

EIGHTH MEETING

Friday, 23 January 2009, at 09:10

Chairman: Mr N.S. DE SILVA (Sri Lanka)

1. ORGANIZATION OF WORK

The CHAIRMAN said that he had received a request to take up item 4.11 on counterfeit medical products immediately after consideration of item 4.9.

In reply to Mr HOHMAN (alternate to Dr Wright, United States of America), who said that he had no objection in principle but wanted to know the reasons for the suggested change, the CHAIRMAN explained that, if the item were taken up at an early stage, it might be possible to arrange informal consultations in order to avoid protracted discussion.

Mr FISKE (Denmark) suggested that, as there existed substantial differences of opinion on the subject, an informal working group should be set up before the Board embarked on a substantive discussion.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that if the item were opened in order to allow an informal group to be set up, without any formal discussion, he would have no objection.

Dr REN Minghui (China) said that there was no reason to advance consideration of item 4.11; it was a complex topic on which members of the Board held differing views. He could agree to the suggestion to set up an informal group if a volunteer could be found to lead its deliberations.

The DIRECTOR-GENERAL said that the proposal to advance consideration of item 4.11 had aimed to facilitate the establishment of an informal group in order to narrow differences of opinion. She sought a volunteer to lead the group's discussions.

Dr BUSS (Brazil), supported by Dr LUKITO (alternate to Dr Supari, Indonesia) and Dr BIN SHAKAR (United Arab Emirates), favoured advancing consideration of item 4.11 for preliminary discussion before the setting up of an informal working group, if necessary.

The CHAIRMAN, noting the absence of consensus, said that the agenda item would be taken up in the order originally planned.

It was so agreed.

2. TECHNICAL AND HEALTH MATTERS: Item 4 of the Agenda (continued)

WHO's role and responsibilities in health research: Item 4.9 of the Agenda (Documents EB124/12, EB124/12 Add.1 and EB124/12 Add. 2) (continued from the seventh meeting)

Dr BUSS (Brazil), welcoming the quality of the reports, expressed support for the draft strategy on research for health. Drawing attention to the relationship between health research and the theme of innovation and intellectual property, he said that the draft strategy would avoid duplication of efforts if it were linked with resolution WHA61.21 on the global strategy on public health, innovation and intellectual property. He also drew attention to key points in the Bamako Call to Action on research for health which, in line with the Paris Declaration on Aid Effectiveness, and urged efforts to respond to that call.

Dr GOPEE (Mauritius) said that the recommendation in the Bamako Call to Action that national governments should allocate at least 2% of budgets of ministries of health to research was a major constraint to low- and middle-income countries, including Mauritius. The current financial crisis might result in reduced allocations. He appealed to the Director-General to defend the allocation at the Sixty-second World Health Assembly and in other forums.

Mr HOHMAN (alternate to Dr Wright, United States of America), clarifying the intervention he had made the previous day on the extent to which WHO should engage in research, acknowledged that WHO had a strong role in research through IARC, the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases and the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. There existed many legitimate ways in which the Organization conducted research, but the emphasis should be placed on translating research findings into information in order to help Member States to reach informed policy decisions.

Dr LUKITO (alternate to Dr Supari, Indonesia) welcomed the report and the draft strategy (document EB124/12). In paragraph 12 of the report, he proposed to qualify the definition of research by adding the words "through an evidence-based approach" and "and responsible" so that the paragraph would read: "research is defined as the development of knowledge through an evidence-based approach with the aim of understanding health challenges and mounting an improved and responsible response to them". The additional wording would reflect the multifaceted nature of research, which comprised ethics, management, the interpretation of research outcomes and their translation into health policies. After hearing the observations made by the member for the United States, he asked to what extent and how WHO was already engaged in the translation of research into policy development. It was important for the Board to be kept informed about such activities.

Turning to the draft resolution contained in document EB124/12, he proposed adding two new preambular paragraphs after the paragraph beginning "Realizing ...":

Affirming the roles and responsibilities of WHO, as a leading global health organization, in health research;

Recognizing the need to strengthen the capacity of public sectors in health research;

He further proposed the addition, in subparagraph 3(4), of the words "and other determinants of health" after the words "infrastructure development".

Finally, he sought clarification on the sums mentioned in connection with funding in paragraphs 78 and 79 of the draft strategy on research contained in the annex to document EB124/12.

Dr GIMENÉZ CABALLERO (Paraguay), welcoming the report, expressed support for the draft strategy and the call to observe the Bamako Declaration. Both action and research were required in the field of public health and WHO's role in research, as outlined in the documents, was justified. It was WHO's function to help to develop health policies based on the conclusions of public health research.

In the context of the new strategy, research on primary health care and on the social determinants of health should be emphasized. Publications had tended to focus on biomedical subjects whereas the countries in the Region of the Americas also needed relevant and reliable research on health management and systems, on which they could base decisions; WHO should strengthen research in those areas. Research should be promoted through regional networks, by setting up databases and regional research teams; problems of methodology and financing could then be shared and result in the elaboration of new policies.

Dr ASLANYAN (Canada)¹ welcomed the draft WHO strategy on research for health, and expressed support for the draft resolution. He endorsed the Bamako Call to Action. The draft strategy would influence how research was performed in Member States, and the Secretariat would need to respond to countries' requests for support in strengthening national capacity for conducting, managing and using health research.

In order to implement the strategy, WHO should strengthen its internal research structures and special programmes and initiatives, and make linkages to the Global Plan of Action approved by the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property. He emphasized partnerships, including public-private research partnerships and those with specialized organizations such as the Global Forum on Health Research and the Council on Health Research for Development.

Dr CHAUHAN (India),¹ expressing appreciation for WHO's efforts to support, promote and conduct health research, said that the five interrelated goals identified in the draft strategy would be useful in building capacity. WHO's role in health research should be strengthened in the face of widening disparities between nations on access to technology and research in the field of medicine and health care. In addition to WHO's research work, much research, both classic and normative, was done by other agencies, either independently or in association with WHO, and he asked whether the draft strategy would influence or guide the policies of such bodies.

He drew attention to the need for coordination with health authorities in pursuing national health priorities and for capacity-building to carry out operational research in countries where no such structures existed. A large number of innovations failed to reach the point of evaluation for introduction into health systems, and WHO should develop a mechanism to assist in that regard. More public-private partnerships should be established and information on successful models should be shared, for adoption elsewhere. Health economics, policy and social sciences should be integrated in a more comprehensive manner.

Dr MUÑOZ (Chile),¹ welcoming WHO's coordinating efforts to direct research towards global health priorities, emphasized research to develop medicines and interventions to treat the diseases that disproportionately affected developing countries.

Findings on interventions that responded to country priorities, particularly the health-related Millennium Development Goals, could be disseminated, and he welcomed the draft strategy's focus on priority health needs. Strengthening national capacities to analyse the ethical aspects of research with human beings should also be a priority.

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Mr RAJALA (European Commission) said that WHO should demonstrate the application of the draft strategy throughout its operational mandate, and link it to the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property and other relevant initiatives.

Collaboration with WHO was important to the European Commission, helping it to determine its strategic areas for research and to develop its strategic vision. Current European Union research focused on public health, and on health systems at the global level within the context of the Millennium Development Goals; WHO's participation in project consortiums was also welcomed.

With European Union funding, WHO would support research and development on tropical and neglected diseases related to poverty, and research aimed to improve: access to medicines in developing countries; technology transfer of pharmaceuticals; and local production. Those activities would facilitate consultation and set priorities for other research and demonstrate how the two institutions could best collaborate on issues of mutual interest.

Dr BUSS (Brazil), in response to the comments made by the member for Indonesia, drew attention to the Evidence-Informed Policy Network, a WHO initiative that encouraged policy-makers in low- and middle-income countries to use evidence generated by research.

Dr ALVIÁREZ (Bolivarian Republic of Venezuela)¹ welcomed the draft strategy and emphasized the economic and social importance of science and technology in improving conditions in developing countries. The draft strategy should enhance the Secretariat's capacity to encourage Member States and other bodies to work in a coordinated way in order both to produce data and research tools, and to guarantee technology and knowledge transfers that would improve peoples' health and quality of life. The principle of equity should guide ethically conducted research that benefited poor and dependent populations.

The proposed goal on standards should include establishing agreements on good practices, scientific benchmarks, bioethical guidelines and accountability mechanisms; and should take into account social, economic and technological circumstances, so as to respond to national realities. Concerning the goal on translation, the application of knowledge and new technologies was a lengthy social process and must be introduced in a manner that ensured sustainability and cultural acceptance.

With regard to the research community, joint networks were vital in decision-making and should be included in the process, not merely consulted. Research stimulated the development of vaccines, medicines and diagnostics where market forces alone were insufficient. The preparation of the draft strategy should reorient WHO's actions and promote social development in all Member States.

Mr MATLIN (Global Forum for Health Research), speaking at the invitation of the CHAIRMAN, welcomed the draft strategy. His organization had been pleased to participate in the consultation. He expressed appreciation for: the use of the phrase "research for health" in the draft strategy rather than "health research", which acknowledged that health determinants were not only biological; the strategy's emphasis on WHO's normative and stewardship role; and the need for WHO to be a model of good practice in the acquisition and use of research evidence.

Implementing the draft strategy would require partnerships that crossed disciplinary and sectoral boundaries, and innovative approaches to structures and financing. The complex composition of entities concerned with research for health, which led to high transaction costs and inefficiencies, needed a streamlined and coordinated approach, and he looked forward to working with WHO and others to overcome the challenges involved.

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Dr LHOTSKA (Consumers International), speaking at the invitation of the CHAIRMAN, welcomed the draft strategy, but pointed out that safeguarding health policy-setting from undue commercial influence had not been included in the guiding principles. The research base used in formulating public health policy should always be evaluated by an independent body and should contain the largest possible proportion of independently-funded research, notably with regard to policies affecting the health of infants, young children and most vulnerable adults. In order to ensure that public health policies were made entirely in the public interest, WHO should include the principle of independence in the draft strategy. It should strengthen its policy on interactions with the private sector to include mechanisms for minimizing conflicts of interest.

Dr EVANS (Assistant Director-General), responding to comments made, said that, with respect to the importance of translating research findings, most of WHO's research activities centered around secondary systematic synthesis of information to inform the development of guidelines and policy. The prominence of the organizational goal within the draft strategy would encourage WHO to strengthen its research culture in line with good practice. The Evidence-informed Policy Network, to which the member for Brazil had drawn attention, was part of the Secretariat's efforts to work with countries to ensure that research findings and evidence were translated into the policy process.

Turning to paragraph 63 of the annex to the report, he acknowledged that the concepts of copyright and intellectual property did not necessarily constitute barriers to the access of research results, although complementary policies were often required in order to enhance access. However, the text of the paragraph could be revised for the purposes of clarity. The text of the report could also be amended to take account of the comments made by the member for Bangladesh with regard to multi-centre studies.

He acknowledged the calls for WHO's leadership with regard to the Paris Declaration on Aid Effectiveness and the current organization of research globally, in respect of which the Organization would take action in conjunction with its partners, and for clear linkages with the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property.

In response to the member for Indonesia, he clarified that the figures given in paragraphs 78 and 79 of the annex to the report were for expenditure not budget figures, as WHO had no single budget line for research. The figures were based on analysis of the biennium 2006–2007. The introduction of the Global Management System would enable more continuous and up-to-date analysis of WHO's research expenditure.

All five goals, including the organizational goal, had implications for the functioning of the Secretariat, and the draft strategy therefore represented a significant agenda for improvement.

He acknowledged the comments made by the representative of the European Commission and the fruitful collaboration between the two institutions.

Professor WHITWORTH (Chairman of the WHO Advisory Committee on Health Research, ACHR) said that the Committee had worked closely with the External Reference Group, WHO headquarters and the regional offices in the development of the WHO strategy on research for health, and appreciated the wide consultation process. At its previous meeting in October 2008, ACHR had fully endorsed the draft strategy and had considered that it would be fundamental to WHO's remit, its role in the provision of best evidence and its capacity to support Member States in improving health for all and achieving the health-related Millennium Development Goals.

The strategy provided an opportunity: to consolidate and harmonize research and evidence across the whole Organization, as requested by the member for China; to strengthen technical support to countries; and to re-establish WHO leadership in global health research, as emphasized by the member for Bangladesh. It synthesized the advice and direction given, and priorities set, by ACHR in recent years and incorporated the Committee's key initiatives, including: reviews of ethics and guidelines; good scientific conduct; the clinical trials registry; and knowledge translation activities such as the Evidence-informed Policy Network, in line with the comments made by the members for

Indonesia, Paraguay and the United States. In response to regional and country suggestions, the strategy was flexible and adaptable to the needs and priorities of the diverse WHO regions, as requested by a number of Board members.

ACHR would celebrate its fiftieth anniversary in 2009 and remained committed to continuing its support for WHO either in its present capacity or with a revised mandate. The key to successful implementation of the strategy was efficient structure for its governance and an inclusive participatory approach that would link WHO's diverse but related research activities, including: the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, as requested by the member for Brazil; the Task Force on Health Systems Research; and the Bamako Call to Action, as highlighted by the member for Mali. She urged Member States and other partners to endorse the draft WHO strategy on research for health and to support its implementation.

The DIRECTOR-GENERAL said that she would convene a meeting, if possible before the Sixty-second World Health Assembly in May 2009, in order to consider how the complex global organization of research for health might be streamlined within and outside WHO. She reiterated the assurance she had given many times in the past that, while she would pursue an inclusive approach, working with Member States, industry and other partners to seek effective solutions, she would fiercely guard WHO's independence to ensure that its integrity could not be compromised.

The CHAIRMAN invited further comments on the draft resolution set out in paragraph 33 of document EB124/12 and the financial and administrative implications of the draft resolution listed in document EB124/12 Add.1.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that he had a number of amendments to propose and believed that that was also the case for other Board members.

The CHAIRMAN invited members to submit their proposals in writing, and the Secretariat would amend the draft resolution accordingly and circulate a revised text for consideration at a later meeting.

It was so agreed.

(For continuation of the discussion, see summary record of the tenth meeting.)

Commission on Social Determinants of Health: Item 4.6 of the Agenda (Document EB124/9) (continued from the sixth meeting, section 2)

The CHAIRMAN invited comments on the revised draft resolution on reducing health inequities through action on the social determinants of health, proposed by Brazil, Canada, Denmark, Hungary, Latvia, Norway, Paraguay, Slovenia, Sri Lanka and the United Kingdom of Great Britain and Northern Ireland, which read:

The Executive Board,
Having considered the Secretariat's report on the final report of the WHO Commission on Social Determinants of Health,¹

RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:

The Sixty-second World Health Assembly,
Having considered the Secretariat's report on the final report of the WHO Commission on Social Determinants of Health;

Noting the 60th anniversary of the establishment of WHO in 1948 and its Constitution which affirms that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Noting the 30th anniversary of the International Conference on Primary Health Care at Alma-Ata in 1978, which reaffirmed the essential value of equity in health and launched the global strategy of primary health care to achieve health for all;

Recalling the principles of "Health for All", notably the need for intersectoral action (resolution WHA30.43);

Confirming the importance of addressing the wider determinants of health and considering the actions and recommendations set out in the series of international health promotion conferences, from the Ottawa Charter on Health Promotion to the Bangkok Charter for Health Promotion in a Globalized World making the promotion of health central to the global development agenda as a core responsibility of all governments (resolution WHA60.24);

Noting the global consensus of the **United Nations** Millennium Declaration to achieve the Millennium Development Goals by 2015 and the concern at the lack of sufficient progress towards many of these goals in some regions at the half-way point;

Noting the publication of *The world health report 2008* on primary health care and its focus on ways to improve health equity by reforming health and other societal systems;

Mindful about the fact that responses to environmental degradation and climate change include health equity issues and noting that the impact of climate change is expected to negatively affect the health of vulnerable and disadvantaged populations (resolution WHA61.19);

Mindful about the facts concerning widening gaps in life expectancy worldwide;

Attaching utmost importance to the elimination of gender-related health **inequities** ~~inequalities~~;

Recognizing that millions of children globally are not reaching their full potential and that investing in comprehensive supports for early child development that are accessible to all children is a fundamental step in achieving health equity across the lifespan;

Acknowledging that improvement of unfavourable social conditions is primarily a social policy issue;

Noting the need to improve coordination among global, national and subnational efforts in tackling social determinants of health through work across sectors, while simultaneously promoting social and economic development, with the understanding that

¹ Document EB124/9.

such action requires the collaboration of many partners, including civil society and private sector,

1. EXPRESSES its appreciation for the work done by the Commission on Social Determinants of Health;
2. CALLS UPON the international community, ~~such as~~ **including** United Nations agencies, intergovernmental bodies, **civil society and the private sector**:
 - (a) to take note of the final report of the Commission on Social Determinants of Health and its recommendations;
 - (b) to take action in collaboration with ~~the WHO's Secretariat and~~ Member States **and the WHO Secretariat** on assessing the impacts of policies and programmes on health ~~inequalities~~ **inequities** and on addressing the social determinants of health;
 - (c) to work closely ~~together with the WHO's Secretariat and~~ Member States **and the WHO Secretariat** on measures **to enhance health equity in all policies in order** to improve health for the entire population and reduce ~~inequalities through addressing social factors that influence health~~ **inequities**;
3. URGES Member States:
 - (a) to develop and implement goals and strategies to improve public health with a focus on health ~~inequalities~~ **inequities**;
 - ~~(b) to strengthen the role of public health in policy development to reduce health inequalities, including ensuring access to all aspects of public health: health promotion, disease prevention and health care;~~
 - ~~(c) to strengthen efforts to achieve equitable access to public health interventions, including health promotion, disease prevention and health care for the entire population;~~
 - (b) to take into account health equity in all national policies that address social determinants of health and to ensure equitable access to health promotion, disease prevention and health care;**
 - ~~(d) (c) to ensure dialogue and cooperation among relevant sectors and be a driving force for this cooperation with the aim of integrating a consideration of health into relevant public policies;~~
 - ~~(e) to educate health providers on how to take social factors into delivering appropriate care to their patients;~~
 - (d) to increase awareness among public and private health providers on how to take account of social determinants when delivering care to their patients;**
 - ~~(f) (e) to contribute to the improvement of the daily living conditions of major importance for~~ **contributing to** health and social well-being across the lifespan by involving all relevant partners, including civil society **and the private sector**;
 - ~~(g) (f) to contribute to the empowerment of individuals and groups, especially those who are marginalized, and take steps to improve the societal conditions that affect their health;~~
 - ~~(h) (g) to develop~~ **generate new**, or make use of existing, methods and evidence, tailored to national contexts in order to address the social determinants and social gradients of health and health ~~inequalities~~ **inequities**;
 - (i) (h) to develop**, make use of, and if necessary, improve health information systems in order to monitor and measure the health of national populations, with data disaggregated according to the major social ~~factors~~ **determinants** in each

context (such as **age**, gender, ethnicity, education, employment and socioeconomic status) so that health ~~inequalities~~ **inequities** can be detected and the impact of policies monitored **in order to devise appropriate policy interventions to minimize health inequities**;

4. REQUESTS the Director-General:

- (a) to work closely with partner agencies in the multilateral system on appropriate measures that address the social determinants of health **and promote policy coherence to minimize health inequities**; and to advocate for this topic to be high on the global development and research agendas;
- (b) to strengthen the capacity within the Organization with the purpose to give sufficient priority to relevant tasks related to addressing the social determinants of health in order to reduce health ~~inequalities~~ **inequities**;
- (c) to implement measures, including **objective** indicators for the monitoring of social determinants of health, across relevant areas of work and promote addressing social determinants of health to reduce health ~~inequalities~~ **inequities** as an objective of all areas of the Organization's work, especially priority public health programmes;
- (d) to ensure that ongoing work on the revitalization of primary health care addressing the social determinants of health is aligned with this, as recommended by *The world health report 2008*;
- (e) to support Member States in implementing a health-in-all-policies approach to tackling ~~inequalities~~ **inequities** in health;
- (f) to support Member States, **upon at their** request, in implementing measures with the aim of integrating a focus on social determinants of health across relevant sectors and to design, or if necessary redesign, their health sectors to address this appropriately;
- (g) to support Member States, **upon at their** request, in strengthening existing efforts on measurement and evaluation of the social determinants of health and the causes of health ~~inequalities~~ **inequities** and to develop and monitor targets on health equity;
- (h) to support research on effective policies and interventions to improve health by addressing the social determinants of health that also serve to strengthen research capacities and collaborations;
- (i) to support the regional directors in developing a regional focus on issues related to the social determinants of health and in engaging a broader range of countries in this issue, in accordance with the conditions and challenges of each region;
- (j) to ~~prepare~~ **convene** a global event, with the assistance of Member States, before the Sixty-fifth World Health Assembly in order to highlight the developments, progress and renewed plans for addressing the alarming trends of health ~~inequalities~~ **inequities** and to increase global awareness on social determinants of health, including health equity;
- (k) to report on progress in implementing this resolution to the Sixty-fifth World Health Assembly **through the Executive Board**.

The financial and administrative implications of the draft resolution were:

1. Resolution Reducing health inequalities through action on the social determinants of health	
2. Linkage to programme budget	
Strategic objective: 7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.	Organization-wide expected results: 7.1 Significance of social and economic determinants of health recognized throughout the Organization and incorporated into normative work and technical collaboration with Member States and other partners. 7.2 Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels in order to address social and economic determinants of health and to encourage poverty reduction and sustainable development. 7.3 Social and economic data relevant to health collected, collated and analysed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).
(Briefly indicate the linkage with expected results, indicators, targets, baseline) Implementation of the resolution will greatly assist the ability of the Organization to integrate work on the social determinants of health into its programmes and to support Member States in developing national capacity to measure health inequities and implement intersectoral policies on the social determinants of health.	
3. Financial implications	
(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 29 850 000 over the years 2009, 2010 and 2011.	
(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant) US\$ 9 760 000 covering work at headquarters level to extend existing activities, and work in regional offices to build capacity and facilitate regional efforts, in line with the resolution.	
(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009? All activities for the biennium 2008–2009 can be subsumed under the Programme budget 2008–2009.	
(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds) Not applicable.	
4. Administrative implications	
(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant) All levels of the Organization.	

(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant)

3.5 staff members (full-time equivalent) across the six regional offices in order to build regional capacity to work with countries, in line with the resolution.

(c) Time frames (indicate broad time frames for implementation)

Three years (2009–2011), with a report on progress to be submitted to the Sixty-fifth World Health Assembly in 2012 in line with the resolution.

Mrs GOY (Luxembourg),¹ expressing support for the initiative to reduce health inequities through action on the social determinants of health, said that the Board's discussion of item 4.7, Monitoring of the achievement of the Millennium Development Goals, had illustrated the importance of such action both in the realization of the Goals by 2015 and in activities to follow up resolution WHA61.18. She proposed the insertion of a reference to that resolution; the Board might therefore consider inserting a new seventh preambular paragraph to read: "Welcoming in this regard resolution WHA61.18, which initiated annual monitoring by the World Health Assembly of achievement of the health-related Millennium Development Goals". She confirmed the interest that had been expressed in swift action to implement resolution WHA61.18. She emphasized the interdependence of the two subjects and the interests of greater consistency.

Dr VOLJČ (Slovenia) seconded the proposed amendment.

Professor ALI (alternate to Professor Haque, Bangladesh) also supported the proposal.

The resolution, as amended, was adopted.²

International recruitment of health personnel: draft global code of practice: Item 4.10 of the Agenda (Document EB124/13, EB124/13 Add.1 and EB124/INF.DOC./2)

The CHAIRMAN drew attention to the draft resolution set out in document EB124/13 and to its financial and administrative implications, which were listed in document EB124/13 Add.1. The draft code of practice, developed in pursuance of resolution WHA57.19, was annexed to the draft resolution.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union and its 27 Member States, welcomed the WHO code of practice on the international recruitment of personnel. The international mobility of health-care workers was leading to loss of human resources in lower-income countries yet failing to meet workforce needs in higher-income countries. The European Union was seeking an equitable balance of interests among health personnel and source and destination countries. WHO's Member States had a responsibility to develop workforce strategies, although collective action would be needed to minimize the adverse effects on health systems in countries of origin. The proposed draft should be voluntary, since freedom of movement must be respected. One aim should be to balance the rights, expectations and obligations of health workers, without impinging on their right to migrate to countries that wished to admit and employ them. He emphasized the principles of transparency, ethics,

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

² Resolution EB124.R6.

fairness and mutuality of benefits. Monitoring, data gathering and information exchange were important elements of the draft code.

The European Union believed that significant results could be achieved if proper action was taken at Union level and would actively pursue the European Programme for Action to Tackle the Critical Shortage of Health Workers in Developing Countries (2007–2013). The draft code of practice before the Board could provide a basis for further regional and bilateral agreements.

Dr JAYANTHA (alternate to Mr de Silva, Sri Lanka), welcoming the documents provided, expressed appreciation for the support provided by the Regional Office for South-East Asia for the training of paramedical staff from Bhutan and Maldives. Sri Lanka encouraged some health personnel to gain experience and professional development abroad but had suffered from the migration of medical professionals. Sri Lanka provided free education to health personnel, including doctors and consultants to postgraduate level and supported specialist training in developed countries. However, some trainees failed to return home despite a legal obligation to do so, meaning that the Government's investment was benefiting only the recipient countries. Shortage of trained medical professionals could jeopardize Sri Lanka's attainment of the health-related Millennium Development Goals.

Article 5 of the draft code of practice on mutuality of benefits must be enforceable; it should be strengthened in order to ensure greater compliance, perhaps providing for compensatory mechanisms that would enable developing countries to invest in training of new students.

Dr OULD JIDDOU (Mauritania), speaking on behalf of the 46 Member States of the African Region, said that increased migration of health professionals from developing countries had weakened fragile health systems and was jeopardizing the attainment of the health-related Millennium Development Goals. Resolutions WHA57.19 and WHA58.17 had requested the Director-General, *inter alia*, to formulate mitigation strategies; policies to improve retention; and to develop, through wide consultation, a code of practice for international recruitment. The only existing code in that area to date was the 2003 Commonwealth Code of Practice for the International Recruitment of Health Workers. The draft code before the Board would have universal coverage.

The African Health Workforce Observatory aimed to support the dissemination of information to guide decision-making and WHO had supported the formulation of guidelines on retention of health personnel. Case studies to document the situation in remote areas had been conducted in Mali in April 2008 and Senegal in July 2009. In 2008 the Regional Office for Africa had participated in the technical working group led by WHO established to develop the draft code.

The First Global Forum on Human Resources for Health had been organized jointly by WHO and the Global Health Workforce Alliance. Member States had been invited to comment electronically on proposed measures of the draft code, which set out principles and guidelines for international recruitment. Challenges included the lack of financial resources for training and retention activities and implementation of the proposed code of practice at national and regional levels.

Dr AHMADZAI (Afghanistan), speaking on behalf of the Member States in the Eastern Mediterranean Region, supported the draft global code of practice and the aims of equitable distribution of health personnel. Low-income countries were suffering from the effects of health-worker migration and many countries lacked formal systems of migration management or retention policies. Furthermore, the absence of data hindered evaluation of the ethical, legal and financial implications of the problem.

He highlighted the need to generate evidence on migration and its national, regional and global policy implications. Further analysis should include pull and push factors, incentive schemes and career opportunities centered on performance. Innovative solutions to health-worker migration, including multilateral agreements, could be facilitated through collaboration between the Secretariat, Member States and partners.

Professor ALI (alternate to Professor Haque, Bangladesh) said that, if handled correctly, health-worker migration could be mutually beneficial. However, the global financial crisis was, in some cases, resulting in migrant health personnel losing their jobs and returning to their country of origin, thereby contributing to employment problems in the source country.

Although health workers in many developing countries received similar training to that provided in more affluent countries, they could be discouraged from working in developed countries if their training emphasized local needs. Economic factors were at the heart of migration of health personnel. Financing was therefore needed in developing countries in order to provide employment opportunities and training facilities, both of which would help to control the migration of health workers.

Dr ABABII (Republic of Moldova) said that the migration of health personnel to countries offering better economic prospects was posing a serious threat to his country's health system. Rural areas were particularly affected. Data on the numbers involved were unavailable, such was the speed at which health workers were migrating. He questioned the benefit to the State of providing training to medical personnel if their knowledge and experience were being used in other countries.

His Government had legislated to give health personnel who had sat competitive examinations better career prospects and benefits if they did not migrate. However, those measures had proved insufficient. A global policy was needed that could both tackle the macroeconomic problems which lay at the root of health-worker migration and mitigate the negative effects of international recruitment. He stressed the need for: targeted technical assistance; further medical equipment and technology; improved access to trained personnel; assistance in the continued training of health personnel; and help on issues such as the granting of licences. The remit of WHO and its regional offices should be extended to cover human resource management and training of health personnel.

He supported the draft global code of practice, but encouraged strengthened recommendations on cooperation, with compensation for countries of origin.

Dr ZARAMBA (Uganda) said that the negative repercussions of health-worker migration had been particularly hard on developing countries. He noted with satisfaction that the draft global code of practice stressed the involvement of all countries in dealing with that crisis.

The draft code should emphasize the individual's right to free movement but within the context of the right to health of populations in the source country, whose taxes were used in the training of health personnel, but who did not receive the corresponding benefit. The draft code should also underline the need for recipient countries to be sensitive to the concerns of source countries.

He thanked the Secretariat for gathering electronically the data contained in the draft code, but questioned its comprehensiveness. In that regard, he suggested the establishment of a stakeholders' working group and a drafting group in which the views of the Secretariat, source countries and recipient countries could be represented, in order to prepare a revised draft of the global code of practice for submission to the Sixty-second World Health Assembly.

Mr CAMPOS (alternate to Dr Buss, Brazil) said that the Brazilian ministries of health, education and labour had been tackling the issue of health workforce development in collaboration with WHO, its Regional Office for the Americas and the Global Health Workforce Alliance. In that regard, the two principal challenges involved creating appropriate working conditions for the three million health workers in Brazil, and linking health services with educational institutions. The impact of health-worker migration on the poorest countries was potentially devastating. He agreed with the comments made by the members for Sri Lanka and Uganda that it was ethically unacceptable for the taxes of very poor populations to benefit the richest countries.

He supported the establishment of a code of practice that would redress health inequity, and guide countries and institutions. The introduction of compensatory mechanisms, although difficult to implement, could alleviate health inequities among countries.

He proposed amending the title of Article 7 of the draft code to “Strengthening information and research” and requested support for the creation of health observatories on national and regional levels. Extensive data were essential to a sustainable decision-making process.

Dr REN Minghui (China) supported the creation of a draft code of practice to standardize the international recruitment of health personnel. However, greater emphasis should be given to the responsibilities and obligations of destination countries. Global cooperation would be necessary. Destination countries should offer additional assistance to source countries through specialized training, technical support, and transfer of know-how; and by implementing measures to facilitate the long-term or periodic repatriation of migrant health workers.

Dr MOHAMED (Oman) said that further funding was needed globally to train health workers. Oman was already contributing substantially funds to the training of health workers. Migrant health workers were recruited to work in his country’s modern hospitals and, following rotation periods of seven years, returned to their country of origin with valuable training and new skills which could be used to strengthen their own health systems.

He agreed with previous speakers regarding compensation for developing countries which had lost human resources. He supported the introduction of bilateral and regional agreements for the international recruitment of health personnel, developed in partnership with WHO.

Mr MIGUIL (Djibouti) said that the draft global code of practice should be strengthened through consultation. Wealthy countries should generate enough human resources to ensure that their health systems functioned well; refrain from the active recruitment of health professionals trained in developing countries; and assist the poorest countries in creating an environment conducive to the retention of health personnel. However, countries of origin should take responsibility for improving their health systems, and thus retain health professionals for longer.

In Djibouti, salaries for doctors and paramedicals had doubled since 2006, and a specialist physician currently received twice the salary of a minister. Although a faculty of medicine had been established in Djibouti, many students were still trained abroad. A recruitment policy encouraged medical students to return to the country after completion of their fifth year of study, and many students were returning. However, such actions had dramatically increased health spending over five years and that could not continue indefinitely; countries like his could not compete with the salaries offered by developed countries.

The draft code should give greater attention to the management of international migration, which must not be in one direction only. Real solutions must be found to reduce the detrimental effects on the countries of origin. The time had come for concrete measures rather than statements of good intent. If the Millennium Development Goals were to be attained by 2015, bilateral agreements would have to be developed under the auspices of WHO. Countries of origin should be compensated for the training of health personnel. The draft code should also focus on the means of strengthening training institutions in the countries of origin.

Ms SCHLACHTER (alternate to Dr Wright, United States of America) said that the draft global code of practice offered many strengthened policy responses to the migration of health personnel. Shortages of health personnel were a serious concern, particularly in the developing world. Factors such as poor economic conditions in the home country, low job status, lack of professional recognition and opportunities, and poor working conditions were the root causes of migration. Those needed to be addressed, and the United States was ready to assist. The President’s Emergency Plan for AIDS Relief had assisted 2.6 million training opportunities for health-care personnel, and would train 140 000 health-care providers over the next five years.

The United States would be unable to support the adoption of the draft global code of practice unless it was clear that the code was voluntary, and she suggested that the title should be amended

accordingly. Member States should use the draft code as guidelines. As it currently stood, the text could impose behaviours, legal and administrative frameworks, and research and reporting processes upon Member States and stakeholders. Those were intrusive measures and went far beyond existing legislation and policies in many countries. It also contained very ambitious goals regarding the coordination of national policies and international recruitment of health worker. Those were not necessarily realistic, particularly for countries, such as hers, that did not have nationalized health-care systems. The concept of mutuality of benefits set out in Article 5 could be interpreted as creating a sense of obligation on destination countries to link the migration of health workers to development aid for specific source countries. The concept of linked compensation was unacceptable and infringed the rights of sovereign nations to decide, through bilateral consultations, when and where to provide assistance to individual developing countries. The draft code should also reflect the roles and responsibilities of countries of origin and of migrants themselves. The need to respect the human rights of migrant workers should also be recognized. Her Government was concerned that the draft encouraged recruiters to exclude entire populations of health-care workers from the international recruitment process because they worked in a country with a vulnerable health-care system. The burden for the viability of a country's health-care programme should be placed on the government, not on individual health-care workers.

Additional consultation between Member States was critical, and she suggested that a working group should be established to give Member States the opportunity to discuss and revise the text of the draft code before the Sixty-second World Health Assembly.

Dr GIMENÉZ CABALLERO (Paraguay), having expressed support for the draft resolution, said that, although most health personnel migrated for economic reasons, other factors, including poor working conditions, were also relevant. He emphasized the strengthening of health systems. Many nurses in Paraguay migrated to Europe, and doctors to the United States and Europe. The shortage of health-care workers in his country would become more acute because of the inequitable distribution of human resources. His Government's strategy would involve the education sector, universities and also trade unions.

The draft resolution should encourage recipient countries and countries of origin to invest in their institutions and gradually reduce the shortage of human resources.

Article 5 of the draft code should be strengthened by covering social security benefits for migrant health personnel.

Dr KÖKÉNY (Hungary) emphasized the need for a clear code of practice regarding the international recruitment of health personnel. The issue was sensitive and there should be further consultation with Member States and stakeholders before a draft code was submitted to the Sixty-second World Health Assembly. The text should be made more explicit, shorter and simpler, balancing various interests while at the same time protecting the health systems of poor countries. The principles of self-sufficiency and moderation in cross-border recruitment should be explored. At all events, unethical recruitment practices should be avoided and the impact of migration on health systems better presented. In the current financial crisis, the Director-General should call on Member States to assist developing countries and countries with economies in transition in providing all health professionals with incentives to continue their careers in their home countries.

Dr JAKSONS (Latvia) said that guidance concerning multilateral arrangements and mutual benefits required further elaboration, and greater clarity in the text was needed. Given the important and diverse views expressed on some aspects of the code, he suggested that a one-day consultation should be organized before the Sixty-second World Health Assembly.

Dr KAMOTO (Malawi) endorsed the views expressed by the members for the Republic of Moldova, Sri Lanka and other Member States on mutuality of benefits (Article 5) and called for the

text to be reviewed with the aim of providing further support to developing countries. At present, some 60% of the doctors trained in Malawi remained outside the country, owing to incentives offered by developed countries. She urged the developed countries to help countries like her own to devise better arrangements, since poor countries also required specialized personnel. She observed that the United Kingdom's Department for International Development and the Global Fund to Fight AIDS, Tuberculosis and Malaria were currently helping Malawi by giving incentives, including a salary top-up, to all health personnel working in the country. She suggested that developed countries should follow the example set by Australia, which did not permit doctors from Africa to remain in the country upon completion of their training.

Dr ADITAMA (alternate to Dr Supari, Indonesia) said that the free flow of health personnel was contributing to public health problems in the developing world. Recipient countries should have a clear obligation to countries of origin that suffered from the migration of health personnel.

Dr DAHL-REGIS (Bahamas) said that, although the draft code of practice proposed built on the Commonwealth Code of Practice for the International Recruitment of Health Workers, it did not go far enough. Low-income countries and small-island States were disproportionately affected, and therefore the focus and language of the text should be strengthened. She supported the recommendation for further consideration to be given to the code with a balanced representation of all stakeholders.

Ms ROCHE (New Zealand) expressed support for the idea of further consultations. However, participants from Member States who would be unable to travel to Geneva for a one-day meeting should not to be disadvantaged.

Ms TOLSTOÏ (France)¹ expressed appreciation for the work undertaken to produce the draft code of practice and the related electronic consultation. The migration of qualified health personnel from countries with fragile health systems weakened those systems even further. Such countries were already coping with major burdens of morbidity with limited human resources. For example, Africa, which bore 25% of the global disease burden, had only 3% of the world's health personnel. It was thus urgent to limit those terrible effects on health systems, while also respecting the right of health personnel to move in search of greater opportunities. In that context, the code should speak more explicitly about those negative consequences.

Further in-depth analysis was necessary to find solutions, of which good recruitment practices were only one aspect. Incentives for local personnel to remain within their own country must be a priority. Both developed and developing countries should undertake personnel planning so as to meet their own needs in terms of health personnel. For the developed countries, that planning must lead to a reduction in the recourse to migrant health personnel.

Ms DLADLA (South Africa)¹ suggested that countries that had cooperated in workforce matters should use the draft code to build on existing relationships, which should also be consulted at regional level, in order to guide their collaboration. The draft code should be considered in conjunction with other cooperation instruments dealing with trade and investment.

One serious challenge was the lack of credible data, even at country level, on the health workforce. Investments should be made to mitigate that shortcoming. Since the draft code was to be voluntary, a monitoring system should be developed to ensure that it was adhered to.

South Africa called on international donor agencies and financial institutions to increase their technical and financial support to assist in the implementation of the code. Source countries needed

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

assistance to retain health personnel, while also allowing for an exchange of ideas, knowledge and technical expertise.

Ms NYAGURA (Zimbabwe)¹ said that the flight of health workers was a major concern for the African Region, as the recruitment practices of some Member States had led to the overstretching of countries' health sectors. The emigration had depleted health-care resources and widened the gap in health inequities. While the draft code was a positive step towards redressing the global imbalances, it was regrettable that its implementation would depend on the political will of the receiving countries. Zimbabwe therefore supported the establishment by WHO of a mechanism to monitor implementation of, and adherence to, the draft code.

Recalling that paragraph 2(4) of resolution WHA57.19 had requested the Director-General to support Member States in strengthening their planning mechanisms and processes in order to provide for adequate training of personnel, she proposed that the paragraph be inserted under paragraph 3 of the draft resolution, as it was relevant to Article 6 of the draft code of practice.

Mr ADAM (Israel)¹ said that his country attached great importance to the draft code, and was committed to voluntary implementation of those principles, both in the national and the private health system. Israel, too, suffered from the outbound migration of doctors and other health personnel, as well as from immigration of health personnel who were less trained and less skilled, particularly in the operation of modern medical equipment. Israel intended to maintain the high standards of its medical and health systems and to continue to support developing countries through its international cooperation and health programmes, in collaboration with United Nations agencies such as WHO.

Dr ALVIÁREZ (Bolivarian Republic of Venezuela)¹ said that the problem underlying the migration of health workers was the shortage of such workers in the developed countries, which did not have sufficient political will to train enough health professionals for their own needs. Therefore, the developed countries had to face up to their responsibilities.

Venezuela was currently training 25 000 doctors and more than 30 000 nurses a year, with the overall goal of training 200 000 doctors in 10 years, to meet its own need and those of certain Latin American countries. WHO should first analyse the shortfall in health professionals and technicians at all levels and then propose a global training programme for health workers. That could be financed largely by the developed countries.

Ms WISKOW (International Labour Organization) said that ILO considered the draft code of practice as an important and timely initiative. She recommended consistency in the wording of the draft code of practice with existing international instruments dealing with labour migration. For example, when the draft code of practice referred to equality of treatment and opportunities in Article 3.5, it spoke of "domestically trained health workforce" as a reference group. However, in international instruments, the reference group was "national workers". Even foreign workers or foreign students could be domestically trained, but that did not give them rights equivalent to national workers.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN and also on behalf of the International Pharmaceutical Federation, the World Dental Federation and the World Medical Association which, together formed the World Health Professions Alliance, said that the numbers of migrating health workers had significantly increased, with patterns of migration becoming more complicated. He expressed concern that the migration of trained

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

personnel was further weakening health systems in crisis, and undermined the ability of those countries to achieve the Millennium Development Goals and national health targets. Health professionals would welcome special attention in the draft code to the 57 countries identified by WHO as facing alarming shortages in health workforces.

The Alliance welcomed the formulation of national and international policy instruments to mitigate the negative impact of migration of health personnel, while providing strong safeguards for their fair and equal treatment. Adherence to the objectives and guiding principles of the WHO code of practice would enhance a global coordinated approach to reduce migration of health workers, improve retention and enhance the performance of health systems.

The DIRECTOR-GENERAL observed that the discussion had revealed a strong desire on the part of Member States for further consultations on the topic, to be facilitated and organized by WHO, before the Sixty-second World Health Assembly. There had been a clear call for balanced stakeholder representation and avoidance of disadvantage to Member States unable to attend such consultations. Accordingly she proposed that an informal discussion session should be held to develop some ideas on how and when to organize such consultations, and to give consideration to issues of cost.

The CHAIRMAN took it that the Board agreed with that approach. The item would thus be kept open.

It was so agreed.

(For continuation of the discussion, see summary record of the eleventh meeting, section 1.)

The meeting rose at 12:30.