



World Health  
Organization

REGIONAL OFFICE FOR Europe

# Implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel in the European Region

## A POLICY BRIEF



# Implementing the WHO Global Code of Practice on International Recruitment of Health Personnel in the European Region

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*DRAFT*

*FOR DISCUSSION AT THE REGIONAL COMMITTEE 62, TECHNICAL BRIEFING 2*

## **A POLICY BRIEF**

by

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## Key messages

- *The WHO Global Code of Practice on the International Recruitment of Health Personnel (the “Code”)* is an instrument that can help Member States in designing and implementing fair recruitment and effective utilization of foreign health workers policies.
- The *Code* reaffirms the right to migrate, the duty of recruiting countries to ensure that internationally recruited health personnel enjoy the same legal rights and responsibilities as nationals.
- The *Code* calls upon Member States to avoid actively recruiting in countries facing a health workforce crisis.
- The *Code* guides Member States in the process of strengthening their workforce and workforce policies and planning, to better respond to the health needs of their population in a sustained manner.
- Member States have committed to promoting and implementing the *Code* and to report every three years [at the World Health Assembly] on their progress in doing so.
- In preparation for the first report, due in 2013, the WHO Regional Office for Europe has collected information on progress to date; of 41 Member States (out of 53) with designated national authorities for monitoring and reporting the implementation of the *Code*, 32 reported that they have taken action on disseminating the *Code* and on promoting its application among employers (public and private), recruitment agencies and professional councils and organizations.
- Several countries have taken additional steps to better manage the recruitment and integration of foreign health workers. Some receiving countries have signed agreements with source countries to create conditions that are mutually beneficial.
- Civil society organizations have also been active in promoting the *Code* and supporting and monitoring its implementation.
- Many challenges remain: to engage stakeholders in the health sector and beyond (education, finance, labour, and foreign affairs) in implementing a core set of principles; to build a solid information base on mobility flows of health personnel; to build the national capacity to produce, analyze and disseminate the relevant information; to forecast future health worker needs in terms of numbers and competencies; to design and implement policies responding to those needs; to develop inter-country cooperation in exchanging data, in sharing tools and good practices to better manage the health workforce.
- The role of the WHO Regional Office is to convince Member States to recognize the relevance of the *Code* and the potential benefits of its

implementation. WHO will support the exchange of data and information through its publications and by convening policy dialogues.

- WHO will refine the National Reporting Instrument to better capture the impact of the *Code*, for instance in ensuring that there is no discrimination against foreign health workers, and in triggering efforts in planning and managing more effectively the national health workforce.
- WHO will foster the cooperation between national authorities responsible for the implementation of the *Code* through support to networking and the definition of a common agenda.

### Executive summary

This document describes the status of the implementation of the WHO *Global Code of Practice on the International Recruitment of Health Personnel* in the European Region as of September 2012. The *Code* was unanimously adopted by the 63<sup>rd</sup> World Health Assembly in May 2010 (Resolution WHA63.16).

The *Code's* primary purpose is to promote the fair recruitment and utilization of internationally recruited health workers along with basic principles such as the recognition of the right to migrate, the duty of recruiting countries to adequately inform migrant health workers of their rights, to provide them with the same working conditions enjoyed by nationals, and to avoid recruiting in countries facing a health workforce crisis. It is also an important instrument to guide Member States in the process of strengthening their workforce to better respond to the health needs of their population in a sustained manner.

This Brief summarizes what Member States are expected to do and what support WHO will provide. It then highlights the actions reported by countries to date: 41 of the 53 Member States in the WHO European Region designated a national authority to monitor the implementation of the *Code*, and 36 of them have submitted national reports. Most have taken action to disseminate the *Code*, including translating it into the national language(s), and to encourage stakeholders such as professional councils and organizations, employers and recruitment agencies to abide by its principles. In a number of countries, steps were taken to better inform potential foreign recruits and to support their integration.

The Brief also reports examples of country actions aiming at strengthening the planning and management of the health workforce: actions by Finland, Germany, Ireland, Norway and Switzerland are briefly described. In addition, the Brief summarizes various actions initiated by civil society in a variety of countries, such as Belgium, Germany, Italy, the Netherlands, Poland, Romania, Spain and the United Kingdom. This illustrates that a combination of actions by government and civil society organizations can foster the effective implementation of the *Code*. The Brief concludes by identifying the remaining challenges that Member States and WHO face to move forward towards achieving the objectives of the *Code* and itemizes the steps that need to be taken.

## Policy brief

### Background

In 2004, the World Health Assembly mandated the Director General to develop a non-binding code of practice on the international recruitment of health workers in consultation with Member States and all relevant partners (Resolution WHA57.19). This resulted from the debate about the impact of some high income countries who were recruiting qualified health workers from poorer countries. Concerns had been raised that this had the potential for deleterious effects on the health system capacity of the latter, including their ability to achieve the three health Millennium Development Goals (MDGs) which the international community committed to in 2000 in the *United Nations Millennium Declaration*.

In the following years, negotiations took place among the 193 Member States and on May 21, 2010 the WHO *Global Code of Practice on the International Recruitment of Health Personnel* (the “Code”) was unanimously adopted by all Member States at the World Health Assembly.

The WHO Regional Office for Europe played a leading role in the development of the *Code* and now strongly supports its implementation in the Region. In parallel to engaging Member States in the negotiating process, it combined efforts with the European Commission and the International Organization of Migration to improve analysis and understanding of the phenomenon of the mobility of qualified health workers. The WHO Regional Office for Europe collaborated with the EU funded studies of health worker mobility: Prometheus<sup>1</sup> and MoHProf<sup>2</sup>, which respectively studied 17 EU countries and a mix of 25 countries of Europe, Africa, Asia and North America<sup>3</sup>.

Although mobility flows are difficult to quantify with accuracy, the Prometheus report, using the most recent available OECD data, categorized Switzerland, Slovenia, Ireland and the United Kingdom as having a very high level of reliance (between 22.5% and 36.8% ) on foreign medical doctors; Austria, Belgium, Norway, Portugal, Spain and Sweden, as having high reliance (11.1–18.4%); Germany and Finland having moderate reliance (5.2% and 6.2%, respectively); and Estonia, Slovakia, Poland, Hungary, Italy and France low reliance (less than 5%). Reliance on foreign nurses was negligible in Turkey and Slovakia and relatively low in Spain, Hungary, France, Finland, Sweden, Germany, Portugal and Belgium. Italy is in the moderate reliance category, and the United Kingdom, Austria and Ireland have high or very high reliance on foreign nurses (Wismar et al 2011).

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<sup>1</sup> <http://www.euro.who.int/en/who-we-are/partners/observatory/activities/research-studies-and-projects/prometheus>

<sup>2</sup> <http://www.mohprof.eu/>

<sup>3</sup> The EU is also funding a research project on migrations between Latin America and Europe in which the Pan American Health Organization is involved ([http://www.mpdc.es/index.php?option=com\\_content&task=view&id=58&Itemid=1](http://www.mpdc.es/index.php?option=com_content&task=view&id=58&Itemid=1))

Considering that the EU Commission estimates a shortage of one million qualified health professionals, including 230,000 physicians and 590,000 nurses, by 2020<sup>4</sup>, while other OECD countries are also projecting increasing shortages of health professionals (Buerhaus et al. 2009, Health Workforce Australia, 2012), the implementation of the *Code* and of its principles at global level is of critical importance. These shortages may bring richer countries experiencing them to recruit abroad, and this may affect the exodus of professionals from poorer countries aspiring for better wages, working conditions and opportunities for professional growth and development.

### ***What is in the Code?***

The *Code* includes a preamble and ten articles covering the following: objectives; nature and scope; guiding principles; responsibilities, rights and recruitment practices; health workforce development and health systems sustainability; data gathering and research; information exchange; implementation of the *Code*; monitoring and institutional arrangements; and partnerships, technical collaboration and financial support

The *Code* enunciates principles for the ethical international recruitment of health personnel. These include the recognition of the right to migrate, the duty of recruiting countries to adequately inform migrant health workers of their right and to provide them with the same working conditions enjoyed by nationals. Another important principle is to avoid recruiting actively in countries facing a health workforce crisis<sup>5</sup>.

The *Code* goes beyond setting norms for recruitment practices and addresses that issue in the broader context of the need for stronger and more self-reliant health systems. It promotes the planning of the education and training of health workers to meet future service needs and the development of working environments facilitating the retention of personnel.

The *Code* also proposes a framework for global dialogue and cooperation to address challenges associated with the international mobility of health workers. The *Code* offers examples of good practices such as integration programs of migrant health workers, bilateral agreements to regulate migratory flows, and strategies to promote and support circular migration to the benefit of sending and receiving countries.

### ***What are countries expected to do?***

In adopting the *Code*, countries committed to taking its principles and recommendations into account when developing and implementing health sector employment policies and

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<sup>4</sup>European Commission Staff Working Document on an Action Plan for the EU Health Workforce Strasbourg, 18.4.2012 - SWD(2012) 93 final

[http://ec.europa.eu/dgs/health\\_consumer/docs/swd\\_ap\\_eu\\_healthcare\\_workforce\\_en.pdf](http://ec.europa.eu/dgs/health_consumer/docs/swd_ap_eu_healthcare_workforce_en.pdf)

<sup>5</sup> The World Health Report 2006 (WHO 2006) identified 57 countries facing a health workforce crisis severely limiting their capacity to deliver the services which their population needs.

practices. This includes promoting and implementing fair labour practices for all health personnel and striving to meet their needs through appropriate education, recruitment, deployment and retention health workforce policies.

Countries which primarily “receive” health workers from abroad are expected to encourage and facilitate circular migration to the benefit of source countries. This implies the adoption of enabling measures such as bilateral agreements facilitating the temporary return of migrant health workers to their country of origin to practice or to train national personnel.

In terms of the monitoring and reporting requirements, governments should first designate a national authority responsible for the implementation of the *Code* and periodically report on progress achieved as well as cooperate in the exchange of information with WHO and with other countries. This authority should disseminate the *Code*, which in many countries will require its translation in the national language(s). Ministries of Health and other government agencies employing qualified health personnel should avoid recruiting from countries facing critical shortages and discourage national private organizations from doing so.

#### ***What is WHO expected to do?***

As a technical agency, WHO’s role is to support countries in the dissemination of the *Code*, e.g. helping with translation, to provide guidelines for minimum data sets on the health workforce in general and specifically on mobility of health workers, and to give access to information on good practices on the implementation of the *Code* and generally on health workforce development.

At the regional level, WHO will monitor the progress and constraints in the implementation of the *Code* through a National Reporting self-assessment tool covering the following topics: legal rights of migrants, bilateral agreements, research on health personnel mobility, statistics, and regulation of authorization to practice.

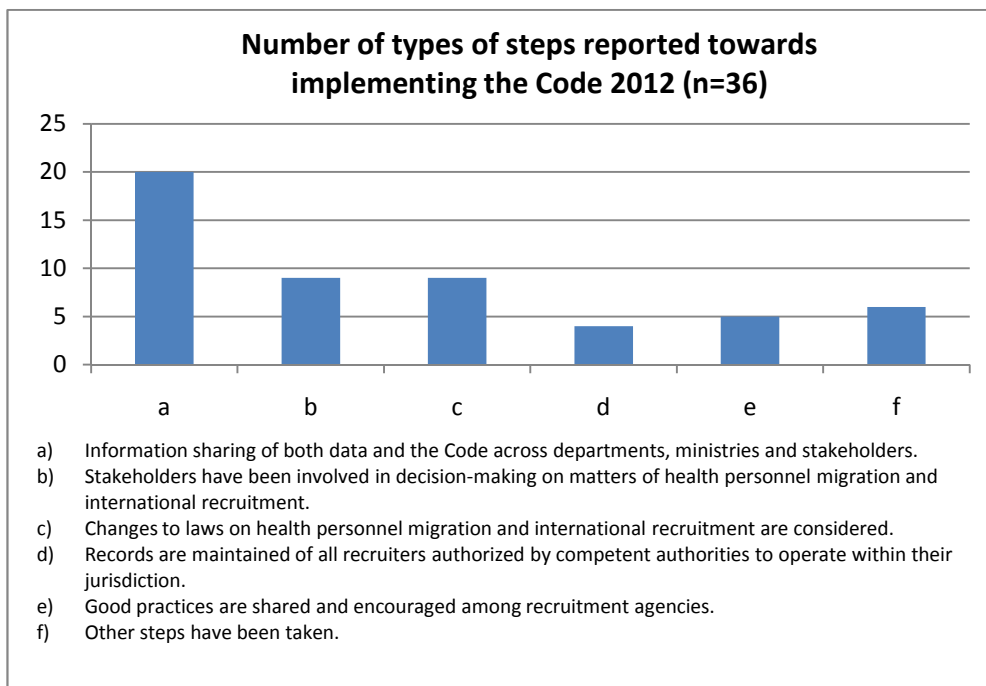
#### ***Progress to date: (1) actions by Member States in the region***

Actions by Member States of the WHO European Region can be summarized as follows:

- Designated National Authorities (DNA) for monitoring and reporting the implementation of the *Code* have been established in 41 of the 53 Member States (Annex 1).
  - 36 are in the Ministry of Health
  - 5 are in research institutions
- 36 Member States have completed the National Reporting Instrument and submitted the reports to the WHO Secretariat (Annex 1);
  - 7 of them reported that no steps have been taken towards implementing the *Code* other than designating an authority to take responsibility of the process.



Reported actions directly related to the *Code* include its translation into the national language<sup>6</sup>, its dissemination to relevant stakeholders including recruitment agencies and employers, providing information to potential migrant health workers, bilateral and multilateral agreements, and information and data exchange. Five countries report that stakeholders have been involved in decision-making on matters of health personnel migration and international recruitment. Six countries reported that they are considering changes to laws on these issues, and in three countries, data is collected on recruiters authorized by competent authorities to operate within their jurisdiction. Finally, three countries indicated that good practices are shared and encouraged among recruitment agencies. Most of the twenty countries which reported actions focused on raising awareness as the first step in the implementation of the *Code*.



Other actions which had already started before the adoption of the *Code* and which are in line with its objectives are continuing and even have been strengthened.

A number of **bi- and multilateral agreements** on the recruitment of health personnel are reported. Some are between neighboring countries:

- Cyprus-Greece
- Denmark-Finland-Iceland-Norway
- Monaco-France and the Netherlands

Some between high and lower income countries:

- Italy-Tunisia
- Germany-Croatia
- Qatar-Armenia
- UK-Libya

And at least one between two lower income countries:

- Tajikistan-Yemen.

<sup>6</sup> It is available from WHO in English, French, Russian and Spanish:  
<http://www.who.int/hrh/migration/code/practice/fr/index.html>

Most agreements predate the adoption of the Code, but they respect its principles of better planning of migration flows and ethical recruitment practices.

An example of multilateral agreements is that of **Mobility Partnerships**: these are “non-legally binding frameworks for well-managed movements of people between the EU and a third country” which EU Member States join on a voluntary basis. A recent case is that of a partnership with Armenia in 2011 in which ten EU countries<sup>7</sup> participate. The Mobility Partnership with Armenia is the fourth MP, following those launched with Moldova and Cape Verde in 2008 and with Georgia in 2009<sup>8</sup>.

With regard to actions in relation to the planning and management of their national workforce, twelve countries report that they have pursued efforts towards creating a more reliable data and information base in government agencies or national research centers. Eighteen countries have mechanisms to regulate the authorization to practice by internationally recruited health personnel and maintain statistical records on these authorizations. Eighteen countries keep statistical records of health personnel whose initial qualification was obtained in a foreign country. National reports do not provide details on the type of data collection mechanisms and institutions, which make it difficult to assess the quality of information and their cross-national comparability. Five countries (Albania, Finland, Latvia, Slovenia and Turkey) have established a database of laws and regulations related to international health personnel recruitment and migration.

With regard to **recruitment practices**, twenty reports state that foreign health professionals are recruited on the basis of the same criteria as national ones and seventeen specify that foreigners have access to the same education opportunities. The extent to which these principles are applied on the ground is difficult to assess, even in countries where laws exist to prohibit discrimination<sup>9</sup>. Foreign health personnel typically face higher information costs in their home country, and lack of knowledge of the language of the destination country and of the expectations from employers make access to employment potentially more difficult. Providing access to relevant information to potential migrants is a strategy to help them; examples of good practice are observed in a number of countries.

**Finland** is a country with a tradition labour market planning, and the maintenance of a sufficient workforce in the social and health care sector is treated as a priority. The Ministry of Social Affairs and Health in collaboration with relevant national agencies, defines norms on international recruitment in accordance with the *Code*. The Finnish

<sup>7</sup> See <http://europa.eu/rapid/pressReleasesAction.do?reference=IP/11/1257&type=HTML>; the following countries participate in the Mobility Partnership with Armenia: Belgium, Bulgaria, the Czech Republic, France, Germany, Italy, the Netherlands, Poland, Romania and Sweden

<sup>8</sup> Moldova; [register.consilium.europa.eu/pdf/en/08/st09/st09460-ad01.en08.pdf](http://register.consilium.europa.eu/pdf/en/08/st09/st09460-ad01.en08.pdf) .  
<http://europa.eu/rapid/pressReleasesAction.do?reference=IP/08/893&guiLanguage=en%20>. Cape Verde:  
[register.consilium.europa.eu/pdf/en/08/st09/st09460-ad02.en08.pdf](http://register.consilium.europa.eu/pdf/en/08/st09/st09460-ad02.en08.pdf);  
<http://europa.eu/rapid/pressReleasesAction.do?reference=IP/08/894&guiLanguage=en>. Georgia:  
[www.consilium.europa.eu/uedocs/cms\\_data/docs/pressdata/.../111525.pdf](http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/.../111525.pdf);  
<http://europa.eu/rapid/pressReleasesAction.do?reference=IP/09/1853&type=HTML>

<sup>9</sup> Countries which report such laws indicate that they apply to all sectors and do not contain specific provisions for the health sector.

Institute of Occupational Health launched “Developing fair recruitment practices”, to promote non-discriminatory recruitment practices for a more culturally diverse workforce. Its objective is to increase awareness of national legislation, EU directives and ILO policies regarding fair recruitment and selection practices. It promotes “sustaining diverse talent” through mentorships, recognition of cultural and values differences, and offers support to career development and training in multicultural communication and management. In Finland, there are mechanisms to facilitate information flows between foreign job seekers and domestic employers, to integrate immigrant workers and to coordinate recruitment activities by the various stakeholders. The Ministry of Social Affairs and Health translated the *Code* into Finnish and posted it on its website; professional organizations also provide information in English to immigrant health care professionals on their website<sup>10</sup>. Local government employers have established a network that supports the process of international recruitment and the exchange of experiences in employing immigrants. The National Supervisory Authority for Welfare and Health (Valvira) which grants rights to practice provides information in English on relevant legislation, on the application process, on language requirements for practicing medicine, nursing and other professions in health care along with useful contact information<sup>11</sup>. *Attractive Finland*, a project developed by the National Institute for Health and Welfare in 2008-2010 with support from the European Social Fund, provided a framework for the international recruitment of nurses by the City of Helsinki and by the Helsinki Uusimaa Hospital District. It promoted bilateral cooperation and networks for cooperation in the recruitment of foreign employees<sup>12</sup>. Finally, Statistics Finland maintains a register of foreign health care professionals.

In **Germany**, at least three projects aimed at promoting mutually benefiting mobility flows between Germany and countries of origin of workers, including in the health sector, who migrated or who belong to families of immigrants.

- (1) The Returning Experts Program helps qualified workers trained in Germany, but originally from low and middle income countries, in collaborating with their country of origin<sup>13</sup>. It offers financial support (travel costs and salary top-up in country of origin) and access to professional networks. It is implemented by the Centre for International Migration and Development (CIM) on behalf of the Federal Ministry for Economic Cooperation and Development (BMZ). This has already interested more than 11000 experts from all sectors and from all parts of the world since 1980, with a concentration from Asian countries (215 in 2010)<sup>14</sup>.
- (2) The Triple-win Migration pilot project intends to enhance the potentially positive effects of circular migration and reduce its risks for three parties: origin

<sup>10</sup> Finnish Medical Association: [www.laakariliitto.fi/files/Guide\\_for\\_foreign\\_Doctors\\_working\\_in\\_Finland.pdf](http://www.laakariliitto.fi/files/Guide_for_foreign_Doctors_working_in_Finland.pdf) ; Finnish Dental Association: [www.hammaslaakariliitto.fi/dentistry-in-finland/](http://www.hammaslaakariliitto.fi/dentistry-in-finland/); Union of Health and Social Care Professionals [www.tehy.fi/en/about-us/about-finland/helpful-links/](http://www.tehy.fi/en/about-us/about-finland/helpful-links/), Finnish Nurses Association: [www.nurses.fi/nursing\\_and\\_nurse\\_education\\_in\\_f/](http://www.nurses.fi/nursing_and_nurse_education_in_f/) ; Finnish Union of Practical Nurses: [www.superliitto.fi/en](http://www.superliitto.fi/en)

<sup>11</sup> [www.valvira.fi/en/licensing/professional\\_practice\\_rights](http://www.valvira.fi/en/licensing/professional_practice_rights)

<sup>12</sup> See [www.thl.fi/thl-client/pdfs/c542a578-9a22-4291-a191-87d46ba03e2c](http://www.thl.fi/thl-client/pdfs/c542a578-9a22-4291-a191-87d46ba03e2c)

<sup>13</sup> See: [www.zav-reintegration.de/default.asp?lng\\_main=en](http://www.zav-reintegration.de/default.asp?lng_main=en)

<sup>14</sup> See: [www.migrantservicecentres.org/userfile/Johannes%20Schilling.pdf](http://www.migrantservicecentres.org/userfile/Johannes%20Schilling.pdf)

country, destination country and migrant workers. The 2-year project started in 2011 and consists in developing, testing and evaluating a “coherent overall management system for temporary labour migration”. It targets engineers from Vietnam and Indonesia and to health workers from Bosnia-Herzegovina and Albania. It offers placement services, supports preparation to migrate and advises on status issues in Germany<sup>15</sup>.

(3) Germany also participates in the “*Mobility partnerships*” mentioned above.

**Ireland’s** Health Service Executive (HSE) is exploring collaborative arrangements, including bilateral agreements with a number of countries, to address issues related to the recruitment of health personnel, circular migration, training, and capacity building in source countries. In February 2012, Ireland joined the European ESTHER Alliance<sup>16</sup> which promotes twinning between European hospitals and other health institutions in low income countries to strengthen capacities in the fight against HIV/AIDS and its associated infections. Ireland’s ESTHER program will be implemented under a Memorandum of Understanding (MOU) between the HSE and Irish Aid, and will focus on strengthening the health workforce in partner institutions.

In **Norway**, the Directorate of Health has translated the *Code* into Norwegian and posted it on its website<sup>17</sup>. It requires recruitment agencies to put the WHO *Code* on their web site and comply with its principles. It has promoted the *Code* in various settings (regional government authorities, the association of higher education in health and healthcare services) and has encouraged relevant professional organizations, stakeholders and private recruitment companies to publish it on their website and to commit to its principles. Two national seminars have been organized (2011, 2012) to raise awareness of the *Code* among relevant stakeholders and authorities from other sectors, public and private, academia, professional associations, hospitals, the Norwegian Association of Local and Regional authority, NGOs, recruitments companies etc. At the World Health Assembly 2012, Norway, which has been a leader in the international negotiations which led to the adoption of the Code, received the Health Worker Migration Initiative award from the Health Worker Migration Policy Council “for establishing ethical international recruitment, building sustainable health systems both in Norway and abroad, health workforce development, supporting developing countries, collecting and reporting data to the WHO, setting up formal training for unskilled migrant workers and ensuring fair treatment of migrant health personnel”.

Finally, in **Switzerland**, the Federal Department of Foreign Affairs has signed bilateral agreements with a number of countries, in accordance with an interdepartmental framework “intended to ensure a coherent Swiss migration policy (...) that operates in the interests of all partners by promoting the positive sides of migration while also providing a constructive framework within which to solve the challenges it poses”<sup>18</sup>. These agreements, which are not specific to the health sector, have objectives ranging from strengthening the state structure in the country of origin, to managing integration

<sup>15</sup> See: [www.wapes.org/infos/filestream.jspz?idfile=11748](http://www.wapes.org/infos/filestream.jspz?idfile=11748)

<sup>16</sup> See: [www.esther.eu/](http://www.esther.eu/)

<sup>17</sup> [www.who.int/hrh/migration/code/WHO\\_CODE\\_NationalReportingInstEn.pdf](http://www.who.int/hrh/migration/code/WHO_CODE_NationalReportingInstEn.pdf)

<sup>18</sup> [www.eda.admin.ch/eda/en/home/topics/migr/migpa.html](http://www.eda.admin.ch/eda/en/home/topics/migr/migpa.html)

in Switzerland, to harmonizing visa policy and twinning of educational institutions. Such a partnership was signed with Nigeria in 2011.

In sum, the adoption of the *Code* has triggered various initiatives by countries of the Region and encouraged those that were already active on matters of fair international recruitment to further pursue their objectives.

### ***Progress to date: (2) actions by civil society***

Well before the adoption of the *Code*, European NGOs raised the issues of fair recruitment, the need for retention strategies, the importance of data sharing, while reaffirming the rights to mobility and to work, as well as the obligation for states to provide essential health care for all its citizens. This advocacy was coordinated with international professional organizations such as the World Medical Association, the International Council of Nurses and Public Services International. Civil society organizations have requested the setting up of frameworks to regulate migratory flows of health workers and have proposed models (Dhillon et al. 2010).

WEMOS, a Dutch organization advocating for the right to health and health equity within international policies, Member of the Medicus Mundi International (MMI) network and chair of its HRH working group<sup>19</sup>, has collected examples of civil society actions in relation to the *Code* in nine countries:

- In **Belgium**, Be-Cause Health, the Belgian platform on international health, has a working group that exchanges good practices and knowledge on health workforce. It supports the implementation of the *Code* at national level. In June 2012, this group conducted a multi-sectoral expert workshop, resulted in the adoption of the charter on health workforce strengthening by all stakeholders. Belgium will take up the issue of the implementation of the *Code* further as a Member of the WHO - Executive Board since May 2012.
- In **Germany**, Terre des Hommes and OXFAM have been working on health workforce strengthening as part of the *Action for Global Health Network (AFGH)*, a network present in France, Germany, Italy, the Netherlands, Spain and the UK that advocates for sustained health investments as part of development cooperation<sup>20</sup>. Its report (AFGH2011) describes domestic policies on human resources for health as well as the effect of health workforce shortage in some source and destination countries. Following-up on this report, stakeholder dialogues were held to discuss priorities in implementing the *Code*. The next step is to develop a foreign health policy group that will work on health

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<sup>19</sup>See <http://www.medicusmundi.org/en/network-programs/mmi-program-who-code-of-practice>

<sup>20</sup> See <http://www.actionforglobalhealth.eu/index.php?id=4>

workforce strengthening and *Code* monitoring<sup>21</sup>. AFGH also runs the Health Heroes campaign<sup>22</sup>.

- In **Italy**, from March – June 2012, AMREF, an organization promoting lasting health change in Africa, initiated a campaign called “Personale sanitario per tutti” (“Health workers for all”), focused on the shortage of health workers, estimated to be 35.000 per year, migration and rights of health workers from Eastern-Europe and non-EU countries and on the obligation of the Italian state to implement the *Code*. With other partners, it produced a Manifesto with 9 recommendations (AMREF-Italy 2102). More than 80 organizations have now signed the Manifesto, which has received ample attention in the media. In May 2012, a consultation was conducted with relevant ministries and government agencies, the designated national authority, and WHO to agree on the steps to implement the *Code* during 2012-2015. Commitment to strengthen the health workforce was expressed by the relevant ministries, but it has proven so far difficult to engage the autonomous regions, as well as private employees and recruiters.
- In **The Netherlands**, WEMOS launched in 2009 the Dutch multi-sectoral Human Resources for Health Alliance that promotes sustainable health workforce issues at national and international level. Through the media and publications, it has influenced parliamentarians, employers and the Ministry of Health to limit the recruitment of foreign health workers and to develop covenants for diversifying and expanding the national workforce. The Alliance has produced a policy brief with recommendations for actions and policies for strengthening the sustainability of the health workforce and national self-reliance (WEMOS 2010). The Alliance conducted roundtable discussions with relevant stakeholders on the implementation of the *Code* in 2010 and 2011. This contributed to raise awareness about the problem, and to propose measures to reduce migration from outside the EU.
- In **Poland**, which is simultaneously a source and a destination country, including for medical students, Redemptoris Missio, a humanitarian aid foundation, works with the Medicus Mundi International network to promote awareness of global health problems. It has launched multi-sectoral discussions with policy makers to address the issue of migratory flows in the context of the forecasted deficit of health workers within the EU.
- In **Romania**, the Center for Health Policies and Services (CHPS) has conducted a number of “Opinion barometers” studies at national level, covering issues of quality of care, health worker distribution, job satisfaction, professional training, etc. The Ministry of Health uses the reports for policy guidance. CHPS plans to conduct stakeholder dialogues on the mobility of health workers and how they can be retained for the national health system and underserved areas.

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<sup>21</sup> AFGH. Teeth for the tiger: Action for Global Health conference 2012. <http://www.actionforglobalhealth.eu/blog/?p=1634>

<sup>22</sup> See: [www.healthheroes.eu](http://www.healthheroes.eu)



- In **Spain**, the Federation of Medicus Mundi Spain together with the Spanish AFGH network monitors Spain's activities in international health development cooperation, including health workforce strengthening. An annual report is produced each year (Medicus Mundi Spain 2011). In June 2011 a multi-sector dialogue was held with the Ministry of Health on the implementation of the *Code* and how to continue its implementation<sup>23</sup>.
- In **Switzerland**, the Medicus Mundi Switzerland network has a working group focusing on health workforce within foreign policies of the Swiss government. The network produced a manifesto in January 2012 on health workforce migration in collaboration with professional associations and labour unions (Medicus Mundi Switzerland 2012). The network is part of an international health dialogue group that discusses Swiss global health strategies with the ministries. The network held discussions with the designated national authority and other departments and contributed to the commitment of Switzerland to further implement the *Code* and take its principles into account in its foreign health policies.
- The **United Kingdom** has a long history of addressing the issue of recruitment of health workers from countries with shortages. The Department of Health in England developed guidelines on international recruitment in 1999 and introduced a code for the international recruitment of healthcare professionals in 2001 which was strengthened in 2004. This code covered the National Health Service and some private sector employers. In the development sector, the AFGH Working Group on Human Resources for Health has been closely involved with policymakers during the lead up to the adoption of the *Code* in 2010. For example, Voluntary Service Overseas (VSO), an international non-governmental development charity, published a report on "Brain Gain – Making Health Worker Migration work for Rich and Poor Countries" in 2010<sup>24</sup>. Health Poverty Action is part of the AFGH working group on HRH and has been closely involved with policymakers in supporting the adoption of the *Code* in 2010. It has close relations with the UK All-party parliamentary group (APPG) on global health, which has recently released a report on improved skill –mix as a way to overcome the global health workforce crisis (APPG, 2012). The UK has signed bilateral cooperation agreements with Brazil, China, Libya, Saudi Arabia, and South Africa, which include collaboration on "human resources for health issues, focusing particularly on health workforce analysis and planning".

WEMOS concluded the following from the analysis of the experience of these nine countries:

- Health workforce policies should not be addressed in isolation but become part of national global health strategies, drafted by a multi-sectoral government agency in consultation with NGOs and professional associations. This global health strategy should be discussed and approved by Parliament. Part of its focus should be on the need for self-sustainability.

<sup>23</sup> See <http://www.actionforglobalhealth.eu/blog/?p=1219>

<sup>24</sup> [www.vso.org.uk/.../Brain%20Gain%20Report\\_FINAL%20lores1\\_tcm79-28845.pdf](http://www.vso.org.uk/.../Brain%20Gain%20Report_FINAL%20lores1_tcm79-28845.pdf)

- The Development NGOs working on global health workforce issues should liaise with other civil society actors that have a stake in national workforce development; e.g. labor unions, medical associations, patient and consumer organizations, etc.
- Civil Society Organizations (CSO's) can promote and monitor fair, binding, bilateral and multilateral agreements on a balanced health workforce, within the EU as well as with other countries.
- CSO's can promote and become part of national HRH observatories that systematize and monitor data on health workforce developments and mobility.
- CSO's can look further into the mobility of informal and less-formalized health workers like auxiliary nurses or volunteer caregivers within a social or family context. The stress on social protection systems pushes for more care to be conducted in the informal sector. It is in these sectors that there is a growing trend of workforce mobility within and to the EU.

At the regional level, the **European Hospital and Healthcare Employers' Association** (HOSPEEM) and the **European Federation of Public Service Unions** (EPSU) have signed a code of conduct on ethical cross-border recruitment and retention to address inequalities and unnecessary burdens on healthcare caused by unethical recruitment practices. It is also worth mentioning that the importance of the *Code* is recognized by the EU strategy on Global Health<sup>25</sup>.

Civil society will continue advocating at the regional level that health workforce mobility within the EU as well as health worker migration from countries outside the EU should not undermine international human rights agreements.

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<sup>25</sup>EU Council conclusions on the EU role in Global Health. 10May 2010, [http://www.eu-un.europa.eu/articles/en/article\\_9727\\_en.htm](http://www.eu-un.europa.eu/articles/en/article_9727_en.htm)



## Challenges and next steps

As the deadline for the first Report to the WHA approaches, there remain many challenges to address and obstacles to overcome in achieving full implementation of the *Code*. The main challenge is to engage various stakeholders in the health sector and beyond (education, finance, labor, and foreign affairs), who have different interests and objectives, in implementing a unique core set of principles.

Each country faces the need to balance individual rights of health workers and the duty to provide health services to all its citizens. Designated National Authorities who filled in the National Reporting Instrument identified the **lack of awareness of the Global Code amongst stakeholders** as the first obstacle to overcome confirming a preliminary evaluation of the implementation of the *Code*: “Despite pressing demands for globally regulating the international recruitment of health workers, there is currently only limited awareness of the *Code* among national and sub-national actors involved in recruitment to the four English-speaking developed countries with the greatest numbers of migrant health workers. Awareness for and prioritization of particular health issues at the global level does not guarantee awareness at the national or sub-national level” (Edge, Hoffman 2011).

**Better collaboration and coordination of all stakeholders** such as government agencies, registration bodies, professional associations, education institutions, and employers of health workers is needed at various levels, starting with the development of reliable databases on the health labour market, including on mobility flows in and out of the country. **Sound information** is the main ingredient in building strategies to raise stakeholders’ awareness of the importance of health workforce issues and of the support which the Global *Code* can bring in addressing them.

A related challenge in many countries is to **build and strengthen the national capacity** to produce, analyze and disseminate the relevant information, to forecast future health worker needs in terms of numbers and competencies, to design and implement health workforce policies responding to those needs, and to mobilize the stakeholders and coordinate their actions in their support.

Another challenge is to **develop inter-country cooperation** in exchanging data, in sharing tools and good practices to better manage the health workforce. Countries which lose health workers to the benefit of others are not always in a position of strength to discuss agreements on ways to mitigate the negative consequences of their losses. The *Code* provides a framework which they can use to that purpose.

The role of the WHO Regional Office is to bring Member States to recognize the relevance of the *Code* and the potential benefits of its implementation. In addition to providing information on the *Code* itself, WHO will support the exchange of data and information through its publications and by convening policy dialogues. It will collaborate with initiatives such as the Joint Action on Health Workforce Planning and Forecasting to be launched in December 2012 by 18 EU countries.

As it will review and analyze country reports in preparation of the WHA 2013, WHO will refine the National Reporting Instrument to better capture the impact of the *Code*, for instance in ensuring that there is no discrimination against foreign health workers,

and in triggering efforts in planning and managing more effectively the national health workforce.

Finally, WHO will foster the cooperation between national authorities responsible for the implementation of the *Code* through support to networking and the definition of a common agenda.

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## Annex 1. Designated national authorities (up to 30 August, 2012)

<b>Country (*=report not yet submitted)</b>	<b>Institution</b>	<b>Contact person</b>
Albania	Ministry of Health	Ms Mirela Meko
Armenia	Human Resources Department, Ministry of Health	Dr Samvel Soghomonyan
Austria	Federal Ministry of Health – Department II/A/2 General Legal Affairs and Health Professions	Dr Meinhild Hausreither
Azerbaijan	Public Health and Reforms Centre, Ministry of Health	Dr Malik Kerimbekov
Belarus	Republican Scientific-Practical Centre of Health Technologies, Informatization, Management and Economics	Dr Marina Satchet
Belgium	SPF Santé Publique, Sécurité de la Chaîne Alimentaire et Environnement Service des Relations Internationales	Mr Daniel Reynders
Bosnia and Herzegovina	Ministry of Civil Affairs, Health Sector	Dr Drazenka Malicbegovic
Cyprus	Ministry of Health	Mr Despo Chrysostomou
Czech Republic	Ministry of Health	Ms Katerina Pribylova
Denmark	National Board of Health, Ministry of Health	Ms Birte Obel
Estonia	Health Board, Ministry of Social Affairs	Mr Üllar Kaljumäe
Finland	Ministry of Social Affairs and Health	Dr Marjukka Vallimies Patomäki
Georgia	LEPL Agency for State Regulation of Medical Activities of the Ministry of Labour, Health and Social Affairs	Eka Paatashvili and Babilina Turkia
Germany	Global Health Division, Federal Ministry of Health	Chariklia Balas and Bjorn Kummel
Hungary	Office of Health Authorisation and Administrative Procedures	Nandor Rikker
Ireland	Department of Health	Mr Brendan Murphy
Israel*	Legal Department, Ministry of Health	Ms Avital-Weiner -Auman
Italy	Directorate General for Health Professions, Human Resources and NHS, Ministry of Health	Dr Cristina Sabatini
Kazakhstan	The Republican State Enterprise on the right of economic competence “Republican Center for Health Development”	Professor Maksut Kulzhanov
Kyrgyzstan	Ministry of Health	Dr Meder Ismailov
Latvia	Ministry of Health	Ms Silvija Pablaka
Lithuania*	Ministry of Health	Mr Jonas Bartlingas
Monaco	Department of Social Affairs and Health, Ministry of State	Mme Anne Negre
Montenegro	Centre for Health System Development, Institute of Public Health	Dr Marija Palibrk

The Netherlands	Ministry of Health, Welfare and Sport	Mrs. Mr. D.I.M. Hoefnagel
Norway	National Board of Health	Dr Otto Christian Rø
Poland	Ministry of Health	Ms Mariola Mitchell
Portugal*	Central Administration of Health System	Rui Santos Ivo
The Republic of Moldova	National Center of health management, Department of HRH Mobility Management and Data	Dr Nicolae Jelamschi
Romania*	General Directorate for Human Resources and Certification, Ministry of Health	Dr Beatrice Nimereanu
The Russian Federation	Federal Research Institute for Health Organization and Informatics of the Ministry of Health of the Russian Federation”	Professor Vladimir Starodubov
Slovakia*	Ministry of Health of the Slovak Republic	Ms Miloslava Kovacova
Slovenia	Ministry of Health	Dusanka Petric
Spain	Ministry for Health, Social Services and Equality	Ms Pilar Carbajo Arias
Sweden	National Board of Health and Welfare	Mrs Maria Möllergren
Switzerland	Federal Office for Public Health, Federal Department of Home Affairs	Ms Delphine Sordat
Tajikistan	Ministry of Health	Professor Salomudin Isupov
Turkey	General Directorate of Research, Turkish Ministry of Health	Elif Islek
Turkmenistan	Ministry of Health and Medical Industry	Dr Hurma Orazova
The United Kingdom of Great Britain and Northern Ireland	Department of Health	Ms Julie McMillan
Uzbekistan	Ministry of Health	Mr Abdunomon Sidikov

**Annex 2. National Reporting Instrument**

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

**National Reporting Instrument**



Geneva  
February 2012

## Background

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

The Code establishes and promotes voluntary principles and practices for the ethical international recruitment of health personnel and the strengthening of health systems. The Code was designed by Member States to serve as a continuous and dynamic framework for global dialogue and cooperation to address challenges associated with the international migration of health personnel.

The Code encourages information exchange on issues related to health personnel and health systems in the context of migration, and suggests regular *reporting every three years* on measures taken to implement the Code. The reporting process is an integral component of the effective implementation of the voluntary principles and practices recommended by the Code.

To facilitate the reporting process under the Code and in accordance with the request of the World Health Assembly (Resolution WHA63.16) a series of consultations and discussions were conducted between June 2010 and November 2011, including consultation with Member States and other stakeholders concerned with the Code. Upon a number of reviews by experts, member states and regional offices, the document was further condensed into the *National Reporting Instrument* as a “kick start” country-based, self-assessment tool to monitor the progress made in implementing the Code. Comprising 15 questions, the instrument will enable WHO to examine the global status of health personnel recruitment and where possible assess the availability of data to explore time trends with inputs from governments and other stakeholders.

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

## Submission of reports

To submit Reports, Member States are invited to directly complete the online reporting questionnaire via the following link: *(to be added)*. The **deadline** for submitting reports is **30<sup>th</sup> May 2012**.

If technical difficulties prevent national authorities from filling in the online questionnaire, it is also possible to download it via the following link: *(to be added)*, to contact WHO Secretariat or, preferably, the Regional office (see Annex A), either by email or telephone or to complete it in a separate document, returning it to the WHO Secretariat or Regional office, either electronically or in hard copy.

## National Reporting instrument

Name of Member State:

Date National Report submitted:

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

Full name of institution:

Name and title of contact officer:

Mailing address:

Telephone number:

Fax number:

Email:

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

Yes

No

In addition, please provide information on the national contact responsible for the preparation of this report.

Full name of institution:

Name and title of contact officer:

Mailing address:

Telephone number:

Fax number:

Email:

- 1. In your country, do equally qualified and experienced migrant health personnel enjoy the same legal rights and responsibilities as the**



**domestically trained health workforce in terms of employment and conditions of work?**

Yes       No      ..... (If "No", please proceed to Q(4))

**2. Which legal mechanisms are in place to ensure that migrant health personnel enjoy the same legal rights and responsibilities as the domestically trained health workforce? Please tick all options that apply from the list below:**

**2.a** Health personnel are recruited internationally using mechanisms that allow them to assess the benefits and risk associated with employment positions and to make timely and informed decisions regarding them?

**2.b** Health personnel are hired, promoted and remunerated based on objective criteria such as levels of qualification, years of experience and degrees of professional responsibility on the same basis as the domestically trained health workforce

**2.c** Migrant health personnel enjoy the same opportunities as the domestically trained health workforce to strengthen their professional education, qualifications and career progression

**2.d** Other mechanism, please provide details if possible:

**3. Please provide evidence of the legal mechanisms identified in Q(2) either as attachments or links to on-line files.**

**4. Has your country or its sub-national governments entered into bilateral, regional or multilateral agreements or arrangements addressing the international recruitment of health personnel?**

Yes       No      .....(If "No", please proceed to Q(6))

**5. Please use Table A below to describe these bilateral, regional or multilateral agreements or arrangements:**

Table A Description of Bilateral, multilateral, regional agreements or arrangements

Type of Agreement	Countries Involved	Coverage	Categories of Health workforce (choose all that apply)	Please attach a document ation file if possible	Please provide a web-link if possible
1) <b>Bilateral</b> 2) <b>Multilateral</b> 3) <b>Regional</b>		1) <b>National</b> 2) <b>Sub-national</b>	1) <b>Doctors</b> 2) <b>Nurses</b> 3) <b>Midwives</b> 4) <b>Nurses/Midwives*</b> 5) <b>Other</b>		
....e.g. (a)		....e.g. (a)	....e.g. (a)		
<i>Add as necessary...</i>					

\* Please use this category only if the information available has no clear separation in reported numbers between the two cadres

**6. Does your country have any (government and/or non-government) programs or institutions undertaking research in health personnel migration?**

Yes       No      .....(If "No", please proceed to Q(8))

**7. Please use Table B below to provide the contact details for these research programs or institutions**

Table B Detailed information on research programs or institutions assessing health personnel migration

Name of Program or Institution	Name of contact person	Contact details	Web-link (if available)
7.1			
7.2			
<i>Add as necessary.....</i>			

**8. Has your country taken any steps to implement the Code?**

Yes       No      ..... (If "No", please proceed to Q(10))

**9. To describe those steps taken to implement the code, please tick all items that apply from the list below – the box can be ticked even if only some of the elements per step have been applied:**

- 9.a** Actions have been taken to communicate and share information across sectors on health worker recruitment and migration issues, as well as the Code, among relevant ministries, departments and agencies, nationally and sub-nationally
- 9.b** Measures have been taken to involve all stakeholders in *any* decision-making processes involving health personnel migration and international recruitment.

- 9.c** Actions are being considered to introduce changes to laws or policies on the international recruitment of the health personnel.
- 9.d** Records are maintained of all recruiters authorized by competent authorities to operate within their jurisdiction.
- 9.e** Good practices are encouraged and promoted among recruitment agencies.
- 9.f** If *other* steps have been taken, please give more details:

**10. Please list in priority order, the three main constraints to the implementation of the Code in your country and propose possible solutions:**

Main constraints	Possible solution
10.a1	10.a2
10.b1	10.b2
10.c1	10.c2

**11. Has your country established a database of laws and regulations related to international health personnel recruitment and migration and, as appropriate, information related to their implementation?**

- Yes       No      ..... (If "No", please proceed to Q(12))

**11.1 Please provide details of the database reference or a web-link:**

**12. Does your country has any technical cooperation agreement, provides or receives financial assistance related to international health personnel recruitment or the management of and migration?**

- Yes       No      ..... (If "No", please proceed to Q(13))

**12.1 Please provide more information or evidence of agreements as appropriate:**

**12.2 Please provide more information or evidence of financial assistance provided or received as appropriate:**

**13. Does your country have any mechanism(s) or entity(ies) to maintain statistical records of health personnel whose first qualification was obtained overseas?**

Yes       No      ..... (If "No", please proceed to Q(14))

**13.1 Please use Table C below to provide the contact details of each entity.**

**Table C Contact details of mechanism(s) or entity(ies) maintaining statistical records of health personnel whose first qualification was obtained overseas**

Name of mechanism or entity	Contact details	Web-link (if available)
13.1a		
13.1b		
13.1c		
Add as necessary.....		

**13.2 For the entity named in Q(13.1) please use Table D below to specify whether the information gathered include the following:**

**Table D Description of the statistical information available on the internationally recruited health personnel**

Entity	Occupation category (1) Doctors (2) Nurses (3) Midwives (4) Nurses/Midwives* (5) Other	Country of first qualification (1) Yes (2) No	Year of first recruitment (1) Yes (2) No	Age (1) Yes (2) No	Sex (1) Yes (2) No
13.1a					
	Add as necessary.....				
13.1b					
	Add as necessary...				
13.1c					
	Add as necessary.....				

\* Please use this category only if the information available has no clear separation in reported numbers between the two cadre

**13.3 For the entity(ies) named in Q(13.1) which status best describes the possibility of accessing and sharing the information detailed in Q(13.2):**

Entity	Information-sharing status
	(1) Information cannot be shared (2) Information may be shared (3) Sharing relationships not yet explored
13.a1	13.a2
13.b1	13.b2
13.c1	13.c2

**14. Does your country have any mechanism(s) or entity(ies) to regulate or grant authorization to practice to internationally recruited health personnel and maintain statistical records on them?**

Yes  No .....(If “No”, please proceed to Q(15))

**14.1 Please use Table E below to provide the contact details of each entity.**

**Table E Contact details of mechanism(s) or entity(ies) regulating or granting authorization to practice to internationally recruited health personnel**

Entity	Contact details	Web-link (if available)
14.1a		
14.1b		
14.1c		
Add as necessary.....		

**14.2 For the entity named in Q(14.1) please use Table F below to indicate whether the information gathered include the following details:**

**Table F Description of information available on authorization and regulation of practice of internationally recruited health personnel**

Entity	Occupation category	Country of first qualification	Year of first recruitment	Age	Sex
	(1) Doctors (2) Nurses (3) Midwives (4) Nurses/Midwives (5) Other	(1) Yes (2) No	(1)Yes (2) No	(1)Yes (2) No	(1) Yes (2) No
14.1a					
	Add as necessary.....				
14.1b					
	Add as necessary.....				
14.1c					
	Add as necessary.....				

\* Please use this category only if the information available has no clear separation in reported numbers

between the two cadres

**14.3 For the entity(ies) named in Q(13.1) which status best describes the possibility of accessing and sharing the information detailed in Q(13.2):**

Entity	Information-sharing status  (1) Information cannot be shared (2) Information may be shared (3) Sharing relationships not yet explored
14.a1	14.a2
14.b1	14.b2
14.c1	14.c2

**15. Please submit any other complementary comments or material you wish to provide regarding the international recruitment and management of migration of the health workforce that would relate to implementation of the Code.**

**WHO Contacts – National Reporting Instrument**

	<b>Focal Point</b>	<b>Mailing Address</b>	<b>Email</b>	<b>Telephone &amp; Fax</b>
Headquarters	Mario Dal Poz	(HSS/HDS/HRH) World Health Organization Avenue Appia 20 CH-1211 Genève 27 Switzerland	<a href="mailto:dalpozm@who.int">dalpozm@who.int</a> <a href="mailto:hmrinfo@who.int">hmrinfo@who.int</a>	+41 22 791 3599 +41 22 791 4153
WHO Regional Office for Africa (AFRO)	Adam Ahmat	(WHO/AF/RGO/HSS/HRH) Cité du Djoué, P.O.Box 06 Brazzaville, Republic of Congo	<a href="mailto:ahmata@afro.who.int">ahmata@afro.who.int</a>	+47 241 39169 +47 241 39563
WHO Regional Office for the Americas (AMRO/PAHO)	Silvina María Malvárez	(AMRO/HSS/HR) 525 Twenty-third Street, N.W., Washington, D.C. 20037, USA	<a href="mailto:malvares@paho.org">malvares@paho.org</a>	+1 202 974 3298 +1 202 974 3612
WHO Regional Office for the Eastern Mediterranean (EMRO)	Walid Abubaker	(WHO/EM/RGO/DHS/HRD) Abdul Razzak Al Sanhoury Street, P.O. Box 7608, Nasr City, Cairo 11371, Egypt	<a href="mailto:abubakerw@emro.who.int">abubakerw@emro.who.int</a>	+202 22765343 +202 22765416
WHO Regional Office for Europe (EURO)	Galina Perfilieva	(WHO/EU/RGO/DSP/HRH) Scherfigsvej 8 DK-2100 Copenhagen Ø Denmark	<a href="mailto:gpe@euro.who.int">gpe@euro.who.int</a>	+45 39171544 +45 39171818
WHO Regional Office for South-East Asia (SEARO)	Budihardja Singgih	(WHO/SE/RGO/HSD/HRH) World Health House Indraprastha Estate Mahatma Gandhi Marg New Delhi 110 002, India	<a href="mailto:singgihb@searo.who.int">singgihb@searo.who.int</a>	+91 11 23309303 +91 11 23370252
WHO Regional Office for the Western Pacific (WPRO)	Rodel Nodora	(WHO/WP/RGO/DHS/HRD) P.O. Box 2932 1000 Manila Philippines	<a href="mailto:nodorar@wpro.who.int">nodorar@wpro.who.int</a>	+6325289029 +6325211036

## The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

### Member States

Albania  
Andorra  
Armenia  
Austria  
Azerbaijan  
Belarus  
Belgium  
Bosnia and Herzegovina  
Bulgaria  
Croatia  
Cyprus  
Czech Republic  
Denmark  
Estonia  
Finland  
France  
Georgia  
Germany  
Greece  
Hungary  
Iceland  
Ireland  
Israel  
Italy  
Kazakhstan  
Kyrgyzstan  
Latvia  
Lithuania  
Luxembourg  
Malta  
Monaco  
Montenegro  
Netherlands  
Norway  
Poland  
Portugal  
Republic of Moldova  
Romania  
Russian Federation  
San Marino  
Serbia  
Slovakia  
Slovenia  
Spain  
Sweden  
Switzerland  
Tajikistan  
The former Yugoslav  
Republic of Macedonia  
Turkey  
Turkmenistan  
Ukraine  
United Kingdom  
Uzbekistan

World Health Organization  
Regional Office for Europe

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