Adoption of this approach would enable destination and source countries to improve stock of health workers.	Mixed methods case study
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and International Placement Service of the Federal Employment Agency (ZAV) *(22)*	2022	Germany-Philippines	Programmes for recruiting foreign nurses to work in the private sector in Germany	• Germany and source countries collaborate to identify, prepare and place nurses in Germany. • Ongoing support and training are provided for nurses once in Germany. • Strong track record of placements (4900 as of January 2022).	Descriptive case study
Makulec A *(23)*	2014	Philippines-multiple countries	Bilateral labour agreements and Filipino health worker mobility	• Data collection will be essential for evaluating health worker mobility agreements and for tracking movement of health workers. • Between 2002 and 2006, the United Kingdom recruited 6124 Filipino nurses, of whom only 175 were recruited under the Philippines-United Kingdom agreement. • More action should focus on mitigating negative impacts on source country health system when workers move. • Compensation for source countries could be considered. • Bilateral agreements should include support from other mechanisms to increase the chances of implementation.	Mixed methods case study
Efendi F et al. *(24)*	2017	Japan-Indonesia	Health worker mobility under the Indonesia-Japan EPA	• Health worker mobility requires appropriate local, national and global policies for more ethical and efficient management. • Between 2010 and 2014 only 18% of Indonesian health workers (n = 481) were able to pass the Japanese nursing exam. • In particular, governments must consider the interests of individual health workers while balancing the needs of the health workforce. • Ethical recruitment should be a core principle of any renegotiation of the Indonesia-Japan Economic Partnership Agreement (IJEPA).	Mixed methods case study

Lead author	Year	Geographic focus	Focus of article	Key findings	Type of study[a]
Efendi F et al. *(25)*	2016	Japan-Indonesia	Lived experience of Indonesian nurses in Japan under the EPA	• Given the shortage of nurses in Indonesia, the country may wish to renegotiate the arrangement with Japan. • International nurse recruitment is merely a quick fix for countries with health worker shortages. • Communication challenges and cultural differences have been reported as problematic by the Indonesian nurses.	Qualitative case study
Sato F, Hayakawa K, Kamide K *(26)*	2016	Japan-Indonesia	Investigation of mental health in Indonesian health workers immigration to Japan under the EPA	• 22.5% of the study participants (n = 71) found to be at risk of developing mental health problems. • The main factors that influenced nurses' mental health status were gender and difficultly obtaining a national qualification. • Indonesian nurses felt they had become de-skilled by restrictions placed by Japan. • A continuous and comprehensive support system for Indonesian EPA immigrant workers warrants consideration.	Mixed methods case study
Yagi N et al. *(27)*	2014	Japan-Philippines	Health worker mobility and the Japan-Philippines EPA	• Shortcomings in the agreement have limited the positive impact on mobility and health care delivery. • In the first 4 years of implementation of the agreement, only 7% of Filipino health workers were able to pass the exam required for professional practice. • Mutual recognition of qualifications, more financial support and training for health workers could improve outcomes.	Mixed methods case study
Takahashi K *(28)*	2018	Japan-Philippines	Health worker mobility and the Japan-Philippines EPA	• The EPA is an exception to strict Japanese immigration policies. • The system that Japan uses when accepting Filipino care workers is not effective for either party involved. • The impact on Filipino health workers of this agreement was negative, as many return home or take jobs that don't utilize their skills. • Although the agreement was for 200 Filipino nurses and 300 caregivers to come and work in Japan annually, between 2009 and 2016, the maximum number of arrivals in any year were 93 nurses and 278 caregivers.	Mixed methods case study
Kurniati A et al. *(29)*	2017	Japan-Indonesia	Mobility of Indonesian nurses under EPA with Japan and their return to Indonesia	• Indonesian nurse returnees experienced de-skilling and struggled to re-enter the nursing profession. • Further investigation is needed regarding the impact of the agreement on individual nurses who return home.	Qualitative case study

Lead author	Year	Geographic focus	Focus of article	Key findings	Type of study[a]
Yeates N and Pillinger J *(30)*	2018	Countries in the Asia-Pacific region	Examination of international policy responses to cross-border health worker migration within the Asia Pacific region	• Significant variety exists among agreements for health worker mobility. • Power differences between destination and source countries may affect outcomes. • Monitoring and evaluation of the agreements over time is necessary, including in relation to workers' welfare and the needs of source countries. • Decent working conditions and increased social protection should be included in health worker mobility agreements.	Qualitative descriptive study
Gough I *(31)*	2013	ASEAN	Mobility and access to surgical care	• MRAs do not seem to have enabled increased freedom of movement for health workers. • Health agreements should be negotiated with involvement by ministries of health. • A patient-centred approach to health worker mobility agreements is paramount.	Qualitative descriptive study
Te V et al. *(32)*	2018	ASEAN	MRAs and mobility of doctors and nurses	• MRAs support mobility but not on their own. • MRAs must be aligned with trade and immigration policies, and political goals, to deliver results.	Review
Plotnikova E *(33)*	2014	United Kingdom-multiple countries	Agreements and policies for health worker mobility enacted by European countries	• Action across all channels helps to ensure ethical recruitment of health workers. • Bilateral agreements may improve trade and business relations more than health services. • It can be difficult to measure impact in the real world of policies such as the United Kingdom's Code of Practice. • Private recruitment agencies are playing a larger role in health worker mobility compared with bilateral labour agreements.	Qualitative descriptive study
Weber T and Frenzel H *(34)*	2014	United Kingdom and Germany with multiple countries	Circular migration of health workers	• Circular migration schemes have been largely unsuccessful in Europe. • There is a focus on aligning agreements with the United Kingdom's Code of Practice and ensuring ethical recruitment and training. • De-skilling has been reported as a challenge for foreign nurses who come to work in the United Kingdom.	Qualitative descriptive study
Blacklock C et al. *(35)*	2012	United Kingdom-South Africa	United Kingdom policies on medical migration	• The United Kingdom Code of Practice was not effective in reducing the number of overseas doctors registering in the United Kingdom. • The number of new South Africa-trained doctors registered in the United Kingdom fell from 3206 in 2003 to 4 in 2004. • Key challenges include competing government priorities and lack of policy coordination. • Bilateral agreements and immigration laws appear to have reduced health worker movement to the United Kingdom.	Mixed methods case study

Lead author	Year	Geographic focus	Focus of article	Key findings	Type of study[a]
De Oliveira APC, Dussault G, Craveiro I *(36)*	2017	Portugal-multiple countries	Policies in Portugal to extend access to health care, including recruitment of foreign doctors	• Strategies to improve the geographical maldistribution of doctors included recruitment of foreign doctors through bilateral agreements. • 88 doctors from Cuba, 82 from Columbia and 9 from Costa Rica worked in Portugal as a result of the bilateral agreement with these countries. • Further research is needed regarding the causes of poor health worker distribution in Portugal, and whether recruitment of foreign doctors can help.	Mixed methods case study
Glinos IA *(37)*	2015	European Union	Mobility of health workers within the EU	• Arrangements for health worker mobility within the EU can improve health systems but increased coordination is needed. • The risk is that agreements will disproportionately benefit richer EU countries. • Health workforce intelligence and data, plus financial support to offset negative impacts, are needed.	Qualitative descriptive study
Hammett D *(38)*	2014	Cuba-South Africa	Cuban medical support for South Africa	• Cuban doctors benefit from experience gained working abroad, as well as the work providing a financial incentive. • Challenges with this arrangement include insufficient coordination to ensure international medical training meets the need of the source country. • Source country can secure resources in exchange for sending personnel.	Qualitative descriptive case study
Asante AD et al. *(39)*	2012	Cuba-Pacific Island nations	Cuban medical cooperation with Pacific Island nations	• Cuban medical cooperation agreements could improve health systems in the Pacific Island nations. • 177 medical students from seven Pacific Island nations studied in Cuba; 33 Cuban doctors worked in four countries. • Drawbacks of temporary mobility must be addressed, such as budget issues and qualification recognition. • Data collection and evaluation required in relation to this and other health worker mobility agreements.	Mixed methods case study

ASEAN: Association of Southeast Asian Nations
COVID-19 coronavirus disease
EPA: economic partnership agreement
EU: European Union
MRA: mutual recognition agreement

Note: The papers included are explanatory and descriptive in nature; they are thus considered to be evidence with low certainty.
[a] All publications (peer-reviewed and grey literature) are categorized by the methods used.

The review found a variety of bilateral agreements on health worker mobility between countries. Depending on the context, the design and purpose of the agreements vary, ranging from addressing health worker shortages including during emergencies *(1,18)*, or maldistribution through international recruitment of health workers *(22)*; limiting international recruitment from specific countries *(35)*; supporting training of international medical students; advancing cooperation *(39)*; and advancing trade and economic goals *(31)*.

The focus of the literature is largely on the design of agreements to yield positive results. However, there is limited information on if and how these agreements were implemented and monitored. For example, a positive element identified in the literature is the establishment of a joint committee, comprised of representatives from the ministries of labour and health and from trade unions, which monitors the implementation of the agreement over time *(30)*; however, the information on the activities performed by such committees is missing.

There appears to be a general agreement among most authors that health worker mobility agreements have the potential to promote ethical recruitment and be mutually beneficial for the participating countries *(19,33,38).* However, studies that analyse bilateral labour agreements' effectiveness to do so are few and, given the descriptive focus and methodology, do not provide robust evidence on outputs and outcomes attributable to the agreements.

The literature cautions against high expectations from bilateral agreements. The expected benefits from bilateral agreements can be difficult to attain because of several factors. First, since international mobility is largely an individual choice, the movement of health workers through bilateral agreements may only account for a small proportion when compared with other pathways *(5,33)*. Second, the power differences between high-income destination countries and low-income source countries, and the voluntary and non-binding nature of international instruments such as the Code, may place destination countries at an advantage in the negotiation of the agreements *(20)*. Third, agreements on health worker mobility can be negotiated without adequate consultation with ministries of health, in which case political and economic considerations may be prioritized rather than health *(31)*. Further, managing differences in the regulatory requirements for practice and work performed by specific types of health workers, ensuring the skills of internationally trained health workers match local needs, and addressing the language, culture and working conditions, requires coordination and communication between different stakeholders *(32,38,39)*.

Mutually beneficial agreements that benefit all parties' health workers, and the health systems of both source and destination countries, can be hard to achieve. International recruitment of health workers through government agreements can contribute to provision of health services in the destination country, including in underserved areas *(36)*. While some agreements offer financial and/or professional incentives for health workers *(38,39)*, migrant health workers have also reported de-skilling and dissatisfaction with working conditions in the destination country and difficulty in reintegration after returning home *(25,26,28,29,34)*.

There are also instances where international health workers choose not to move to countries with which a government agreement for mobility exists or fail to meet the necessary requirements for entry to practice in the destination country *(27)*. In addition, the cultural and language differences and mismatched expectations could create a situation where neither health workers nor the source or destination country gain the expected benefits from the agreement *(28)*. There could also be resistance from health workers in the destination countries to accepting foreign health workers *(32,39)*. Provisions that focus on health worker welfare and individual experiences of health workers are important factors for retention of migrant health workers in the destination countries *(27,28,29)*.

Several authors raise concerns about the disproportionate benefit from the agreements to the higher income destination country and the effect on health services in the source country, which could widen inequities *(5,32,37)*. They propose inclusion of elements, such as investments, safe recruitment targets or compensation measures to address the negative effect on the source country in supporting implementation of the agreement *(23,37)*.

Examples of source countries benefiting from the agreements on health worker mobility are rare *(38,39)*. Skills partnerships have been proposed to enable both source and destination countries to sustainably expand their stock of health workers. The destination country would provide technology and financing to train health workers in the source country with targeted skills, to facilitate employment once they move to the destination country. The source country would deliver the training, receiving support to also train health workers who choose to stay in the source country *(21)*.

Some authors highlight the challenges with evaluating the impact of the agreements on health systems. Collecting reliable data on health worker mobility, tracking health worker movement and monitoring the implementation of the agreements are necessary to measure the impact of the agreements *(23,37,39)*. The

phenomenon of health worker mobility does not occur in isolation. It is difficult for the government agreements to achieve the desired impact unless complemented by government policies on health, immigration and trade *(32,35,36)*. While using bilateral agreements can be a strategy to address health worker shortages in one country through international recruitment, the underlying cause of these challenges also needs to be addressed in parallel *(19)*. Monitoring and evaluation of bilateral agreements is necessary to measure effectiveness in improving health outcomes and identify key issues requiring attention *(30,39)*.

Discussion

Available literature suggests that bilateral and regional health worker mobility agreements signed by governments vary significantly in their form, objectives, content and scope.

Different types of agreements have been used to: facilitate the recruitment of international health workers to address labour shortages; promote education and training of health workers; facilitate health worker mobility by reconciling differences in education and training, and regulation; enhance regional mobility of health professionals as part of trade in services agreements; advance health cooperation and development; and support service delivery in underserved areas.

Among these objectives, the discussion is largely on the use of bilateral and regional agreements to address recruitment and shortages in destination countries, and to better manage health worker mobility. There is optimism that, if structured correctly and in a manner that reflects the Code, bilateral agreements can deliver a positive impact on mobility, health care delivery and health workers. To this end, constructive proposals and new approaches for future agreements have been proposed such as skills partnerships.

At the same time, this review identified a range of challenges in negotiating and executing bilateral and regional health worker mobility agreements. For instance, it may be difficult to secure a truly mutually beneficial arrangement, and countries may be challenged to ensure their health worker mobility agreements are implemented in full. Some authors look at systemic challenges such as how to offset the cost to health care systems of lost health workers, while others focus on challenges at the individual level, presenting the types of negative experiences that may be experienced by health workers moving abroad.

Authors also discuss: the need for coordination to ensure that health care needs, on the one hand, and services and skills, on the other, are a good match; programmes to support the success of individual workers on the ground, including dispute settlement; and the need to regulate health worker mobility through private as well as public channels, given the substantial flows of workers via private recruitment channels and the reality that such movement is not subject to the conditions in bilateral government agreements.

This review found limited evidence of benefits to the source countries' health systems from bilateral agreements. Multiple factors may contribute to this. Certain factors relate to individual preferences of health workers, including reasons for moving abroad, choice of destination country and preferred channel for movement. Other factors are systemic, such as the push and pull factors that influence and drive health worker mobility. These include differential earnings and opportunities abroad, or even the stark reality faced by many source countries that they will likely continue to lose workers despite signing bilateral agreements to manage health worker mobility.

Limitations

The review did not identify quantitative analysis or formal evaluations of such agreements, based on data. The lack of quantitative evidence makes it difficult to describe with certainty the impact of these agreements. Although the texts of agreements from some countries – for instance, the Philippines and United Kingdom – are publicly available, they are not accompanied by implementation data or evaluation reports.

The review did not identify information about the activities of the joint committees mentioned in the literature. Nor did it identify reporting by other official bodies that may have been tasked with monitoring the implementation of health worker mobility agreements or gathering data about their impact. It is possible that joint committees are actively monitoring health worker mobility agreements but that their proceedings are not available publicly. Another explanation may be that countries are insufficiently engaged in gathering and analysing data regarding the impact of their bilateral and regional health worker mobility agreements.

Given the above, it is not possible state with certainty the impact of the known government agreements without further information on their background, context, implementation and evaluation. Primary research could help to identify best practices, so these can be shared among WHO Member States and applied to future health worker mobility agreements.

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Annex 2. Ethical management of international health worker mobility: textual analysis of health worker mobility agreements

Summary of the analysis

Health worker mobility agreements have the potential to be an important tool for improving access to health care. They can be used to fill gaps in health systems, provide opportunities for training, facilitate the recognition of qualifications for health workers from abroad, and ensure that workers are recruited ethically and afforded appropriate working conditions in the destination country.

Based on the more than 150 health worker mobility agreements that have been notified so far under the WHO Global Code of Practice on the International Recruitment of Health Personnel ("the Code") since 2010, these agreements take many forms and they reflect many different approaches. They range substantially in terms of level of detail of the commitments, management of mobility, dispute resolution and administration, and other elements. There is no one template for a health worker mobility agreement.

In this paper, the authors describe different health worker mobility agreements, based on texts submitted to WHO under the Code. They make initial observations about practices that could potentially maximize these agreements' contribution to public health and the orderly movement of health workers across borders, and to the welfare of the workers themselves.

The authors recommend further transparency with regard to such agreements, and for more data collection, particularly about their impact once implemented. They suggest that health ministries should be engaged with, if not leading, any negotiation of health worker mobility agreements to ensure these agreements serve the broader health care goals of the countries concerned.

Context

The international mobility of health workers – with health workers moving permanently or temporarily across national borders – is increasing in scale and complexity. Currently, substantial reliance on migrant health workers is evident across countries of varying income groups. The accelerating demand for foreign-trained health workers, prominent in many high-income countries, is also evident *(1)*.

More than ever, migrant health workers are ensuring populations' access to health services and supporting responses to health emergencies. At the same time, for several countries, international health worker mobility may potentially threaten the achievement of these same goals.

The need for approaches that practically advance ethical international health worker mobility is highly relevant for health systems around the world. It is especially relevant in the context of the ongoing COVID-19 pandemic, as explicitly discussed at the 73rd World Health Assembly in 2020 *(1)*.

The urgency for strengthened international governance of health worker mobility has grown, within and also outside the health sector. Indeed, international health worker mobility is increasingly recognized as bringing value across several other Sustainable Development Goals, including decent work and economic growth, human capital development, international trade, and safe, orderly and regular migration.

Health worker mobility agreements provide one mechanism to strengthen the ethical management of international health worker mobility. Governments, with increasing frequency, are negotiating such agreements to improve the orderly management of health worker mobility internationally and to ensure workers' welfare. Such agreements, whether intended to give rise to international legal obligations or to advance a broader normative or political purpose, are becoming a mainstay of modern international relations.

Recent policy directives in several high-income countries, including in the EU and the United Kingdom, point to an intensification of agreements with respect to international health worker mobility.

As illustration, the EU's New Pact on Migration and Asylum explicitly identifies "health, medical care and agriculture" as areas with specific skills shortages in the EU. The EU Talent Partnerships initiative, launched in June 2021, seeks to strengthen legal pathways and international partnerships in these areas of priority for the EU. Earlier in 2021, the United Kingdom launched its approach to accelerate the international recruitment of health personnel, consistent with the WHO Code. The updated United Kingdom Code of Practice identifies its intent and approach to pursuing mutually beneficial agreements, in line with the recommendations of the Code *(2)*. The United Kingdom approach makes explicit that its agreements will not exacerbate domestic shortages and will include support to strengthen the source country's health workforce and health system.

Moreover, national and supranational (i.e. EU) approaches to agreements on international health worker mobility are themselves influenced by a diversity of global norms and standards. These include the UN Global Compact for Safe, Orderly and Regular Migration, the WTO GATS and associated regional trade agreements (RTAs), the ILO Conventions and Recommendations focusing on ensuring labour rights, and norms promulgated by UNESCO. With the rise of health emergencies, and associated need for the temporary mobility of emergency health personnel, the role of international humanitarian law and standards is also increasingly important.

The Code, adopted by WHO Member States in 2010, establishes and promotes principles and practices for the ethical international recruitment of health personnel. The Code serves as the only international guidance that specifically and comprehensively focuses on international health worker mobility, whether permanent or temporary. Importantly, the Code does not proscribe health mobility agreements. Rather, it provides guidance for the development of agreements such that a multiplicity of rights, including the human right to health, can be assured, benefits can accrue to the health systems in both source and destination countries, and the welfare of the health workers themselves can be safeguarded.

In addition to providing guidance, the Code reporting includes notification of bilateral agreements related to international health worker mobility. Following three rounds of national reporting, starting in 2010, the existence of over 150 health worker mobility agreements has been notified to WHO. Full texts of some of these agreements have also been shared with WHO. In addition, certain agreements notified to WTO, and available on the Integrated Trade Intelligence Portal (I-TIP) database, also have a health worker mobility component *(3)*. Analysis of these texts forms the basis of this paper (Table A2.1).

Table A2.1 Bilateral and regional health worker migration and mobility agreements analysed

Sources of the full text of agreement	Number of agreements
WHO	31
WTO	7
Total (after removing duplicates)[a]	37

[a] One agreement in the WTO portal was also available via reports on implementation of the Code.

Analysis of the form and substance of health worker mobility agreements

Objectives, methodology and limitations

The primary objective of the research is to inform WHO Member States, especially ministries of health and their relevant stakeholders, on the form and substance of the diversity of international health worker mobility-related agreements. In developing this analysis, we seek to provide a basis for further work by WHO, its international partners and other stakeholders to strengthen the ethical management of international health worker mobility, consistent with the Code.

This descriptive paper analyses the texts of health worker mobility agreements, as formally notified to WHO through reporting under the Code. We also include RTAs notified to WTO that contain health services commitments, and we reference relevant trade commitments under the WTO GATS (see Table A2.1 for the sources of the full texts of agreements).

This analysis also utilizes previous analysis done jointly by WTO and WHO with respect to GATS and RTAs notified to WTO.

The 37 agreements examined for this research project are wide-ranging in terms of their objectives, structure, level of detail, negotiating entities, timeframe and context. They were provided in different languages (English, French and Spanish). The texts of the agreements were evaluated based on various factors related to process (e.g. did health ministries participate in negotiations?), individual impact (e.g. what benefits are guaranteed to health workers under the agreement?) and expected impact on health care systems (e.g. did the agreement improve health care delivery in both the sending and receiving countries?). We also considered the relationship between the provisions of each agreement and the Code (e.g. does the text mention the Code?). We did not have access to any data regarding the impact of the agreements once implemented; we did not have access to information about how the agreements came into being; and we did not have any results of formal monitoring and evaluation of the agreements. The analysis was based only the text of the agreement.

Our analysis considers the impact that could be expected from the health worker mobility agreements, again, based only on their texts; on: first, the orderly movement of health workers; second, the welfare of health workers crossing borders, in terms of their rights and working conditions; and third, the health systems of the countries involved.

While we were able to review the text of the 37 agreements, information about their context and the process by which they were negotiated is not publicly available. This is an important limitation of the analysis presented in this paper. Moreover, while notification of the agreements under the Code has steadily improved over time, there remain important gaps in evidence on the impact and execution of notified agreements. Specifically, several agreements reviewed are high-level framework agreements that set out intentions and goals, with programmatic details to be determined later; we did not have access to information on their execution.

We emphasize the need for further notification of not only the full texts of agreements to WHO, but also for more complete information about the negotiation, execution and performance of the agreements once in place. We also note the need for strengthened data collection and exchange, within the agreements, between the parties and with WHO, so that promising practices can be more rigorously evaluated and replicated in the future.

Despite these limitations, through our textual review of 37 agreements, we were able to establish an informal typology of health worker mobility-related agreements, identify promising practices, and suggest some recommendations going forward.

Overview of findings

International health worker mobility-related agreements are agreements that aim to support and stimulate the cross-border movement of health personnel. They are aimed, overall, at filling gaps in health care systems. The agreements generally do this in two key ways:

- fill gaps in skills and people in the receiving country's health care system (e.g. fill jobs, temporarily or permanently, with skilled workers from abroad); or
- fill gaps in the sending country's health care system (e.g. supply training, education, innovation, tools/technologies, financial support, policy-making best practices) through collaboration and the mobility of natural persons.

The two aspects can also be done in conjunction, as called for by the Code and increasingly recognized in national and supranational policies (e.g. United Kingdom Code of Practice, EU Talent Partnerships), as well as by global development partners. The recent Center for Global Development policy paper, *Ethical recruitment of health workers: using bilateral cooperation to fulfill the World Health Organization's Global Code of Practice*, in particular, highlights how the two elements can be brought together, with a focus on operationalizing the EU approach to "Talent Partnerships" *(4)*.

Based on the agreements reviewed as part of the present analysis, along with previous WHO-WTO research and broader reporting on the Code, we can observe some emerging trends related to the negotiation and execution of these agreements:

- Health worker mobility agreements are not simply supporting movement from low- and middle-income countries to high-income countries. Evidence indicates that health worker mobility, under the more than 150 agreements notified to the WHO, contributes to filling gaps in health systems globally.
- The number of health worker mobility agreements notified to WHO is increasing over time, which is consistent with evidence of increasing health worker mobility, and which suggests an increase in cooperation by governments in this area.
- An important achievement of the Code is to have strengthened transparency with respect to health worker mobility agreements.
- There are many different types of health worker mobility agreements, which focus on education partnerships, health cooperation, labour mobility and/or trade.
- The entities negotiating the agreements were federal government officials as well as regional government officials, representing a range of government bodies. Generally, those negotiating the agreement – and whether officials from the health ministry were among them – depended on the type of agreement concluded.
- Some of the most recent agreements explicitly refer to the Code.

We note the importance of health ministries being, at the very least, aware of agreements that may affect health care delivery, including agreements that pertain to international health worker mobility. Ideally, they should not just be informed about them – they should have an active role in negotiating these and any other agreements potentially affecting health care. This helps to ensure the agreements preserve and improve the health system. Better still, health officials should proactively and strategically lead efforts to negotiate such agreements with other WHO Member States in the context of a broader national health care strategy, in order to secure the training, skills, personnel, facilities and other elements needed to improve health care. The increasing leadership of ministries of health in discussions previously reserved for other parts of government points to a new and increasingly important role for ministries of health, which the current research supports.

Description of the health worker mobility agreements

To simplify the process of analysing the various texts, we categorized the 37 agreements into seven categories based on their overall area of focus (Table A2.2). We included agreements in each category based on a qualitative analysis of what the text emphasized most. This categorization is designed to facilitate comparison of the texts in this study.

There follows an overview of our findings, describing the agreements by category. We underscore that there is some overlap in the categorization. At the same time, we believe that the categorization itself points to important distinctions in the substantive provisions and procedures across the agreements reviewed.

Table A2.2 Health worker mobility agreement categories

Focus area of agreements – categories		
1	Agreements with emphasis on filling workforce gaps in destination countries and protecting migrant health workers' rights	12
2	Health cooperation agreements	7
3	Trade in services agreements	7
4	Agreements for short-term training of health workers	4
5	Agreements for philanthropic and technical support	3
6	Agreements on recognition of qualifications	3
7	Agreements to establish quality training programmes abroad	1

Category 1: Agreements with an emphasis on filling workforce gaps in destination countries and protecting migrant health workers' rights

We analysed 12 agreements that focus specifically on the treatment and recruitment of migrant health workers. Many of these agreements set out frameworks, rules and procedures for these processes, before and after arrival in the destination country. The agreements have a range of titles, including General Agreement, Joint Declaration of Intent, and Memorandum of Understanding.

Most of the agreements, regardless of title, appear to be equivalent to treaties. However, certain agreements explicitly state they are not legally binding. Our sense is that such agreements imply that foreign health workers can also be recruited outside of the arrangement. The agreements may, therefore, be providing a pipeline of workers above and beyond that which would normally exist, to facilitate the hiring of qualified candidates from abroad.

The agreements in this category are often "framework agreements" that set out basic principles, and that are meant to be supplemented by more specific arrangements worked out later. In this respect, some of the agreements specifically call for the creation of a body dedicated to overseeing its execution, monitoring its impact, proposing amendments and other actions required for execution of the treaty. These are called "joint bilateral committees", "joint working groups" or "joint consultative committees". Across agreements, we were not able to confirm these bodies were actually established, and we had no access to records of activities on the deliberations or decisions taken by such bodies. Moreover, many of the agreements do not establish a committee and it is unclear how the gaps in those agreements can be filled over time.

These agreements generally do not involve the health ministries in their negotiation but rather employment-focused government entities. Examples are the Overseas Employment Agency of the Philippines, the Directorate of Labour of Norway, the German Federal Employment Agency, the Danish Minister of Refugees, Immigration and Integration Affairs, the Indian Minister of Overseas Indian Affairs, the United Arab Emirates Minister of Labour, and the Philippines Secretary of Labour and Employment. Corresponding agencies from the negotiating countries do not necessarily engage with each other; for instance, a department of labour may negotiate with the other country's authority for advanced education and employment.

In certain agreements, private sector employers are explicitly given a defined role, and they are generally responsible for covering the costs of recruitment, such as in-person interviews or payments to the sending country authorities that support the selection and recruitment of candidates. In other agreements, it is the public health sector recruitment that is the exclusive focus of the agreement, and/or the private sector entities are not explicitly mentioned. Sending agencies are periodically mentioned in these agreements.

These agreements tend to be explicitly aimed at filling gaps in the receiving country's health care system, while also promoting the welfare of the workers, by giving them job and training opportunities and ensuring fair and adequate remuneration and working conditions. Several agreements specifically mention the need to bring qualified workers into the receiving country, to fill gaps. One agreement aims to establish "sustainable human resources" for health. The press release accompanying a different agreement cites the need for as many as 1 million workers in the receiving country in the coming 5 years. Another agreement identifies, among its aims, the establishment of a long-term framework for recruitment of foreign health care professionals to fill gaps in the domestic health care system ("sustainable recruitment"). Yet another agreement explicitly references support from the sending country to address health-related skills and labour shortages in the receiving territories.

Alongside the desire to create sustainable recruitment, the welfare of workers is at the heart of the agreements in this category. They set out expectations in terms of fair treatment and proper recruitment practices for workers. Some of them set out practical procedures to be followed when matching qualified workers with potential employers and shepherding both sides all the way through identification of workers, recruitment processes, administrative formalities and signing a contract for starting work in the receiving country.

The worker protections set out in the agreements generally focus on the right to receive a contract in advance, fair working conditions including appropriate remuneration, support to understand the conditions in the contract, support to prepare for working in the receiving country and training opportunities. Receiving and understanding an employment contract in advance of taking up a post in the receiving country is a fundamental issue mentioned in several of the agreements. For instance, one agreement states that the accord will seek not only to facilitate the movement of workers but will also provide for certain protections, notably a labour contract for all incoming workers, verified and authenticated by the receiving country's ministry of labour, and based on a standard contract to be developed by that ministry for use for foreign health workers. Another agreement emphasizes the need for sending agencies to not only give employment contracts to workers in advance, but also to make sure workers understand conditions of employment in the receiving country. And other agreements make clear that health workers from abroad must get the same salary and conditions as local hires.

Whereas certain agreements enumerate principles and some regulations for the recruitment of health workers, others set out specific procedures, thus establishing a system for matchmaking. The types of systems established are largely the same across those agreements that take this approach. Generally, two governments facilitate contact between sending agencies or qualified candidates themselves and the private sector employers potentially interested in hiring them. Certain agreements provide more detailed working procedures. One agreement empowers a government agency in the receiving country to identify employers authorized to recruit under the agreement, and a government agency in the workers' country of origin to identify qualified sending agencies; thereafter the employers in the receiving country communicate directly with those agencies. Also, the receiving countries may commit in the agreements to facilitate immigration procedures.

Ensuring workers' qualifications is an important part of ensuring that the receiving countries' health systems benefit from health worker mobility. However, confirming qualifications is not a straightforward matter, and the agreements all deal with this topic in a slightly different way. Most of the agreements in this category at least mention the need to ensure the incoming workers are appropriately qualified. Others, though, do not mention qualifications at all. One agreement references "qualified workers" throughout and includes a commitment from the sending country to "pre-screen" candidates to ensure they are qualified – but leaves the details to be worked out later.

Several agreements refer to specific requirements that help to ensure the workers being recruited from abroad are qualified. These include: a degree or proof of formal qualifications, having practised the profession for a minimum number of years, a recently issued certificate of good standing and appropriate travel documentation. Several agreements also require health workers to pass a medical exam before they can work in the receiving country.

One of the agreements in this category focuses on qualifications and has the stated aim of providing a foundation for an eventual MRA between the two countries. This implies a fairly deep level of harmonization.

Training is alluded to in certain agreements in this category, including in relation to language courses to improve health workers' chances of success in the receiving country. Sometimes training about local conditions in the receiving country is also provided for. One agreement we reviewed provides for a training period during which foreign nurses can work for up to 1 year as nursing assistants before taking a qualifying exam to become recognized as fully qualified nurses.

An agreement in this category refers to "collaboration" in vocational training, as well as in testing and certification, but without providing any details; we were unable to find further information about the practical actions taken to realize such commitments. Another agreement states that the parties will create alliances between education health care institutions in the two countries to increase the supply of competent human resources for health, in addition to developing mechanisms for the sustainable development of human resources for health. The objectives of this agreement reference the need for support to facilitate the reintegration of health workers back in the country of origin, presumably to ensure the skills gained during the overseas assignment can be applied to improve the sending country's health care system through circular migration.

The establishment of training programmes in the sending country is explicitly provided for under certain agreements. These appear to be aimed at creating sustainable systems to enhance the skills of health workers in the sending country, overall, perhaps to offset the migration of skilled workers to the receiving country. In one agreement, financing is anticipated to benefit programmes to train youth in the sending country. Under this agreement, funds would be committed by the private sector for this purpose. The commitments, however, are vague. Where these types of arrangements are envisioned in the health worker mobility agreements, the commitments are generally set forth in best endeavours language rather than as specific commitments.

More often than not, the agreements do not address how to maintain the level of health care in the sending country. This seems to indicate that the benefits envisioned under this category of agreements may largely relate to economic/employment and skills building opportunities for the workers who migrate. This can be expected, once they return home, to enhance the health workers' skills base – but the link is not direct. This could depend on the reintegration policies of the sending country, which would influence the extent to which learning and experience gained abroad is applied upon return of the worker. Where circular and return migration would not occur, it is unclear how the sending country would benefit other than possibly through remittances.

With regard to financial arrangements, certain agreements impose processing fees for health worker recruitment. These are payable by employers or the receiving country government upon the successful recruitment of health workers. In addition, certain sending countries require that employers or receiving country governments make contributions to a domestic fund to benefit workers.

In terms of the administrative elements of treaties, most of the agreements spell out how disputes will be resolved together with other matters. Disputes arising under the agreements are generally settled by negotiation through diplomatic channels and the agreements can generally be amended or terminated through written communication by the parties. We do not have information as to whether the agreements we reviewed were modified, whether disputes arose, and/or how disputes were settled.

Many of the agreements are automatically renewed after the initial period during which they are in force (ranging from 2 to 5 years) but some must be explicitly renewed by the parties to remain in force. There was very little information available online as to whether the agreements had been renewed over time. Where agreements are self-renewing, this may create legal certainty and thus provide a long-term framework promoting legal certainty for the governments, workers and employers.

The majority of agreements in this category do not provide for data collection, analysis and exchange about the execution and impact of the agreement. There are exceptions. For instance, one agreement explicitly refers in its objectives to the collection and exchange of information about health worker mobility between the countries. And a second agreement provides for the exchange of information about policy matters related to the development of health care workforces. A third agreement provides for the exchange of information about the contracts proposed and signed, subject to certain provisions protecting the privacy of the individuals.

The type of migration envisioned under this type of agreement is generally circular, although some agreements provide explicitly for the workers to apply for permanent residency after some years. These are the exception to the norm. Most agreements in this category implicitly endorse circular migration and a few explicitly endorse circular migration. One of the agreements in this category sets out the intention of the sending country to assist the government of the receiving country in supporting workers moving there "temporarily or permanently", and in the development and delivery of programmes that contribute to their settlement and ultimate labour market success.

Finally, two agreements set out arrangements that are not present in the other agreements in this category: namely, a transparency clause regarding either party's intention to negotiate a similar arrangement with another country, provisions mandating MFN treatment in the event such agreements are concluded with other countries, privacy clauses pertaining to the handling of information about individual workers, and confidentiality clauses that outlive the agreement itself. MFN treatment involves a commitment to provide the other party with the best treatment provided to third-party countries under other similar agreements; MFN is a standard feature of bilateral and regional trade agreements.

Category 2: Health cooperation agreements

Agreements under the category of health cooperation for mutual benefit generally take the form of framework agreements that establish the general objectives for cooperation between the parties, in addition to identifying areas for cooperation that may be broad in scope and number. They include areas such as training and temporary work opportunities, hospital sector reform, cooperation between hospitals, research and development, emergency interventions, procurement of drugs and equipment, immunization campaigns, information exchange, among others. We analysed the text of seven agreements in this category.

Areas of cooperation under the agreements are then expected to be further defined and implemented through supplemental agreements, for instance by committees established for this purpose.

For example, one agreement in this category foresees the establishment of a working group to further elaborate the details of cooperation and to oversee the implementation of the memorandum of understanding. It states that "the Working Group will meet at appropriate times/intervals as mutually decided upon" by the parties.

A main characteristic of this type of agreement is that the cooperation between the parties should provide mutual and equal benefits to both parties. One agreement seeks "to establish comprehensive inter-ministerial and inter-institutional cooperation between both countries in the field of health by pooling technical, scientific, financial and human resources with the ultimate goal of upgrading the quality and reach of human, material and infrastructural resources involved in health care, medical education and training, and research in both countries". Another agreement in this category establishes "a framework to promote, develop and increase cooperation in the field of health within their respective jurisdictions by exploring the possibilities of cooperation on the basis of equality and mutual benefit". Another agreement aims at enhancing clinical/technical skills and exploring best practice in health care delivery in both countries.

Given the focus on mutual benefits in this type of agreement, although financial arrangements are not covered in detail, we expect each party to cover the costs related to its participation in activities stemming from the agreement.

Based on their texts, we perceive that health ministries are involved as main negotiating bodies of these agreements, and that data collection and information sharing are important elements of cooperation.

We also consider it likely that the agreements in this category promote the circular migration of health workers. Basing our analysis only on the text, though, we cannot be certain.

With respect to administrative issues, most of the agreements have an average lifespan of 5 years, with termination clauses that require written notice of 3 to 6 months. Dispute settlement provisions focus on amicable solutions, reached through consultation and negotiation between the parties using diplomatic channels.

Category 3: Trade in services agreements

We reviewed seven agreements in this category. The trade in services framework is an important mechanism for the international mobility of health workers. RTAs are agreements negotiated between two or more countries and/or economies. The role of RTAs in the trade in services framework is increasingly prominent, as they are easier to conclude than multilateral talks and can lead to deeper commitments and provisions. There is significant diversity in the form and content of RTAs. An earlier analytical work undertaken by WHO and WTO provides valuable information on the scale and diversity of commitments and/or provisions related to international health worker mobility, as included in RTAs (see Box A2.1).

A key message from the review of trade in services agreements is that they are an important avenue for the international mobility of health workers; with RTA commitments and provisions in the area both more numerous and deeper than in the WTO GATS. Moreover, RTAs contain significant flexibility to advance ethical principles as enshrined in the Code (see Box A2.1).

Category 4: Agreements for short-term training of health workers

We reviewed four agreements in this category. These involve entities, generally within the public health system, in the receiving countries providing tailored training and education to health workers from the sending countries. Although health workers migrating to receiving countries can also have other roles during their stay, emphasis is on the training programmes established under the agreement.

Agreements in this category generally leverage existing mechanisms that are already set up in the receiving countries. They provide the framework and overarching objectives of the expected cooperation with third countries, as well as the requirements and funding considerations depending on the development level of the partner country.

We drew on one agreement as the principal case study illustrating how agreements in this category may operate. The stated objective of the agreement in question is “to enable overseas trainees to gain access to clinical experiences and training that they cannot get in their own country, with a view to enhancing and improving the individual’s medical training and learning and in the medium to long term, the health services in their own countries”.

The agreement is explicitly intended to be mutually beneficial for both countries. It is envisioned for the temporary recruitment of doctors from the sending country to work in the receiving country’s health care system, to receive training beyond what they would receive at home, thus benefiting both countries.

Box A2.1 International health worker mobility and trade in services

95 RTAs in the WTO I-TIP services database were reviewed for commitments that facilitate the temporary international mobility of health workers. Some of the key findings include:

- Commitments and provisions for international health worker mobility are more prominent and often deeper in RTAs than in GATS.
- RTAs can limit scope and differentiate scope (i.e. specialists, facility size).
- Some RTAs include licensing and qualification recognition conditions.
- RTAs can also specify quantitative limitations on entry of foreign workers based on labour market tests.
- Some RTAs distinguish provisions with preferential access to charity or humanitarian missions.
- Some RTAs provide details on the process of admitting health workers from the country of origin, including language requirements and training with a designated institution in the destination country to prepare for exams to obtain authorization for practice.
- RTAs can include technical assistant and financial support to the country of origin.

Source: Adapted from International health worker mobility and trade in services. WHO-WTO Joint Staff Working Paper. Geneva: World Trade Organization; 2019 *(3)*.

The destination country benefits from qualified health workers while the foreign professionals benefit from on-the-job training, and the sending country's health care system benefits from the eventual return of more qualified professionals.

Based on the text alone, this agreement was established in accordance with international codes on recruitment, training and education of health workers, including the Code. Thus the agreement appears to address – or at least to take into account – the need to maintain the level of health care in both the sending and receiving countries.

A core principle of the training programme established under this agreement is that it "will not lead to a reduction in the training capacity or quality of any national domestic training programme for specialists", and that it will meet the "clinical needs of participants as defined by their home country's health service". In this sense, the beneficiary countries play an important role in identifying the existing gaps and needs in their health systems, then sending trainees to the destination country for training in order to fill those gaps.

The agreement is not intended to lead to settlement by foreign health professionals in the receiving country; circular migration is in fact cited as one of the goals of the agreement.

The agreement text does not specify how the well-being and rights of participating health workers will be protected during their training abroad. The framework document states simply that "participants will be directly employed and paid by the relevant health service employer" in the receiving country and in accordance with the conditions for that role. Our sense is that this would ensure equal treatment of foreign and national trainees under the same programme, even if the agreement does not address this matter directly. Based on the text of the agreement, it seems that the visiting doctors have equal rights to those of local doctors.

The agreement further promotes the orderly migration of health workers by promising to liaise as needed with state agencies regarding regulatory and immigration matters and medical registration.

Qualifications are addressed in the agreement. The receiving country is ultimately responsible for accepting participants based on their expertise and qualifications, and on the sending country's recommendation. The agreement provides for recognition by the sending country of the training acquired abroad, upon return of the health professional.

The agreement is not explicit with respect to administrative issues. The normal period of the agreement, based on the text, appears to be 2 years and extension/renewal is not automatic. Based on the textual analysis alone, there is no specific clause provided for the amendment of the agreement, advance termination or dispute settlement.

Category 5: Agreements for philanthropic and technical support

Agreements in this category are, in general terms, characterized by one of the parties providing support to the other in case of health care shortages and/or emergencies. We reviewed three agreements in this category.

In some cases, the countries providing the support have set up arrangements for making available health workers and possibly other types of supports in specific situations where the partner countries are in need of these resources. For example, under one agreement, the country sending health workers commits to helping the receiving country to meet certain health workforce needs, by sharing its experience and expertise and promoting cooperation with the beneficiary country, while also facilitating meaningful contacts between the youth in the countries. In addition, some countries have established medical brigades with the objective of providing support to health systems of other countries with specific shortages or needs.

The relation between the provider and beneficiary country is, in most cases, very clear. For example, one agreement states that its "technical and professional assistance" will "contribute to further strengthening the health system of its people".

Even in cases where one country is acting as a provider and another as a beneficiary, in some cases the agreement is presented as a mutually beneficial agreement. This is the case in one agreement which states that both parties realize "the necessity for promoting co-operation … on the basis of mutual benefits".

As stated above, some of these agreements set up pre-existing mechanisms in the sending country, with budgetary resources already allocated or at least identified prior to situations of need arising. Thus the agreements are likely to maintain the level of health care in the sending countries while at the same time improving health care in the receiving country. These agreements seem to reflect a clear assessment of needs of the receiving countries.

These agreements contain fairly specific provisions on topics such as salary, accommodation, travel and transportation costs, health care and repatriation costs, among others. Given the quasi-philanthropic nature of these agreements, it is normally the sending country that is responsible for the salary and allowances provided to the health workers, as well as the travel costs from the sending to the receiving country. The receiving country is generally responsible for providing accommodation and transportation within the country, as well as for ensuring health care for the visiting health personnel.

One agreement clearly states that the sending country is "responsible for payment of allowances for the maintenance of each Volunteer serving in the Recipient Country", whereas the receiving country is responsible for other issues such as to "provide free medical care to each Volunteer in government health institutions" and to "pay appropriate shift and call duty allowances to Volunteer Nurses and Doctors respectively where their services are utilized beyond the 40 hour per week schedule. If services are utilized outside of the 40 hour per week schedule, the Volunteer shall be compensated at the similar rate of the local counterpart".

The agreements in this category endorse the temporary movement of workers for a defined period of time. Provision is made for the health workers to return to the source country upon completion of their activities or upon expiration of the agreement. At the same time, most agreements do provide for the possibility for health workers to explore employment opportunities of a more permanent nature in the receiving countries, under certain conditions. One agreement in this category states that the receiving country can "offer employment to any of the Volunteers at the completion of their assignment under this Agreement, provided that such Volunteer returns to [the home country] to complete the disengagement formalities". Another agreement references the possibility of workers staying on, pending approval by the sending country and that the person meets the immigration requirements of the receiving country.

A number of agreements within this category explicitly address the facilitation of immigration procedures to ensure that the temporary movement of health personnel is orderly and in accordance with the laws and regulations of the receiving country. In one such agreement, the receiving country explicitly assumes "the cost and processing of visas for entry, stay and departure required in countries of transit and such other documents, permits, travel taxes and duties" required under law. Under another agreement, the receiving country provides "the Volunteer, free of charge, with the relevant two-year service period work permit that will enable him/her to lawfully work" there.

Among these agreements, workers' qualifications are addressed as a matter of course, albeit not in detail. This can be done through recognition of the sending countries' qualifications as equivalent to those of the receiving countries. In certain of these agreements, the sending country is responsible for ensuring that all health workers sent to the receiving country "have the necessary qualifications to practise in health institutions where they shall be located". In some agreements, the receiving country's qualifications apply to the foreign workers based on the same administrative procedures applied to local hires. For example, one agreement states "health professionals recruited under this MOU obtain the necessary registration required … prior to providing any health services covered under this MOU; and comply with the relevant laws and regulations".

Among the general objectives of the agreements in this category, training and education of local health personnel are frequently cited as important actions to be undertaken to support improved health care systems in the receiving countries. However, the agreements do not generally provide details as to the precise content and form of the training. Most leave this as an implicit action to happen as part of the activities of the health personnel while stationed in the receiving country. In the case of one agreement, the sending country accepts the short-term training of doctors from the receiving country and even covers the relevant expenses.

All agreements under this category were negotiated by health ministries. It is unclear whether other stakeholders participated in the negotiations as this is not mentioned explicitly in the text of the agreements. We assume that immigration and customs agencies would have at least been consulted on the immigration-related commitments, given that these are mentioned in certain agreements. We also assume that entities such as hospitals and associations that would play an important role in the execution of the agreements would have been consulted. But, having only examined the text, we are not certain.

Administrative matters – renewal, modification of the agreements, dispute resolution – are basically the same as noted in the first category of agreements, which focus on workers' rights.

Category 6: Agreements on recognition of qualifications

We evaluated three agreements aimed at harmonizing regional policies and/or advancing services trade liberalization for health care. The agreements considered were concluded under the auspices of a regional trading bloc. They were aimed primarily at encouraging the delivery of health care services by individuals from abroad, by facilitating the mutual recognition of workers' qualifications. The MRAs reviewed cover nurses, doctors and dentists. While they address qualifications, they do not actually create the channels for health worker movement.

The agreements aim, each within their particular focal area (nurses, doctors, dentists), to facilitate the mobility of professionals, exchange information and expertise on standards and qualifications, and provide opportunities for capacity building and the training of health care workers. Each agreement sets out trade liberalization objectives at the start, such as: "enhance cooperation in services in order to improve the efficiency and competitiveness, diversity production capacity, and supply and distribution of services within and outside of [the region]; reduce restrictions to trade in services, liberalization trade in services among [the region's] countries." The agreements specifically apply GATS to fill in any gaps in the disciplines set forth therein.

While the agreements are signed by trade and industry authorities, they mention the key role of health authorities in implementation. The agreements set up joint coordination committees that are tasked with resolving disputes amicably and with filling gaps in the agreements as they are implemented. Based on the relevant texts, the committees are meant to meet regularly to facilitate implementation of the agreements, monitor their implementation and exchange information, discuss capacity building programmes, and encourage adoption and harmonization of standards and procedures. The mention in the texts of "harmonization" indicates a strong commitment to advance health worker mobility under these agreements by resolving one element essential to successful mobility: recognition of qualifications. The agreements address part of the necessary framework for the liberalization of health services provision by natural persons, with the committees fleshing out the details subsequently. There is no publicly available information about the establishment, composition, activities and impact of these committees.

We assumed that since there was no limited timeframe for the agreements to remain in force, they must be perpetually in effect until otherwise decided by the parties. It is not clear under the agreements whether the movement envisioned is circular or longer term in nature. Also, with regard to administration of the agreements, disputes that cannot be resolved amicably can be submitted to the regional protocol for dispute settlement within the trading bloc.

As to be expected, qualifications are dealt with in some detail under these regional agreements. Individual agreements set out the requirements for specific categories of health professionals, such as nurses, doctors and dentists. The nursing agreement states that possession of a valid licence from the sending country is required, in addition to 3 years' work experience, compliance with professional development requirements, a certificate of good standing, compliance with other requirements of the receiving country such as local registration and a medical examination. The agreement states that nurses must be able to practise in the language of the receiving country.

With regard to the dentistry agreement, "foreign" dental practitioners (from other countries in the regional trading bloc) must apply for registration. In order to be eligible to practise in the receiving country, they must meet requirements, including: demonstrate certification recognized by sending and host country, have practised for 5 years, possess a certificate of good standing from the sending country, have current registration to practise in the sending country and be compliant with continuing professional development requirements of the country of origin. Of note is that this agreement states that those meeting the requirements "shall be recognized as qualified to practise dentistry" in the receiving country. This is a strong commitment to facilitating the movement of qualified workers within the region. The dentistry agreement explicitly aims at agreement of mutual recognition of qualifications over time. This is similar to the medical professionals' agreement, whereas the nursing agreement differs slightly with a lower level of commitment to mutual recognition.

As is often the case with agreements conducted under the auspices of trade liberalization, these agreements contain a number of exceptions and limitations. For instance, there is the possibility of delaying implementation of the agreements. Also, they contain a safeguard by explicitly recognizing that the receiving countries' medical regulatory authorities are responsible for the protection of health, safety, environment and the welfare of the community and thus may take decisions that override the provisions of the harmonization agreement. Notably, the agreement regarding movement of dentists expressly references the "right to regulate". Also, the "mutual exemption" articles in the dentists' agreement allow receiving countries to impose additional requirements on applicants from other countries, to ensure they are qualified to practise dentistry. The medical professionals agreement, related to the mobility of doctors, specifically mentions the right of the relevant authorities to register foreign professionals to practise – or to refuse.

Category 7: Agreements to establish quality training programmes abroad

Under this category, we reviewed just one agreement. This agreement aims to enhance the health worker education system in the sending country, so it is aligned with the requirements for employment in the receiving country, at the same time providing employment opportunities for the sending country's trained health workers. Whereas some of the agreements emphasizing labour rights, which are described above, commit to provide health worker training in the sending country, this last category of agreement makes this a central tenet of the arrangement, in addition to providing employment and training opportunities in the receiving country for qualified workers who complete their education in the sending country. As with the labour migration agreements that fill gaps in the destination country's health workforce while emphasizing workers' rights, this agreement sets forth provisions protecting the rights of the migrant health personnel.

The respective health ministries, as well as medical and pharmaceutical colleges and other educational institutions, are involved in the negotiation and execution of this agreement, which is automatically renewed on an ongoing basis. This agreement provides for the exchange of data and analysis. Financial arrangements involve in-kind and financial transfers from the receiving country, but these are not explicitly spelled out in relation to all aspects of the agreement.

This is a short main agreement with details set forth in an annex, which lays out the plan for implementation during the period 2015–2022. The text references the sending country's health system development strategy, including parts that relate to training human resources. This indicates that the agreement was negotiated in the context of a broader health care delivery strategy for the sending country. This agreement builds on prior efforts by the sending country to improve its domestic health worker training curricula, including through collaboration with experts from abroad.

The focus of the bilateral agreement is on health worker training and managing migration to the receiving country; it provides for on-the-job training which also supports better health care delivery in that country. The agreement facilitates collaboration between experts, teachers, academic institutions and hospitals to improve health worker training in the sending country. The agreement also provides for teacher exchanges between the two countries. Ultimately, the agreement aims to raise standards for pre-university, university and post-university health education training, to align them with the standards in the destination country. This is done through the delivery of improved curricula (touching on both theory and practice) for six different types of qualifications (nurse, midwife, lab technician, pharmacist, dental technician, nurse epidemiologist hygienist). The destination country commits under the agreement to recruit qualified health workers from the sending country, specifically those trained under the programmes to be built out as a result of this agreement.

Qualifications are dealt with in some detail in this agreement, which works on the assumption that training in the sending country means the health worker meets the qualification requirements to work in the destination country. The agreement provides for both circular and longer term migration.

Provisions in this agreement provide for recruitment under different circumstances. One option is the recruitment of nurses who have fulfilled 3 years of work at home before moving; education plus 3 years working in inpatient or outpatient public medical institution in their home country allows them to be considered to go to the receiving country under this agreement, and there is no return clause in this situation. In addition, new graduates are eligible in the future to go to the receiving country for training, without any return clause, provided they graduate from an institution in the sending country and work for 3 years in the public health system before going to the receiving country.

The agreement sets out several options for training and migration, some of which require return. For instance, health workers from the sending country who are still in the process of completing their training can get on-the-job training in the receiving country but they must return home following a specified training period.

Some approaches set out in the agreement are explicitly aimed at strengthening the health system in the sending country. For instance, one programme provides for emigration with a return clause; qualified high school graduates can obtain training abroad for 3 years, but they have to agree to return home to work for 2 years. Under this programme, the sending country's training institutes for health workers collaborate with the equivalent bodies in the receiving country to provide initial training in the sending country for high school graduates, 4 months of which is paid for by the receiving country's government. The programme includes language training. This is followed by the opportunity for the best students to work abroad in the receiving country for 3 years. If students are not selected following this programme to carry out further training abroad, they can continue their training at home and pay the rest of the tuition.

Parameters for the analysis

As noted earlier, for the descriptions and analysis presented in this paper, we relied largely on the texts of the health worker mobility agreements that were provided to WHO under the Code. On this basis, we sought to identify the goals and needs of the countries negotiating the agreements, as well as the likely impact on their respective health care systems, and on the health workers themselves. We had limited information about the steps taken to actually implement the agreements, or the contexts in which they were negotiated.

Challenges

Our approach, for obvious reasons, has substantial limitations. It is crucial that our work in describing the content of the agreements be supplemented with analysis as to the practical impact of these agreements. This calls for more data collection and evaluation as agreements are implemented.

In particular, it was challenging to evaluate how the agreements fit into countries' broader strategies to upgrade their health care systems. We simply did not have access to information about how the agreements fit into countries' domestic health plans. This alignment with longer term domestic plans and strategies is a critical factor, in our view, for the success of such agreements.

It was perhaps most challenging to assess which country would benefit from each agreement and how. We are not aware of any publicly available data about the impact of health worker mobility agreements on sending and receiving countries' health care systems.

One element of this could involve circular migration, which is implicitly endorsed by most of the agreements but mentioned explicitly in few of them. We did not have

access to data about how many workers actually return home under the agreements reviewed. We assumed that where circular migration does occur, this would mean the source country's health care system benefits from the agreement because workers would bring home additional skills and training. In reality, though, the return of skills to the sending country's health care system is uncertain.

Health workers, like anyone, should be expected to seek the best opportunities for themselves and their families, and they may not return home in all cases. What is more, permanent resettlement is possible under certain health worker mobility agreements. The question as to whether circular migration should be the rule in these agreements deserves further attention and study.

We underscore the lack of information that is publicly available about the agreements, including with regard to basic administrative issues such as whether committees were established and whether the agreements were renewed. In addition to publicizing the texts of the agreements, so that Member States and other stakeholders can learn more about them, we recommend that WHO work towards enhanced reporting and data collection under the Code.

Finally, we note that gender is not directly addressed in any of the agreements reviewed. While texts may seem gender neutral, agreements could certainly be expected to affect men and women differently in the real world. This is widely recognized in connection with trade agreements, for instance. The gender impact of health worker mobility agreements deserves particular attention, given that, depending on the category of health worker, many are female.

Promising practices

We were able to identify some potentially promising practices, based on our assessment of the texts in relation to the three areas mentioned earlier in the paper: first, contribution to orderly health worker mobility; second, the protection of workers' welfare, and third, the preservation or improvement of the health care systems in both countries.

To provide more clarity and legal certainty, along with orderly health worker mobility over the long term, we suggest that the following may be emerging promising practices:

- Certain agreements contain detailed provisions, which can improve legal certainty.
- Some agreements self-renew automatically, which can improve legal certainty.
- Clarity about type of migration, whether circular or permanent, may help both countries to integrate the agreement into broader health care strategies.
- Explicit commitments instead of best endeavours language can lend certainty and potentially improve the chances that obligations are fulfilled.
- Many agreements set up a monitoring body to track progress, identify challenges and suggest ways to remedy them, as well as support broader cooperation.
- Existing overarching framework initiatives can provide a basis to agree programmes with individual countries.

To ensure health workers' rights and welfare:

- Some agreements ensure contracts are provided in advance and provide standard contracts.
- Some agreements commit to equal conditions for foreign and domestic health workers.
- Training opportunities in the receiving country, including language training, are available to the workers under some agreements.
- Entities in the receiving country in some cases must cover the cost of recruitment, rather than the individual.
- Clarity about visa procedures and support offered in securing visa/work permits are helpful.
- Some agreements provided detailed provisions for integration in the host country, including establishment of worker welfare funds.

To ensure both health systems benefit from the agreement:

- Some agreements identify strengthening longer term collaboration as part of the arrangements set forth.
- Qualifications are dealt with in detail in some agreements, which helps to ensure that qualified workers integrate into the receiving country's health system.
- Health ministries are involved in negotiation and execution of certain agreements, if not actually leading the process, to ensure alignment with health needs and goals.
- Entities in the receiving country, under some agreements, must cover the costs of recruitment.
- Tangible commitments to fund or otherwise enhance training in the sending country make it more likely they will be fulfilled; these are preferable to "best endeavours" commitments.
- Some agreements contain provisions for monitoring, data gathering and sharing.

Conclusions

There are many different types of agreements that can affect health worker mobility and, in turn, health care systems. Based on analysis of the texts of the 37 health worker mobility agreements shared with WHO under the Code, along with additional agreements that were notified to WTO, our view is that different formats and types of agreements can be used by Member States to achieve their goals. In other words, there is no one best approach when negotiating a health worker mobility agreement.

Ideally, WHO can be authorized to publish the agreement texts, together with analysis, so that Member States can have the information they require to strategically deploy these agreements.

These agreements appear to be driving health worker mobility in a range of directions and to fill a range of gaps in health care systems, ranging from personnel to skills gaps, from innovation needs to the deployment of new technologies, and from philanthropic support to the creation of new health care infrastructure with the help of outside experts. Again, there is no one ideal format for these agreements. Each has its advantages and disadvantages, and the right choice will depend on the negotiating countries' objectives and context. Each case is unique.

The Code appears to have positively influenced the content of, as well as transparency with regard to, health worker mobility arrangements. As noted earlier, several of the agreements explicitly reference the Code, and others align with its provisions and spirit without explicitly mentioning it. Some WHO Members States have been particularly active in negotiating health worker mobility agreements – and their experiences will be valuable for other countries. We expect that in the coming years, WHO Member States will benefit from the experiences of their peers in using health worker mobility agreements strategically to boost health care systems and workforce training.

We suggest the following actions by WHO might help to build on what has already been achieved under the Code:

- **Empower health ministries to participate in health worker mobility talks:** Our research revealed that health ministries were not always involved in the negotiation and execution of agreements affecting the health care system and workforce, notably health worker mobility agreements. To ensure that public health concerns are integrated into, if not the focus of, these arrangements, health ministries must be informed and well prepared to engage. WHO could raise awareness among health ministries about these agreements, including those concluded under the auspices of economic partnerships, and provide capacity building, as appropriate.
- **Advocate on the Code:** We suggest that WHO continues to raise awareness about the Code and emerging promising practices in relation to its application. Over the last 10 years, the Code has contributed to significantly improved transparency about health worker mobility agreements. It has stimulated the notification of more than 150 regional and bilateral agreements affecting mobility, and the sharing of 37 complete texts. Moreover, there are clear indications that Member States take the Code into consideration when framing their health worker mobility commitments; certain agreements even reference the Code and its principles directly. In this regard, we cite the recent decision by the United Kingdom to explicitly link its international recruitment policy to the Code, including the 2020 Health Workforce Support and Safeguards List.
- **Improve data collection and analysis:** Data collection and analysis about health worker mobility and the relevant agreements should be strengthened. WHO could consider developing templates for reporting under the Code, to ensure the most pertinent information is collected about existing agreements, their implementation and their impact over time. WHO should work with other intergovernmental organizations and stakeholders to analyse the impact of agreements and to support others (notably Member States) in tracking such impacts. To further raise awareness, we suggest a series of case studies illustrating the experience of individual Member States in planning, negotiating and executing health worker mobility agreements.
- **Provide WHO technical assistance:** WHO could consider supporting countries in negotiating agreements that touch on health worker mobility. Guidance and publications can be useful in promulgating best practices. In addition, WHO could support Member States in identifying how health worker mobility agreements fit into their national health strategies. While it can be resource-intensive, we endorse targeted capacity building and technical assistance to be carried out together with partners.

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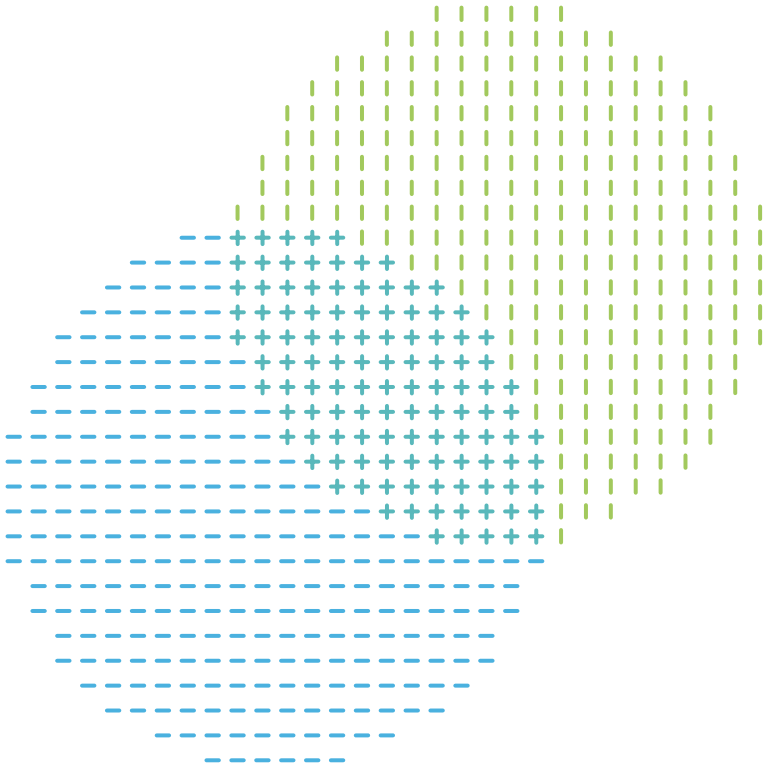


Annex 3. Key stakeholder interviews – health worker mobility agreements

Background

As part of WHO's work to support implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel (the Code), this research sought to identify, describe and study promising practices of health worker mobility agreements to contribute to orderly health worker movement, the improvement of health care systems of both source and destination countries, and the well-being of the health workers themselves.

A series of in-depth interviews with stakeholders was conducted to understand the process and practices in the negotiation, implementation and monitoring of health worker mobility agreements and their impact on the health systems of participating countries and on health worker welfare.

Method

The stakeholders who had direct involvement in the development and/or implementation of health worker mobility agreements were identified initially through a small convenience sample followed by snowball sampling.

A total of 22 stakeholder interviews were conducted. The interviewees included experts from different government entities across source and destination countries, as well as from trade union and advisory bodies (Table A3.1). Migrant health workers were also included.

The interviews took place between November 2021 and January 2022 over Zoom, with verbal consent of participants that their identity would remain confidential. Each interview focused on different aspects of negotiation and implementation of health worker mobility agreements, following an interview guide, in line with the experience and background of the individuals interviewed.

Content analysis of the interview notes was undertaken to explore how the agreements came into being, alignment of the texts of the agreement with implementation, and the successes, challenges and lessons learned during the implementation of the agreements.

Table A3.1 Stakeholder interviews

WHO region	Sector	Gender	Total stakeholder interviews
African (3) Americas (1) South-East Asia (2) European (5) Eastern Mediterranean (3) Western Pacific (6) Global (2)	Health (includes Health and Trade) (10) Foreign affairs (1) Labour (3) Trade union (1) Migrant health workers (3) Advisory body (2) Regulation (2)	Female (10) Male (12)	22

Results

The interviews enabled the identification of certain factors that support the negotiation of health worker mobility agreements that contribute to orderly movement, improved health care and worker welfare – along with challenges that must be addressed. In some cases, factors that have facilitated the negotiation of the agreements are not easily replicated (leveraging personal relationships). In other cases, supporting factors can be identified and put in place (a set process for conducting the negotiations). Interviewees also provided their thoughts as to how WHO can help stakeholders to share information and learn from each other.

This research pointed to the importance of health ministries being, at the very least, briefed about health worker mobility agreements and, ideally, being involved with or leading their negotiation. Such involvement could potentially help to ensure agreements contribute to better health care globally, particularly for the source countries. It was unclear from many of the interviews how the source countries can benefit from health worker mobility agreements, given that they are losing trained health workers who are generally not expected to return home.

The 22 interviewees shed light on the process of negotiating and implementing health worker mobility agreements, contributing to a better understanding than was possible based on the textual analysis alone. The key findings from the interviews are presented below in three broad themes (content and processes of bilateral agreements; challenges; policy implications and the role of WHO) with some illustrative quotes.

Developing bilateral agreements

Most interviewees confirmed that the agreements they had worked to negotiate and implement had been respected in good faith. They provided crucial insights into what works well when putting health worker mobility agreements in place, and implementing them. They pointed to a range of factors that can support the development of sound health worker mobility arrangements:

- A needs assessment carried out prior to negotiation, in terms of health workforce and health care system needs, can confirm the rationale for putting the agreement in place and help to avoid situations where health workers are recruited from countries with shortages. Analysis should ideally be carried out prior to announcing negotiations.
- Embedding the agreement in a broader set of goals, initiatives and/or vision for the relationship between the countries can help to ensure support for the health worker mobility agreement, as well as alignment between the agreement and the overall relationship between the negotiating countries.

"We knew right from the beginning which were the social, economic and other factors we had to deal with and to have support for addressing those was good. Also, the contacts and frameworks for engaging with those countries … the health agreements were really a continuation of the historic relationships with them."

- High-level political support for the arrangement in both countries can help to maintain momentum as the agreement is negotiated, implemented and, ideally, monitored and evaluated.
- A framework for managing negotiation and execution can help to ensure a consistent and efficient process for getting the arrangement in place and then implementing it. A negotiation framework should provide for data collection and analysis at the start of the process, as referenced above.

"Agreements work when there are shared goals, a desire to work together, a shared vision. We always want it to be led and to come from the lower income country. To be based on their needs not ours. When the country itself has articulated that need or desire to have an agreement with us, we will go in and work with them. The country has to be clear about its needs so we can respond. Clear need, clear capacity to support, shared commitment."

- Personal relationships among the negotiating parties can be leveraged to move the project forward. This was the case in relation to certain agreements discussed. For obvious reasons, it's not possible to put this forward as something to replicate purposefully. Nonetheless, this was mentioned by several interviewees as a facilitating factor.
- Committed engagement by specific individuals who give time and effort to make the health worker mobility arrangement a reality can make a significant difference in getting negotiations moving. At the same time, it's not sustainable for these efforts to rely on extraordinarily committed individuals. A team effort can provide more sustainability.
- Cross-government consultations can help to generate coherent positions for each negotiating country (health, industry, labour, trade, foreign affairs). Many interviewees underlined the importance of inter-agency processes to collecting inputs and ensuring agreements reflect the priorities of different agencies, to the extent possible.
- Broad stakeholder engagement was also flagged by many interviewees as essential to developing a health worker mobility agreement (professional bodies, employers, nongovernmental organizations, local workers and government agencies). Consultation with all relevant stakeholders was recognized as strengthening not only the agreement, but also support for its implementation over time.

- Measures to address human elements of health worker mobility must be appropriately prioritized. By the "human element", interviewees meant things like ensuring that migrant workers feel at home in the destination country, that they can interact with others from their own country and have a sense of community, that they have support to learn the language and local customs, etc.
- Appropriate management of recognition of qualifications is important for ensuring that the opportunities available for migrant workers match their experience and training. Qualifications' recognition and management was noted by several interviewees as a necessary but not sufficient condition for a successful health worker mobility arrangement. Ideally, the two countries should compare their education and training systems for categories of health workers, identify any differences, and propose ways to offset those differences to facilitate movement.
- Anticipating and effectively managing concerns from groups that may oppose the agreement was cited by some as an important way of paving the way for a successful health worker mobility arrangement. For instance, local doctors may perceive migrant doctors as less well trained due to differences in education and training in their home country. Management of this situation can help to ensure a good experience for the migrant doctors and improve the outcome from the health worker mobility agreement.
- It was emphasized that public health experts – in particular, health systems experts – must be at the table for each country during negotiations, to gauge the impact of different proposals on the health care systems and workers.
- A mechanism for the parties to consult, update the agreement, and otherwise fill in gaps as the agreement is implemented can help to ensure the agreement is updated as necessary, to ensure it continues to meet the needs of all parties. Interviewees cited joint committees that meet annually, preceded by inter-agency discussions about the agreements and their performance, to provide input into the joint committee meeting, as a positive practice.
- A detailed plan for execution and management of the agreement, developed over time, and reflective of real-world experience and context, can help to ensure the agreement is implemented in a way that aligns with the intentions and objectives of the parties that negotiated it.
- Flexibility to adjust the health worker mobility agreement over time can help to make the agreement a living agreement adaptable to evolving circumstances and needs.
- Data collection and evaluation of the agreement's performance is important for both parties to understand the impact of the agreement on health care systems, migration and workers' welfare, so they can adjust the agreement/approach as necessary.

"We do analyse, together with the partner country, the labour market in the sending country. But we rely on data given to us. This means we can't guarantee a full analysis of the impact on the partner country. Data is very different country to country."

- Investments in health care training or other compensation for the sending country can help to ensure worker mobility does not undermine health care systems in the source countries. One idea that arose during the interviews was for destination countries to take recent graduates only, then invest in their further training once the worker arrives in the destination country; this could help to avoid the departure of more seasoned health workers, while reducing the risk that training programmes established by destination countries in the source countries are underfunded.

Challenges

The interviewees also raised challenges and problems that must be addressed so that health worker mobility agreements provide the maximum benefits for the sending and receiving countries, and for workers.

Something that was not clear from the interviews is how the health care system in the sending country is preserved and improved as a result of the arrangement. This and other challenges should be analysed and possible solutions identified for consideration by countries engaged in negotiations or in the implementation of existing agreements.

- Because it is "early days", so much of negotiating and executing these agreements involves learning by doing. One interviewee pointed out that "there is no manual" for getting the agreements and their execution right.
- Politics can, at times, replace the usual negotiating process, shortcutting the usual processes and potentially undermining the resulting agreement. When handshakes between political leaders result in a commitment to negotiate a health worker mobility agreement before the necessary labour market and health care system analysis can be carried out, the resulting arrangement may be suboptimal.
- When forward movement in health worker mobility talks relies on personal commitment and/or relationships, it may be hard to sustain management of the health worker mobility arrangement. Likewise, it is not feasible to expect to create this dynamic in all situations.

- Scaling the agreements for maximum positive impact can be a challenge. It was noted that a circular training agreement may not be enough to remedy massive health worker outflows from a given country. Also, it was pointed out that an agreement to train a dozen doctors then return them to their home country to practise, while certainly a promising effort, may not significantly improve the health care system of the source country, especially if the doctors are not required to remain in the source country and/or if there are outflows of much higher numbers of doctors.
- The impact on the health care systems in countries with many health workers moving abroad, whether through health worker mobility agreements or other channels, could be expected to be negative. Some interviewees questioned whether remittances or other benefits can offset the potentially negative impacts of health worker outflows on source countries. No interviewee had a definitive answer as to how health worker mobility abroad could be harnessed to improve the health system at home.

"There is a pandemic but we also have a nurse shortage. So the receiving country gets something but the sending country is losing. Our health system is affected negatively."

"We had invested in training these people and they were basically stolen from us – 'recruited' – there should be some support at a minimum for us and the training money we spent. But nobody did this. When you talk with destination countries about this, they say 'we have good salaries, so your people come and are well here'. If not your people, people will come from other places."

- Often there are no needs assessments or guiding principles and goals that accompany the negotiation of an agreement. This lack of data can make it hard to target the agreement appropriately, to ensure that negative impact on the health care systems is avoided.
- Many factors must all work together to create a sound health worker mobility arrangement; negotiating a health worker mobility agreement that works well is a complex undertaking. For instance, a good MRA can facilitate health worker flows, but on its own cannot create space for actual immigration and placement. For this, a commitment to receive health care workers and create the right conditions for them to secure employment is also needed.
- Perceptions of foreign workers may need management domestically, to ensure their qualifications are recognized and respected appropriately, and this can be difficult.
- Different sets of interests must be managed across government agencies and stakeholder groups, and in a global context. Collecting and appropriately weighing stakeholder input, and integrating it into the negotiations, can be a complex, time-consuming process, according to some of the interviewees. It may also require the establishment of new channels for engagement with groups of stakeholders.
- Health worker mobility agreements relate to people, so countries must be considerate of that reality when putting in place health worker mobility arrangements. Sometimes this is overlooked. One interviewee underlined that "health workers are not commodities".
- There tends to be a lack of gender lens in these agreements, even though health care services can be a heavily gendered area of services provision. Interviewees suggested that analysis of issues such as disparate pay for men and women, maternity leave and family reunification could help to ensure that health worker mobility agreements are structured such that men and women can benefit equally.
- Interviewees cited the need for data collection and evaluation to assess how the agreements perform over time. Most countries do not monitor numbers of health workers moving abroad, and they may lose track of their movements over time. At this time, countries do not conduct evaluations of the impact of health worker mobility agreements on health care delivery/systems.

"A big challenge is evaluating these agreements. What happened – and can we report it? How many came, where did they train, what was the impact on individual experience, did they leave or stay? But is this realistic to expect you can follow up with these people for many years? Also, how do you measure transformative impact on the health systems of the countries involved over time? I don't think we can really evaluate that."

- Circular migration is not feasible or reasonable in every case, for different reasons. This may influence the impact of health worker mobility agreements on health care systems, particularly in the source countries which lose skilled workers. This could potentially be offset by facilitating movement abroad only for recent graduates.

"If I could change something it would be to have them only recruit newly licensed nurses. They are currently taking trained and experienced nurses. You must constantly train new staff and this affects quality of care. Just because we are a poorer country should we have this extra burden of constant retraining and, also, our people being cared for by less experienced nurses?"

- Some interviewees noted that it can be hard for migrant health workers to integrate learning from their time abroad into their work upon return. This may be due to resistance from colleagues to changing how things have always been done, lack of relevant equipment or processes, or other factors.
- Some interviewees stated that it can be hard to assess the impact on health care systems of the

agreements and on the workers' welfare, which points to the need for criteria and methodologies for evaluation. At this time, no organization appears to be developing such methodologies.

- Sharing information about positive and negative experiences and learning is difficult because no platform currently exists for this – and perhaps WHO can help. Many expressed an interest in learning from officials from countries that have long had health worker mobility arrangements in place.

"You can't just Google these health worker agreements, or the experiences and the learning associated with them. You can't even find the text of the agreements. When our government became interested to forge a bilateral agreement, it was hard to get information to prepare and get started. So I relied o n personal relationships."

- Certain interviewees pointed out that the Code is not binding and suggested that efforts to move in that direction may be warranted.

Policy implications and the role of WHO

Most interviewees observed that guidance from WHO as to how to optimally prepare for, negotiate and implement different types of health worker mobility agreements could be useful for Member States. Interviewees expressed suggestions about what type of platform or other initiative could be most useful in terms of allowing for exchange of insights and experiences, including the following:

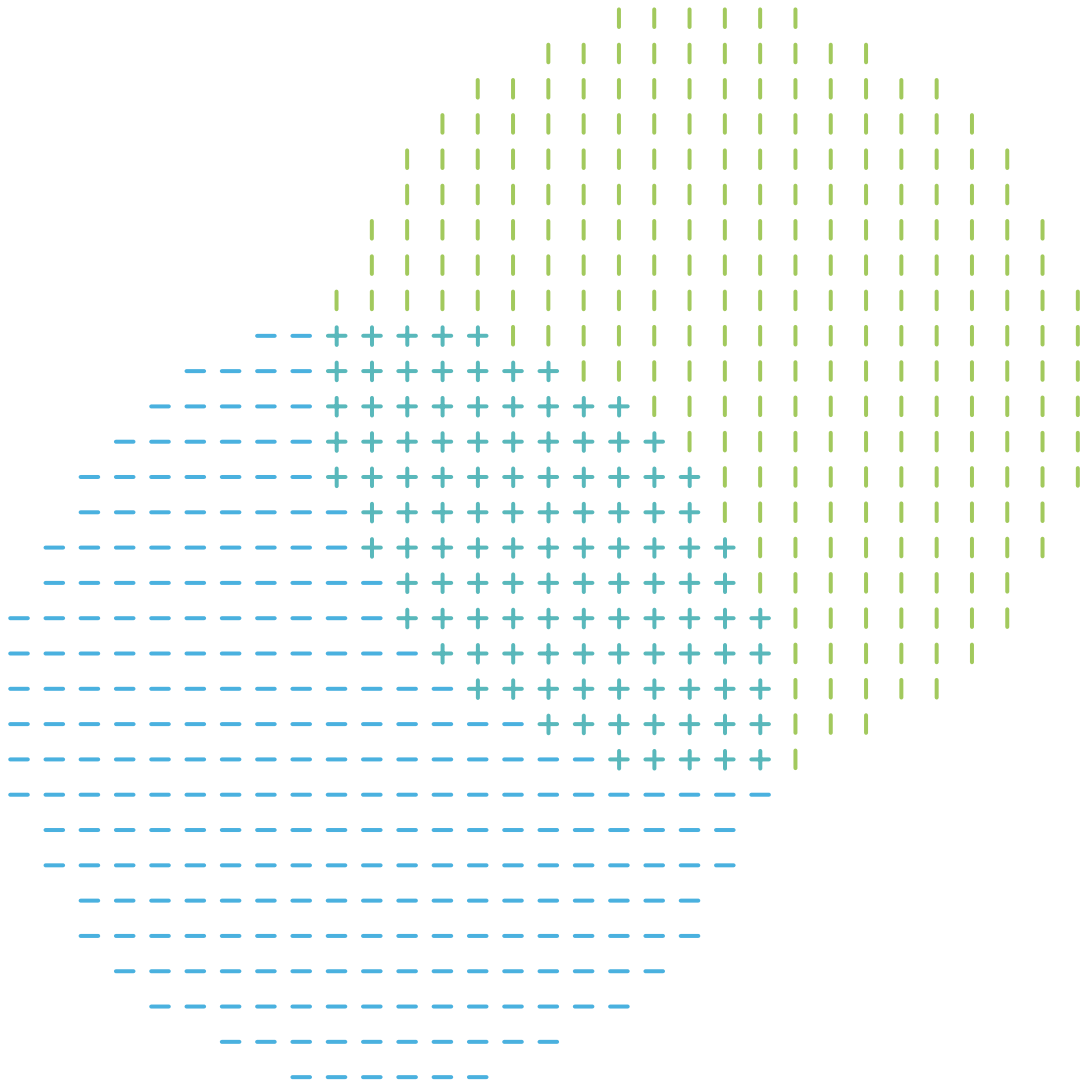
- A repository of texts and other documentation hosted by WHO was viewed as a necessary first step. Interviewees identified this as an "easy" thing to do, but not that useful on its own.
- A repository with detailed information and/or advice as to which steps to follow in the pre-, negotiation and post-negotiation stages could provide useful information for WHO Member States. The repository could include texts of agreements, along with case studies about how they were negotiated and implemented. Eventually, it could contain information about methodologies for evaluating the impact of health worker mobility agreements on health care systems, health worker movement and workers' welfare.
- Creation of a community of practice – a living community and/or network with regular engagement – was viewed as useful by most interviewees. Many suggested that WHO should take on the role of facilitating such interactions.
- Regular exchanges among Member States about their experiences and agreements – to be able to ask questions and get more detailed insights – was similarly prioritized. Many interviewees suggested that WHO should create opportunities for this type of engagement.
- More reporting of texts to WHO was seen as important, in order to increase knowledge of the agreements and transparency.
- More reporting of data and information about implementation of agreements was also considered important as there is little information available publicly about what has happened post-negotiation. In this respect, the onus would be on countries to report more than just the text of health worker mobility agreements, with encouragement and support from WHO.
- Analysis about the impact of the agreements on health care and workers – a true evaluation – was seen as lacking and, here, interviewees saw a clear role for WHO to work with experts to develop and raise awareness about methodologies for this.
- Case studies of health worker mobility arrangements, to provide a snapshot of how they were put in place and how they operate, could be useful in informing WHO Member States about promising practices. WHO could solicit these from governments with substantial experience in negotiating and implementing health worker mobility agreements.
- Interviewees suggested the need for thorough analysis of the different health worker mobility agreements, how they performed over time and their impact. It was suggested that WHO could commission such in-depth studies.
- An explanation of each type of promising practice and how it was implemented in practice was also identified as helpful, with interviewees suggesting that perhaps WHO could develop these types of briefs. In addition to written materials, some of those interviewed recommended that WHO organize seminars and other engagement with academics, experts and practitioners to raise awareness among Member States as to how health worker mobility agreements look and work in practice.
- It was suggested that WHO adopt a higher profile to work to enhance functioning of and respect for the Code.
- WHO could facilitate a dialogue with comparable countries to make sure they are all operating on the same basis in relation to health worker mobility agreements. This could help to secure similar pro-development and pro-health approaches among key destination countries.
- WHO could develop principles to guide specific aspects of negotiating, implementing and evaluating health worker mobility agreements. Integrate a gender lens and analysis into the work, in conjunction with groups with expertise working to dismantle gender gaps in health care services provision.

Conclusions

Based on the in-depth interviews, there are some actions that interviewees recommended be taken by government agencies to ensure that health worker mobility agreements are consistent with and supportive of health care goals in countries of origin and of destination, with the interests of the workers themselves properly addressed. This approach would potentially include the following:

- Before the negotiations, conduct a needs assessment from both a health care and labour perspective.
- Have the health ministry lead the negotiations, as well as the implementation and monitoring. At the very least, the health ministry should be part of the team negotiating the agreement.
- Commit to ensure the agreement will be aligned with the Code, and reference the Code specifically in the text of the agreement.
- Adopt an all-of-government approach, with consultations across government agencies before and during negotiations, and during implementation and evaluation.
- Adopt an all-of-country approach, including engagement with multiple relevant stakeholders on an ongoing basis – including groups potentially opposed to the health worker mobility arrangement.
- Insulate the negotiations from political influence, to the extent possible, by having in place a process for negotiating health worker mobility agreements and following it.
- Identify ways to facilitate the arrival, registration, training and integration of the workers and include that in the agreement, in order to address the "human element" of health worker mobility.
- Create channels to provide personal and professional support for workers, along with potential dispute resolution procedures for all workers coming from abroad. Ensure equal treatment under the law for similarly situated foreign health workers and local workers.
- Consider requiring private recruitment agencies to comply with rules set up under the health worker mobility agreement, to ensure consistency regardless of the channel through which the worker enters the country.
- Identify an appropriate approach to recognition of qualifications, based on objective assessment of the training and education systems of the source and destination countries along with measures to fill any gaps between them.
- Commit to clear, detailed commitments to improve training in the sending country to offset the outflow of skilled health workers – or agree that the destination country can only recruit new graduates, then train them upon arrival to become more specialized.
- Set up a process for filling gaps in the agreement over time, with regular meetings of a joint committee or other mechanism. Preparation for these meetings should involve broad inter-agency and stakeholder consultations.
- Establish a process for data collection regarding the agreement and provide for evaluation of its impact on health care systems, workers' welfare and worker movement.

Annex 4. Other international instruments – main provisions relevant to international migration and mobility of health workers



WHO Global Code of Practice on the International Recruitment of Health Personnel	UN Global Compact for Safe, Orderly and Regular Migration	ILO instruments	WTO GATS	UNESCO Global Convention on the Recognition of Qualifications concerning Higher Education
• *Equal treatment with domestic health workers* • Migrant health personnel should be hired, promoted and remunerated based on objective criteria, such as qualification levels, years of experience and degrees of professional responsibility, on the basis of equality of treatment with the domestically trained health workforce. • Subject to applicable laws, migrant health personnel should enjoy the same legal rights and responsibilities in terms of employment and work conditions, and opportunities and incentives to strengthen their professional education, qualifications and career progression, on the basis of equal treatment with the domestically trained health workforce. • *Self-reliance on health workforce* • Member States should strive to meet their health personnel needs with their own human resources for health, as far as possible and take effective measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country, including areas of greatest need. • *Health systems strengthening* • Member States should consider adopting and implementing effective measures aimed at strengthening health systems,	The **Global Compact** is an inter-governmentally negotiated agreement, prepared under the auspices of the UN, covering all dimensions of international migration in a holistic and comprehensive manner. It is a non-binding document that respects States' sovereign right to determine who enters and stays in their territory and demonstrates commitment to international cooperation on migration. The Global Compact is framed in a way consistent with Target 10.7 of the 2030 Agenda for Sustainable Development in which Member States committed to cooperate internationally to facilitate safe, orderly and regular migration. *The Global Compact is designed to:* • Support international cooperation on the governance of international migration; • Provide a comprehensive menu of options for States from which they can select policy options to address some of the most pressing issues around international migration; and • Give States the space and flexibility to pursue implementation based on their own migration realities and capacities. The actions under the 23 objectives of the Global Compact that are relevant to agreements on health worker migration include, but are not limited to, commitments to:	**International labour migration** *Binding instruments* • All international labour standards, unless otherwise stated, are applicable to migrant workers. These standards include the ten ILO fundamental Conventions identified in the 1998 ILO Declaration on Fundamental Principles and Rights at Work as amended by the International Labour Conference in 2022; the ILO standards on migrant workers, standards of general application, such as those covering protection of wages and occupational safety and health, as well as the governance conventions concerning labour inspection, employment policy and tripartite consultation; and instruments containing specific provisions on migrant workers such as the Private Employment Agencies Convention 1997 (No. 181), the Domestic Workers Convention 2011 (No. 189), and the instruments on social security and on violence and harassment in the world of work. • Migration for Employment Convention (Revised) 1949 No. 97, the Migrant Workers (Supplementary Provisions) Convention 1975 (No. 143), and their accompanying Recommendations Nos 86 and 151. Non-binding instruments • The ILO has two migrant specific ILO Recommendations: Migration for Employment Recommendation	*National treatment* • In the sectors inscribed in its Schedule, and subject to any conditions and qualifications set out therein, each Member shall accord to services and service suppliers of any other Member, in respect of all measures affecting the supply of services, treatment no less favourable than that it accords to its own like services and service suppliers. *Domestic regulation* • With a view to ensuring that measures relating to qualification requirements and procedures, technical standards and licensing requirements do not constitute unnecessary barriers to trade in services, the Council for Trade in Services shall, through appropriate bodies it may establish, develop any necessary disciplines. • Such disciplines shall aim to ensure that such requirements are, inter alia: (a) based on objective and transparent criteria, such as competence and the ability to supply the service; (b) not be more burdensome than necessary to ensure the quality of the service; (c) in the case of licensing procedures, not in themselves be a restriction on the supply of the service. In sectors where specific commitments regarding professional services are undertaken, each Member shall provide for adequate procedures to verify the competence of professionals of any other Member.	*Principles for recognition of qualifications concerning higher education* • Recognition of qualifications should be transparent, fair, timely and non-discriminatory in accordance with the rules and regulations of each State Party, and should be affordable. • Recognition decisions are based on trust, clear criteria, and fair, transparent and non-discriminatory procedures, and underline the fundamental importance of equitable access to higher education as a public good which may lead to employment opportunities. • Recognition decisions are based on appropriate, reliable, accessible and up-to-date information on higher education systems, institutions, programmes, and quality assurance mechanisms which have been provided through the competent authorities of the States Parties, official national information centres, or similar entities. • Competent recognition authorities undertaking recognition assessments shall do so in good faith, giving clear reasons for decisions, and have mechanisms for appealing recognition decisions. • Applicants seeking recognition of their qualifications provide adequate and accurate information and documentation on their

WHO Global Code of Practice on the International Recruitment of Health Personnel	UN Global Compact for Safe, Orderly and Regular Migration	ILO instruments	WTO GATS	UNESCO Global Convention on the Recognition of Qualifications concerning Higher Education
(cont.) continuous monitoring of the health labour market, and coordination among all stakeholders to develop and retain a sustainable health workforce responsive to their population's health needs and adopt a multisectoral approach to addressing these issues in national health and development policies. • Member States should consider strengthening educational institutions to scale up the training of health personnel and developing innovative curricula to address current health needs. • Member States should consider adopting measures to address the geographical maldistribution of health workers and to support their retention in underserved areas, such as through the application of education measures, financial incentives, regulatory measures, and social and professional support. • Member States are encouraged to establish or strengthen and maintain, health personnel information systems, including health personnel migration and its impact on health systems and to collect, analyse and translate data into effective health workforce policies and planning.	• Promote and improve systematic bilateral, regional and international cooperation and dialogue to exchange information on migration-related trends. • Develop human rights-based and gender-responsive bilateral, regional and multilateral labour mobility agreements with sector-specific standard terms of employment. • Review and revise existing options and pathways for regular migration, with a view to optimizing skills-matching in labour markets and addressing demographic realities and development challenges and opportunities. • Expand available options for academic mobility, including through bilateral and multilateral agreements that facilitate academic exchanges, such as scholarships for students and academic professionals, visiting professorships, joint training programmes and international research opportunities. • Invest in programmes that accelerate States' fulfilment of the Sustainable Development Goals with the aim of eliminating the adverse drivers and structural factors that compel people to leave their country of origin, including	*(cont.)* (Revised) 1949 (No. 86), which contains in an annex a Model Agreement on Temporary and Permanent Migration for Employment, including Migration of Refugees and Displaced Persons; and Migrant Workers Recommendation 1975 (No. 151). • ILO Recommendations, while non-binding, provide guidance on how a particular Convention should be applied, or can be a stand-alone instrument providing detailed guidance on certain matters in the world of work. • The ILO Multilateral Framework on Labour Migration (2006) contains non-binding principles and guidelines for a rights-based approach to labour migration, with the scope to assist governments, social partners and stakeholders in their efforts to regulate labour migration and protect migrant workers. • ILO General principles and operational guidelines for fair recruitment and definition of recruitment fees and related costs (2019) aim at promoting and ensuring fair recruitment. The definition of recruitment fees and related costs indicates that workers shall not be charged directly or indirectly, in whole or in part, any fees or related costs for their recruitment.	*Recognition* • For the purposes of the fulfilment, in whole or in part, of its standards or criteria for the authorization, licensing or certification of services suppliers, a Member may recognize the education or experience obtained, requirements met, or licenses or certifications granted in a particular country. Such recognition, which may be achieved through harmonization or otherwise, may be based upon an agreement or arrangement with the country concerned or may be accorded autonomously. • A Member shall not accord recognition in a manner which would constitute a means of discrimination between countries in the application of its standards or criteria for the authorization, licensing or certification of services suppliers, or a disguised restriction on trade in services. *Most favoured nation* • With respect to any measure covered by GATS, each Member shall accord immediately and unconditionally to services and service suppliers of any other Member treatment no less favourable than that it accords to like services and service suppliers of any other country.	*(cont.)* achieved qualifications in good faith and have the right to appeal. *Obligations of the State Parties to the Convention* • Each State Party shall recognize a higher education qualification conferred in another State Party, unless substantial differences can be shown between the qualification for which recognition is sought and the corresponding qualification in the State Party in which recognition is sought. • Alternatively, it shall be sufficient for State Party to enable the holder of a higher education qualification issued in another State Party to obtain an assessment of that qualification, upon the request of the holder. • Each State Party may make the recognition of higher education qualifications acquired through cross-border education or through foreign educational institutions operating in its jurisdiction contingent upon specific requirements of the legislation or regulations of the State Party, or of the constituent unit thereof, or upon specific agreements concluded with the State Party of origin of such institutions.

WHO Global Code of Practice on the International Recruitment of Health Personnel	UN Global Compact for Safe, Orderly and Regular Migration	ILO instruments	WTO GATS	UNESCO Global Convention on the Recognition of Qualifications concerning Higher Education
Orderly migration and mobility • Member States should maintain an updated record of all recruiters authorized by competent authorities to operate within their jurisdiction and to the extent possible, encourage and promote good practices among recruitment agencies by only using those agencies that comply with the guiding principles of the Code. • Member States are encouraged to observe and assess the magnitude of active international recruitment of health personnel from countries facing critical shortage of health personnel and assess the scope and impact of circular migration. • Health personnel should be provided with the opportunity to assess the benefits and risks associated with employment positions and to make timely and informed decisions. • Health personnel should be open and transparent about any contractual obligations they may have and cooperate with regulators and national authorities in the interest of patients, health systems and societies in general. *Support to developing countries* • Bilateral, regional or multinational agreements on health worker migration and mobility should take into account the needs of developing countries through the adoption of appropriate measures that may include the provision	*(cont.)* through poverty eradication, food security, health and sanitation, education, inclusive economic growth, infrastructure, urban and rural development, employment creation, decent work, gender equality and empowerment of women and girls, resilience and disaster risk reduction, climate change mitigation and adaptation, addressing the socioeconomic effects of all forms of violence, non-discrimination, the rule of law and good governance, access to justice and protection of human rights, as well as creating and maintaining peaceful and inclusive societies with effective, accountable and transparent institutions.	**Health** *Binding instruments* C149 – the ILO Nursing Personnel Convention 1977 (No. 149) and its Recommendation No. 157 outline key labour standards, taking into account the special nature of nursing work. In particular, Recommendation No. 157, paragraph 62, refers to bilateral or multilateral arrangements to: A. harmonise education and training for the nursing profession without lowering standards; B. lay down the conditions of mutual recognition of qualifications acquired abroad; C. harmonise the requirements for authorisation to practice. Paragraph 66 states that: 1. "Foreign nursing personnel should have qualifications recognised by the competent authority as appropriate for the posts to be filled and satisfy all other conditions for the practice of the profession in the country of employment; foreign personnel participating in organised exchange programmes may be exempted from the latter requirement. 2. The employer should satisfy himself that foreign nursing personnel have adequate language ability for the posts to be filled.	• The RTAs that meet the requirements of GATS Article V can depart from the MFN obligation of the GATS. • Upon becoming WTO Members certain economies have taken exemptions from the MFN obligation for specific sectors or modes of supply. *Quantitative limit on entry of natural persons supplying services, including based on need* • In sectors where market access commitments are undertaken, the measures which a Member shall not maintain or adopt either on the basis of a regional subdivision or on the basis of its entire territory, unless otherwise specified in its Schedule, limitations on the total number of natural persons that may be employed in a particular service sector or that a service supplier may employ and who are necessary for, and directly related to, the supply of a specific service in the form of numerical quotas or the requirement of an economic needs test. *Support to developing countries* • The increasing participation of developing country Members in world trade shall be facilitated through negotiated specific commitments, by different Members relating to: (a) the strengthening of their domestic services capacity and its efficiency and competitiveness, inter alia through access to	• Each State Party shall establish transparent systems for the complete description of the qualifications and learning outcomes obtained in its territory. • Each State Party, to the extent feasible based on its constitutional, legislative, and regulatory situation and structure, shall put in place an objective and reliable system for the approval, recognition, and quality assurance of its higher education institutions in order to promote confidence and trust in its higher education system.

WHO Global Code of Practice on the International Recruitment of Health Personnel	UN Global Compact for Safe, Orderly and Regular Migration	ILO instruments	WTO GATS	UNESCO Global Convention on the Recognition of Qualifications concerning Higher Education
(cont.) of effective and appropriate technical assistance, support for health personnel retention, social and professional recognition of health personnel, support for training in source countries that is appropriate for the disease profile of such countries, twinning of health facilities, support for capacity building in the development of appropriate regulatory frameworks, access to specialized training, technology and skills transfers, and the support of return migration, whether temporary or permanent. International organizations, international donor agencies, financial and development institutions, and other relevant organizations are encouraged to provide their technical and financial support to assist the implementation of this Code and support health system strengthening in developing countries. *Workforce sustainability in source countries* • To the extent possible, employers and recruiters should be aware of and consider the outstanding legal responsibility of health personnel to the health system of their own country such as a fair and		3. Foreign nursing personnel with equivalent qualifications should have conditions of employment which are as favourable as those of national personnel in posts involving the same duties and responsibilities.	*(cont.)* technology on a commercial basis; (b) the improvement of their access to distribution channels and information networks; and (c) the liberalization of market access in sectors and modes of supply of export interest to them.	

WHO Global Code of Practice on the International Recruitment of Health Personnel	UN Global Compact for Safe, Orderly and Regular Migration	ILO instruments	WTO GATS	UNESCO Global Convention on the Recognition of Qualifications concerning Higher Education
(cont.) reasonable contract of service and not seek to recruit them. • Destination countries are encouraged to collaborate with source countries to sustain and promote health human resource development and training as appropriate and discourage active recruitment of health personnel from developing countries facing critical shortages of health workers.				

Note: The wording of extracts in Annex 4 follows that in the instruments.

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