

SIXTH MEETING

Wednesday, 20 January 2010, at 14:40

Chairman: Dr S. ZARAMBA (Uganda)

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

Monitoring of the achievement of the health-related Millennium Development Goals: Item 4.4 of the Agenda (Document EB126/7) (continued)

The DIRECTOR-GENERAL reported that, following discussions, it had proved unnecessary to convene a working group to consolidate the draft resolution on the Millennium Development Goals, and she thanked Member States for their flexibility in that respect.

Dr DAHL-REGIS (Bahamas), speaking on behalf of the member countries of the Caribbean Community, said that the Secretariat should provide guidance on the WHO definitions of fetal death and neonatal death as those were not being consistently applied across the region. Noting that childhood pneumonia accounted for 60% of child mortality, she stressed the issue of access to and affordability of pneumococcal vaccines. Recalling the region's initiative to prevent mother-to-child transmission of HIV and to eliminate congenital syphilis, she echoed calls for more equitable distribution of funds. The current model for reporting data on maternal mortality should be revised: it disadvantaged countries with small populations where the mortality rate might amount to only one or two deaths per year but was no less of a problem.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), welcoming the achievement of a reduction in child mortality, agreed that support for effective health strategies and strong health systems must be consolidated. Progress towards the Millennium Development Goal on maternal health was disappointing: one woman died every minute as a result of complications during pregnancy and childbirth. Emphasizing the removal of barriers to health services, he strongly welcomed the Consensus on Maternal, Newborn and Child Health (2009), which supported countries that removed user fees levied at the point of delivery as a means to encourage universal coverage.

Dr GIMÉNEZ (Paraguay) said that it was vital to protect health spending, improve the way in which funds were spent through results-based management, monitoring and evaluation. Paraguay had almost doubled its health budget over the previous decade, yet rates of maternal and child mortality had not decreased: clearly, the health system needed a change in focus. Health policies must be integral to social policies with prioritized funding. Following an international seminar hosted by Paraguay in June 2009, health ministers of the countries of the Southern Cone Common Market had agreed to promote health equity by focusing on the social determinants of health; he expressed support for the proposal to hold a global forum on that subject in 2011. He emphasized strengthened health systems through social participation, effective monitoring, information networks, developing human resources, and access to essential medicines and, more immediately, vaccines.

Dr VALLEJOS (Peru), noting varied progress towards achieving the health-related Millennium Development Goals, said that 90% of malnourished children or those suffering from stunted growth were concentrated in 36 countries, including Peru; and around half a million women died each year as a result of complications during pregnancy and birth. The achievement of Goal 5 (Improve maternal

health) required measures aimed at decreasing rates of malnutrition, reducing maternal mortality ratios, ensuring access to medical care during and following pregnancy; and fostering contraceptive use.

Those efforts would have a great impact on the other Goals and must involve all areas of government in a multisectoral, multidisciplinary approach, strategies that had been implemented in Peru with the aim of breaking the vicious circle of poverty and improving general health and well-being. With imagination, hard work and solidarity, solutions would surely be found in order to attain the Millennium Development Goals by 2015.

Mr OSMAN (Brunei Darussalam), welcoming the report's linking of noncommunicable diseases to the Millennium Development Goals, said that progress towards achievement of the Goals would be hampered by the financial crisis, emerging diseases and natural disasters. Susceptible areas included maternal health and access to family planning methods; sanitation and access to clean drinking-water; and access to essential medicines, which included rational use and affordability. The Secretariat should therefore provide technical support to Member States, especially developing countries, in strengthening national health systems to achieve the Millennium Development Goals.

Dr MOHAMED (Oman) said that some countries in the Eastern Mediterranean Region would have difficulty achieving the Millennium Development Goals unless they received assistance. The economic crisis had adversely affected budgets for health services and sufficient funding must be ensured. As the Goals were interlinked, he emphasized that issues should not be considered in isolation.

Dr BIRINTANYA (Burundi) expressed support for the essential amendments to the draft resolution proposed by the member for Malawi.

Mrs ESCOREL DE MORAES (alternate to Dr Buss, Brazil) said that Brazil was committed to the Global Campaign for the Health Millennium Development Goals. In relation to Goal 6 (Combat HIV/AIDS, malaria and other diseases) it was essential for the Secretariat to define a strategy and prepare a programme of work for the period 2011–2015. She also requested a report on progress made with initiatives on universal access.

She welcomed the draft resolution, but Brazil was not in a position to sponsor it. Recalling the commitment under the Monterrey Consensus on Financing for Development (2002) of coordinated support to development, the international community must join forces to preserve financial stability and sustain economic growth, essential to attaining the Goals. Developed countries must fulfil their pledge to allocate 0.7% of their gross national product as official development assistance, and promote reform of global governance.

Mr SATPATHY (alternate to Ms Sujatha Rao, India) said that India had some concerns about the draft resolution and wished to see it amended. Health equity was not only a national requirement but also an international prerequisite for the achievement of the Goals. Therefore the text should also take account of the need for international cooperation and global solidarity in that regard, in order to guarantee a flow of resources and technology, access to knowledge and the availability of medicines.

Social protection related to health but also covered areas such as education, sanitation and habitation. Accordingly, some countries would have difficulty in implementing social protection and require assistance through technical cooperation, resources and efficient budgeting. The concerns expressed in other United Nations bodies regarding social protection should also be taken into account. It was to be hoped that the high-level meeting to review progress on the Millennium Development Goals, to be held during the forthcoming session of the General Assembly, would focus on all the Goals, given their interconnection.

Dr LIU Peilong (China)¹ welcomed the information on noncommunicable diseases and injuries contained in the report; it was to be hoped that they would rapidly be included among the Millennium Development Goals. The draft resolution should make reference to noncommunicable diseases in both its preamble and operational paragraphs.

Mrs NYAGURA (Zimbabwe)¹ said that the report should include both graphic and written information on progress made in individual regions. Her country, like others in sub-Saharan Africa, remained constrained by inadequate financial resources, weak health systems, lack of access to proven interventions and an acute shortage of health workers. Limited progress had been made in achieving the Millennium Development Goals in general, and in some cases, such as Goals 4 and 5, the gains made had been eroded. If further advances were to be made, funding would be needed in maternal and child health and for noncommunicable diseases. She trusted that the Director-General would continue to draw attention to that issue.

Achieving the target of universal access to reproductive health by 2015 was essential to improving maternal health in general. The countries of the African Region required sustained support in order to strengthen family planning programmes; to address all causes of maternal mortality; and to further integrate HIV interventions within reproductive health services. She called on all Member States and development partners to match commitments with concrete and coordinated action.

Ms MNISI (South Africa)¹ said that the report and the draft resolution should include reference to regional disparities. The Regional Committee for Africa at its fifty-ninth session had concluded that most countries in the African Region had made insufficient progress towards achieving the health-related Millennium Development Goals. Only five countries were on track to achieve Goal 4 (Reduce child mortality) and estimates indicated that no progress had been made in the Region towards achieving Goal 5 (Improve maternal health). Only one third of the population with advanced HIV infection had had access to antiretroviral treatment in 2007.

The capacity of health information systems had to be strengthened, in particular for data management, by means of sufficient and trained human resources, adequate financing and logistical support.

She thanked WHO, UNAIDS, UNICEF and UNFPA for their support in assessment of the integration of HIV interventions within reproductive health services. With five years remaining until 2015, countries needed to recommit to all the Millennium Development Goals, which were interrelated, and in particular Goals 4, 5 and 6. She called on development partners to continue their support in the African Region.

Professor KULZHANOV (Kazakhstan)¹ thanked the Director-General for her efforts to promote the achievement of the health-related Millennium Development Goals. Kazakhstan had placed a focus on primary health care as essential for strengthening health systems. A sharp decline in maternal and child mortality rates was due in part to initiatives to promote breastfeeding and maternal health. However, questions remained concerning Kazakhstan's ability to achieve other Goals, owing to the spread of HIV. Difficulties included the identification of risk groups, and the availability of antiretroviral medicines, but Kazakhstan was cooperating closely with the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS, other international organizations and civil society in order to prevent the further spread of the virus in the country. He trusted in support from WHO and other United Nations agencies in that regard.

The report should further emphasize learning from the positive experiences of other countries, including those in central Asia. Kazakhstan would be pleased to share its experience with others.

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

Mr FEYDER (Luxembourg)¹ trusted that WHO would make an important contribution to the high-level meeting on the Millennium Development Goals that was to be held in September 2010 under the auspices of the United Nations. That meeting should highlight the interdependent nature of the Goals, and the importance of establishing health systems. He welcomed the almost four-fold increase in spending on health between 1997 and 2007; health ministries should be given the resources they needed to build health systems from both national budgets and official development assistance. He drew attention to the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008), and to the need for innovative national and international financial mechanisms. To overcome the remaining obstacles to achievement of the Goals, the essential work of international organizations needed to be complemented by concrete action at country level implemented by national ministries of health.

Dr KESKİNKILIÇ (Turkey)¹ said that countries should develop mechanisms to provide free access to primary health care services, in particular for the most vulnerable groups of society. He emphasized the importance of the health workforce for the achievement of the Millennium Development Goals, and welcomed WHO's efforts regarding the establishment of ethical codes. He suggested, in view of the limited time before 2015, the establishment of an action plan covering priority areas for the reallocation and provision of new resources.

Turkey had become the sixth most successful country in reducing child mortality according to UNICEF's 2009 report on the *State of the World's Children*, and provided proof that child mortality could be decreased.

Mr FILLON (Monaco)¹ said that Monaco had committed 0.7% of its gross national income to official development assistance. He supported the draft resolution, which had been the subject of lengthy informal discussions among the parties concerned, and took account of important issues such as equity, solidarity and gender specificity.

Dr SIRIWAT TIPTARADOL (Thailand)¹ said that Thailand was on track to achieve many of the Millennium Development Goals and the country's "MDG-plus" targets by 2015. Following the extension of rural health services to all subdistricts and districts, several of the Goals' indicator targets had been achieved. Those included 98% antenatal care coverage, which had facilitated the scaling up of the national programme on mother-to-child transmission of HIV; and 98% immunization coverage against tetanus, diphtheria and pertussis. Moreover, the antiretroviral treatment programme had been expanded in 2009, with more than 200 000 patients currently enrolled.

Continued support from WHO and donor countries was still vital to enable South-East Asian countries to achieve Goal 4 (Reduce child mortality) and to improve in the areas of neglected diseases and noncommunicable diseases. Technical support for improving health information systems and strengthening public-private partnerships was also critical to the achievement of the Goals.

Ms ARMITAGE (United Nations Population Fund), speaking at the invitation of the CHAIRMAN, commended the Director-General's unwavering commitment to women's health and her recognition of its importance for the achievement of all the health-related Millennium Development Goals. Recent research suggested that, if countries doubled investment in family planning and pregnancy-related care, maternal deaths in developing countries could be cut by 70%, and neonatal deaths by nearly half. Goal 5 (Improve maternal health) should be placed at the centre of global health, health systems strengthening and national funding. Strong health systems delivering services for family planning; maternal, child and newborn care; and the prevention and treatment of HIV/AIDS, tuberculosis and malaria.

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

Her organization, working in collaboration with WHO, UNICEF and the World Bank, was convinced that the health-related Millennium Development Goals could be achieved through broad-based coalitions and mutually supportive action.

Mr BARARUNYERETSE (Organisation Internationale de la Francophonie), speaking at the invitation of the CHAIRMAN, said that, with only five years remaining until 2015, the work needed on maternal and child health should be closely monitored, resources mobilized, and appropriate policies developed before it was too late. His Organization supported the draft resolution.

Mgr TOMASI (Holy See), speaking at the invitation of the CHAIRMAN, welcomed the draft resolution and said that ongoing commitment and effective action would be required to achieve the Millennium Development Goals. The application of measures in that regard, despite the difficult global financial situation, would produce important benefits for the development of nations in need of assistance, and for the peace and well-being of all countries. Referring to steps being taken to reduce maternal and child mortality and morbidity, he reaffirmed the Holy See's position that the terms "sexual health" and "reproductive health" referred to a holistic concept of health and sexual maturity within moral norms, and abortion was not considered to be included in those terms.

Ms KEITH (World Vision International), speaking at the invitation of the CHAIRMAN, recalling the 8.8 million childhood deaths due to preventable diseases every year, said that her Organization's first global campaign "Child Health Now" had been launched in November 2009. Strengthened political commitment was needed to meet the Millennium Development Goals, as seen by the progress made in Liberia as a result of increased financing, better human resources, support of the national health plan, and the decision to ensure free access to health care. Expressing support for the Paris Declaration on Aid Effectiveness (2005), she said that all discussions on innovative financing for health systems should be more transparent and inclusive of civil society.

With regard to the draft resolution, she agreed with the comments made by the members for Malawi, Brazil and Indonesia, and was encouraged by the statement made by the representative of Turkey. Paragraph 1(4) should include a reference to the need to assist States in removing health charges at the point of access and increase resources for social protection mechanisms. Many of the issues being discussed had been agreed previously by the adoption of resolution WHA58.31 in 2005. She asked that health governance and accountability also be included in paragraph 2(4) of the draft resolution.

Ms CHILDS (MSF International), speaking at the invitation of the CHAIRMAN, said that, while 4 million people had access to HIV treatment, 10 million people still did not. The many shortfalls in child and maternal health services included emergency obstetric services. The target related to tuberculosis would not be met without improved diagnostics and medicines. Effective global nutrition programmes to combat child malnutrition would need an estimated US\$ 12 500 million. Ensuring universal access to HIV treatment needed renewed political commitments in the global financial crisis.

The draft resolution should include a reference to the global strategy and plan of action on public health, innovation and intellectual property; ensuring access to health technologies was needed to achieve the Millennium Development Goals. WHO should play a leading role in reporting on health programmes that were at risk from the global financial crisis, in estimating gaps in funding, and discussions on innovative financial mechanisms, such as financial transaction taxes. The 2009 Millennium Development Goals Gap Task Force Report had noted that action was required to improve access to and affordability of essential medicines, such as the patent pool for HIV medicines being set up by UNITAID.

Ms BARUAH (Global Health Council), speaking at the invitation of the CHAIRMAN, welcomed the report and the draft resolution, and noted the progress made. She drew attention to the contribution of the noncommunicable disease network in efforts to combat noncommunicable

diseases. Immunizations were an important child health intervention, and continued funding was needed for new vaccine research, in particular for AIDS, malaria and tuberculosis, and for neglected tropical diseases. There was a need to strengthen health systems; to provide greater human resources; and to focus on leadership, especially at the community level. Member States needed to make key policy changes to enable the Millennium Development Goals to be met, in particular in areas such as gender-based violence and drug use.

Mr WRIGHT (Save The Children Fund), speaking at the invitation of the CHAIRMAN, called for a reference to the Global Consensus on Maternal, Newborn and Child Health to be included in the draft resolution. The Global Consensus encouraged an integrated approach to maternal, neonatal and child health; it supported free access to health-care services, as had already been endorsed by resolutions WHA58.31 and WHA58.33; and it highlighted the strengthening of health systems with the provision of responsive, resourced emergency care. Emphasizing renewed commitment in the short time left to achieve Goals 4, 5 and 6, his organization had launched a global campaign for child survival, called Every One.

Dr EVANS (Assistant Director-General) identified the common elements of the discussion, including: rights and equity, affordable and accessible services, health systems with appropriate and adequate workforces, and a whole-society approach to health care. There would be opportunities for progress in the short-term, such as the high-level meeting of the United Nations General Assembly due to be held in September 2010. In the longer term further developments would be required after the 2015 deadline. He had taken note of specific calls for enhancing standardization in maternal and neonatal health. Good progress had been made in increasing capacity for monitoring and measurement, with more real-time information being used than models and estimates, in particular in small populations and during rare events. In response to the request for a regional breakdown of information, he said that more detailed regional information would be provided in the World health statistics report to be published in time for the next Health Assembly in May.

The DIRECTOR-GENERAL welcomed the consensus on the urgent need to achieve the Millennium Development Goals before 2015, but recalled that 2015 would not be the end of efforts. She affirmed the importance of an integrated approach to meeting the health-related Goals, and the inclusion therein of programmes relating to noncommunicable diseases. In addition, equitable access to primary health care was essential. Important regional and national meetings to assess progress on attainment of the Goals would be held in 2010, and she expressed the hope that related events would also take place during the next session of the Health Assembly. She thanked the member for Brazil for the offer to host a global forum on social determinants in health in 2011. With regard to the importance of an Organization-wide strategy, she said that such a strategy was already being developed, having begun with the need for an integrated approach to HIV/AIDS. She encouraged members to adopt the draft resolution by consensus.

(For adoption of the resolution, see summary record of the seventh meeting, section 2.)

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: Item 4.1 of the Agenda (Documents EB126/4 and EB126/INF.DOC./1) (continued from the fifth meeting)

Dr SEDYANINGSIH (Indonesia), reporting on the outcome of the informal consultations, said that participants had agreed that negotiations between the Member States should be conducted by an open-ended working group, using as a basis the report by the Director-General on the outcome of the

resumed Intergovernmental Meeting on Pandemic Influenza Preparedness.¹ The proposal was that, in order to optimize the use of WHO's resources, the group should convene on 10, 11 and 12 May 2010. The group would aim to reach agreement on remaining elements under the pandemic influenza preparedness framework and to report on the outcome to the Sixty-third World Health Assembly. The Director-General was requested to facilitate that process.

Dr OMI (Japan) expressed support for the proposal but emphasized the need to avoid repetitive discussions and to resolve problems. He therefore urged Member States, in the interests of consensus, to consider and prepare concessions in advance of the proposed meeting.

Dr DODDS (Canada) echoed that support. She suggested that the working group could also refer to the Director-General's consultation with Member States on proposals to finalize remaining elements under the framework.²

The CHAIRPERSON said that he took it that the Executive Board wished to agree to the proposal outlined by the member for Indonesia.

It was so decided.

The DIRECTOR-GENERAL said that she would do her best to facilitate the agreed process but that it might be necessary to approach Member States for the additional funding that would undoubtedly be required, notwithstanding the cost-effectiveness of convening the meeting in the days preceding the Health Assembly. Concerning the Board's earlier request for a review of the pandemic (H1N1) 2009 and the functioning of the International Health Regulations (2005), she would appreciate further guidance. To that end, she would prepare a summary of the review mechanism that she had suggested at the time, including information on the intended components and scope of the review.³

Dr DAHL-REGIS (Bahamas) appealed for every effort to be made to finalize the remaining elements under the pandemic influenza preparedness framework at the meeting to be held in May 2010, thereby ending a process that had been time-consuming, labour-intensive and costly.

The Board noted the report.

International recruitment of health personnel: draft global code of practice: Item 4.5 of the Agenda (Document EB126/8)

Mr DE CAMPOS (alternate to Dr Buss, Brazil) welcomed the fact that the matter had been debated among the six regional committees and that the outcomes of those discussions had been incorporated into a revised draft code of practice. Those advances having been achieved, it was time to move ahead.

Human resources being the key to building a strong health system, Brazil had a national secretariat for dealing with the education and working conditions of its health workforce. It had also participated in international meetings aimed at highlighting those resources. His country was not yet directly affected by the migration of health-care personnel; however, such movement was likely to increase in today's globalized world. He therefore supported the immediate adoption of the draft code

¹ Document A72/5 Add.1.

² Document HSE/GIP/PIP/2009.1.

³ See document EB126/INF.DOC./3.

as a first step towards bringing the issue to the fore, and looked forward to its wide implementation by Member States.

Dr OULD HORMA (Mauritania), speaking on behalf of the Member States of the African Region, said that the increasing migration of health professionals to the richer countries weakened the fragile health systems in the Region and threatened the achievement of the health-related Millennium Development Goals. The current version of the draft code gave rise to concerns, including: the need for a sizeable return on investment to enable the training of health personnel in developing countries; the non-binding character of the draft code, and the lack of any clear mechanisms for dispute resolution; reciprocal benefits and the failure to recognize the detrimental effect of recruitment on countries with poor health systems; protection of the rights of health workers; and the legal implications of restrictions on the free movement of such workers.

A database on human resources for health in African countries was available, established with the aim of aiding decision-making. Policies for retention of the health workforce in rural and remote areas had also been documented in two African countries in order to assist WHO in its task of developing guidelines and recommendations on the subject. As was the case in Mauritania, such retention was encouraged through, *inter alia*, improved planning and management of human resources for health, salary reviews, incentive measures, and enhanced working conditions. The challenge was to mobilize sufficient resources to implement such measures, including any code of practice on international recruitment of health personnel.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, the candidate countries Croatia, Turkey and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro, Serbia, as well as Ukraine, the Republic of Moldova and Armenia, said that the draft code, for which the European Union and the European Region had expressed support, was more accurate and structured in its preamble, and its content should have a positive impact on health systems in developing countries and countries with economies in transition. Its multisectoral approach to tackling structural problems was also a proven key to addressing weak health systems. He welcomed the call for national policies and measures for a sustainable workforce, workforce planning and retention. Data availability and resource constraints should also be taken into account, as the formulation of evidence-based policies demanded systems for reliable data collection and monitoring of the migration of health personnel. He also proposed that national measures, and the role of decentralized authorities, should be mentioned in the preambular paragraphs and definitions of key concepts provided in an annex.

While understanding the need for compromise, the European Union had difficulty with articles 4.2, 7 and 8. It was essential to avoid the impression that individuals were to be held responsible for development in their country of origin or that their right to leave was to be restricted. Policies that could lead to discrimination in the immigration process on grounds of nationality or profession were similarly to be avoided. The financial and administrative implications of the revised draft code should also be specified, particularly in the context of articles 7 and 8, which were potentially demanding. In the area of data-gathering, WHO would do well to cooperate with OECD in order to avoid overlap and ensure high quality data. The voluntary financial mechanisms mentioned in articles 3.3 and 11.3 also required clarification, as did the applicability of article 5.4. He called on the Secretariat to arrange consultations on the draft code, which should be submitted to the Sixty-third World Health Assembly for consideration.

Dr DODDS (Canada) fully supported the overall intent of the draft code. On its basis her Government had developed a unified approach to the recruitment of health personnel that reflected the challenges of the Canadian federation and its multiple jurisdictions. The current draft of the code posed challenges to Canada in so far as the primary responsibility in matters of health personnel resided at the subnational level. The meaning and intent of articles 4 and 5 required clarification. In view of those concerns, she proposed that Member States should exchange comments and suggestions

on the text through the Internet, with a view to finalizing the draft. A revised version of the draft code, taking into account the views expressed, could then be produced for consideration by the Health Assembly.

Mr PETERU (alternate to Ms Toelupe, Samoa) said that the consultations held by the regional committees on the draft code had addressed many of the concerns regarding the specific needs of source countries such as Samoa. He therefore supported the draft code.

Dr ABABII (Republic of Moldova) said that in his country, in addition to international migration of health personnel, internal migration had a dire effect on the population's access to health care: from the health-care system to other branches; from the public to the private sector, including pharmaceutical companies; and from rural to urban areas. In response, the Government was providing financial incentives to physicians practising in rural areas and had legislated to improve the career prospects of newer members in the medical professions.

The impact of losing large numbers of health-care professionals to foreign countries had not been solely negative. Working abroad, health personnel had improved their living conditions, acquired valuable experience in using the latest technology, and mastered foreign languages. However, the difficulty was in keeping track of the rapid pace of that brain drain; hence the need to develop an international monitoring mechanism, as the draft code envisaged.

The ethical principles set out in the draft code, designed to achieve a balance between the rights and obligations of source and destination countries, were in line with contemporary needs. Significantly, the draft code applied to health personnel in both the public and private sectors. Equally important, destination countries should provide technical and financial assistance to source countries aimed at strengthening their health systems. The draft code should also delineate mechanisms for, if not international, at least regional accreditation for schools of medicine and the licensing of physicians, over which WHO must have authority. It took nine to eleven years to train a physician, and a mechanism must be envisaged under which destination countries could compensate source countries public funds spent on such training. The same principle should be applied domestically when health personnel migrated to the private sector.

He requested support in strengthening health-care systems and in training health personnel in countries like his own with economies in transition.

Dr STARODUBOV (Russian Federation), supporting the revisions made to the draft code, considered that clearer wording would facilitate its practical application. The adoption and subsequent application of the draft code by Member States should promote an equitable balance of interests among source and destination countries.

In line with current international practice regarding non-binding instruments, the draft code was intended to facilitate voluntary compliance at the national and international levels, through bilateral agreements, and voluntary mechanisms for the exchange of information and monitoring. In developing the draft code, the regional offices had already begun working on regional coordination and exchange of information, yet no coordinating role was envisaged for them under the draft code.

The migration of health personnel occurred in all countries, including his own, which acted as both a source country and a destination country. Like most Member States, it already applied the principles set out in the draft code and provided educational opportunities for health personnel from other countries, which included reference to bilateral agreements. In future, the use of distance learning for physicians from foreign countries would be expanded. The Russian Federation's existing system for monitoring the lawful migration of workforces did not yet take account of the specificities of health workforce migration. It would like to gain from the experience of WHO and OECD in creating special national and regional databases on the migration of health personnel and was prepared to exchange information with interested countries. The Russian Federation would support further efforts to achieve agreement on the draft code.

Ms ROCHE (New Zealand) said that, as work to refine the draft code continued, it must be recognized that individuals made personal choices about whether to live and work in a different country; that governments needed to manage migration; and that health-service provision must operate within a global health workforce. Recognizing the progress made, New Zealand sought greater clarity with regard to the rationale for global employers of health workers to adopt and implement the draft code; further elaboration of WHO's role in supporting implementation; and better reflection of the global nature of the issue. It supported the suggestion by the Health Worker Migration Global Policy Advisory Council that in the title of article 6, the word "national" be deleted so that it read "Health workforce sustainability and retention".

New Zealand sought recognition of the challenges faced by small island States that often struggled to meet the needs of their widely dispersed populations. Specific objectives and indicators that took account of Member States' capacities would need to be agreed on and used for reporting on eventual implementation of the code. She supported the suggestion by the member for Canada of a web-based consultation because it would enable small countries to participate fully. She suggested that, as had been done for the Commonwealth Code of Practice for the International Recruitment of Health Workers, the WHO draft code, once adopted, should be submitted to relevant stakeholders.

Mr PRASAD (adviser to Ms Sujatha Rao, India), emphasizing the threat posed to already fragile health systems in developing countries by health-worker migration, suggested some further amendments to the draft code. Article 2 should be strengthened to ensure that the draft code applied to all types of health workers, and that should be described in an accompanying glossary. Clear guidelines should be introduced: in article 3.5 to ensure fairness and transparency in recruitment; and in article 9 for implementation of the code by Member States, with particular reference to the private sector. Under article 4.2, migrant health workers should be required to declare legal obligations in their source country to recruiters in the destination country, and under article 4.3 they should have access to detailed job descriptions. Under article 5 or 6, Member States should be required to support migrants wanting to return to source countries; and should be provided with guidelines for systems to redress grievances arising during recruitment and employment. India would welcome a draft global code of practice that responded to the needs of countries that were investing in their health workforce only to lose a good share of it to migration. However, he suggested further examination of the draft code's compatibility with ILO's existing provisions, notably on migration, human rights and freedom of movement: a code specific to the health sector might have discriminatory repercussions in other sectors.

Professor HAQUE (Bangladesh) said that his country suffered from a shortage of health workers but did not oppose their migration to other countries, out of a respect for individual human rights; for the opportunities to gain experience from other work settings in other countries; to promote technology transfer; and to foster flows of remittances back to Bangladesh. The draft code could protect migrants from ill-treatment in destination countries, and the provisions on mutuality of benefits in article 5 were especially noteworthy. A meeting of stakeholders in Bangladesh in 2009, while endorsing most of the draft code, had observed that the costs of training skilled health workers called for a mechanism for destination countries to compensate source countries for their investment, either in monetary terms or through support for the development of their health systems and personnel. They had also emphasized equal treatment of migrant health workers, irrespective of race, religion, age or gender; had suggested that authority for implementation of the draft global code at the national level should lie with ministries of health; and had advocated that source and destination countries should examine ways to prevent migration flows from being influenced by a sudden surge in "push-and-pull" factors.

Dr GIMÉNEZ (Paraguay) said that the situation of the health workforce in his country perhaps epitomised J.T. Hart's "inverse care law", with the fewest workers available where they were most needed. Migration had reduced the size of the workforce to less than half the minimum recommended by WHO, and regional and national statistics showed a deep rural-urban divide. In response, the Government had developed a strategy for human resources based on the Toronto Call to Action

(2005). The draft code might be short on ambition or too general in parts, but it represented a huge step in the right direction and, once adopted, would be of great importance to countries like Paraguay. Expressing particular satisfaction with the provisions under article 5.2, which set out specific measures for ensuring mutuality of benefits, he endorsed the draft code.

Ms ARTHUR (alternate to Mr Houssin, France) acknowledged the efforts to prevent the migration of qualified health workers from further weakening the fragile health systems of developing countries. Adoption of the draft code would be a step towards strengthening those systems, with further work needed after that, for example in regard to good recruitment practices. The revised draft code represented a significant improvement: the preamble clarified the challenges; the principles of ethical recruitment and equality of treatment implied a reference to duties as well as rights; there was improved balance between respect for the freedom of movement of health workers in search of better opportunities, and the impact on health systems in source countries; and article 6 underscored the importance for all countries to formulate management policies for their health workforce. Data-gathering would be essential for implementation of the code, and she commended the joint approach of WHO and OECD to improving the availability and comparability of data, including plans to hold a workshop in June 2010 to identify useful data sources and the types and scope of data required. The consultation process should continue and France would work with other partners to finalize the draft code for adoption at the next Health Assembly.

Dr DAHL-REGIS (Bahamas), noting that the principles contained in the draft code were clearly in line with the Commonwealth Code of Practice, which had been endorsed by every country in the Caribbean region, welcomed the suggestion of the member for New Zealand. Yet clarifications were still required. The ground had shifted in her region: the Bahamas, once chiefly a source country, had become both a source and a destination country after having had to restore its health system. She supported the proposal to hold a web-based consultation to examine the language of the draft code: additional consultations of some kind were in order before a finalized document could be submitted to the Sixty-third World Health Assembly.

Dr OMI (Japan) supported the revised draft global code of practice. It was comprehensive and reflected the need, repeatedly emphasized by his delegation, to stress the voluntary nature of the code.

Dr MOHAMED (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the review process had identified the strengths and weaknesses of the draft code, enabling submission of the draft code to the forthcoming Health Assembly with a view to its subsequent implementation. As already pointed out, the migration of health personnel had its positive aspects; remittances sent to source countries, for example, could be used to great advantage, both in their health sectors and elsewhere.

For its part, the Regional Office for the Eastern Mediterranean worked in close coordination with the Member States of the Region in order to build their health capacities. Through its focus on poorer countries, it had lent support for education facilities and training activities in such countries as Djibouti, Somalia and the Sudan. Changing work conditions were, however, creating difficulties in connection with the recruitment of health personnel. Wages in source countries, for instance, were starting to compete with those paid in destination countries. He expressed support for the draft global code of practice and looked forward to its implementation, on which basis it could then be further revised and amended, as necessary.

Ms DLADLA (South Africa)¹ expressed appreciation for the principles and objectives of the draft code and its potential to protect the interests of developing countries. However, she agreed with the member for the Bahamas on the need for clarifications and some form of consultation. One key point was whether the draft code could, in its present form, ensure a fair return on the investment made in the training of health workers by developing countries, including those in some of the neediest parts of the world. Another was mutuality of benefits, which had been articulated well in the Commonwealth Code of Practice. On the matter of gains and losses of health personnel migration, she asked the Secretariat to clarify exactly what those gains were and, further, to explain why the draft code attributed a statement concerning the balance of gains and losses to the African Region when no mention of the subject had appeared in either the report or the resolutions of the Regional Committee for Africa at its fifty-ninth session.

Ms NYAGURA (Zimbabwe), supporting the comments made by the representative of South Africa, said that hers was one of the countries hardest hit by continuing migration of health workers, weakening the country's health system and had hindering its progress in achieving the health-related Millennium Development Goals. The draft code must redress the inherent inequalities between source and destination countries. The rights of the individual must be upheld, but individuals had to cooperate fully with the State to ensure that all people enjoyed the highest attainable standard of health. That concept of cooperation should be incorporated into the guiding principles of the draft code to bring it into line with the WHO Constitution. The draft code had been sufficiently developed in the course of regional consultations to provide a basis for negotiation at the next Health Assembly. She could agree to the proposal by the member for Canada to conduct web-based consultations as long as the outcomes were not incorporated into the final document; and it was fully prepared to participate constructively in the negotiations to finalize the draft code at the Health Assembly.

Dr NEIKNAM (Islamic Republic of Iran)¹ welcomed the revised text of the draft code, which incorporated specific changes requested by the regional committees. The international migration of health workers was a global health challenge that called for multidimensional solutions. While health workers had a human right to migrate to countries that agreed to admit and employ them, large-scale migration could have a devastating impact on the health systems of source countries. The draft code should accordingly include a recommendation that Member States limit international recruitment from countries with critical shortages to their health workforce. It should also promote the formulation and implementation of bilateral and multilateral agreements based on the principle of mutuality of benefits. Nationalization of medical education, and matching education with local health needs were safeguards against the migration of health workers from developing countries to destination countries and should be promoted by the Secretariat and Member States.

Mr BIÉLER (Switzerland)¹ said that more than one third of health workers in Switzerland came from foreign countries, mostly neighbouring countries. Yet Switzerland was fully aware of the damage done by unauthorized recruitment of physicians and nursing staff from countries where the health systems were most vulnerable. The time had come to strengthen those health systems, in order to address the root of the problem.

The formulation of an effective draft code of practice had immediately appealed to his Government, which had been studying the phenomenon of migration and brain drain. In order for such a draft code to make an impact on national policy, however, it must define more precisely the measures proposed, the partners involved, and the States that would be adopting its recommendations. Regional consultations had suggested that a clearer distinction should be drawn between recommendations to States and to other health care partners; that the wide variations in national legislation on recruitment must be taken into account; and that the concepts of self-sustainability and

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

of compensation should be elaborated. Taking such concepts into account would ensure that the most important elements of the draft code were in line with the legislative capacities of States for practicable implementation. The limited capacities of States with decentralized decision-making powers should not be overlooked. Holding a meeting to finalize the draft code before the Health Assembly was preferable to a web-based consultation.

Mr HOHMAN (United States of America)¹ said that he was aware of the responsibility shared by all to help to alleviate the international shortage of health workers. Working together, countries could begin to find sustainable alternatives that benefited everyone. The draft code had been considerably improved by the views expressed during the regional committee meetings, yet serious concerns remained.

The document should be structured more as a set of guiding principles and less like a legislative act. It should not link provision of development assistance to recruiting practices. It should address the situation in federal States. All countries had legitimate needs and interests, but the document should not attempt to balance rights, which might imply that the rights of one group were more important than those of another. Most importantly, nothing in the draft code should undermine the human rights of health workers who were in the process of migrating.

He supported requests for an opportunity for Member States to contribute further to the draft, perhaps initially through a web-based consultation.

Dr VIROJ TANGCHAROENSATHIEN (Thailand)¹ said that the revised draft code was more balanced, but he agreed with the representative of the United States that further improvement was needed. There were far too many square brackets; a clean text should be sent to the Health Assembly. He suggested that in the fourteenth preambular paragraph, the words “and social obligations” should be inserted between “the rights” and “of health personnel”, in order to ensure a proper balance. Article 3.4 would then have to be amended accordingly. The sixteenth preambular paragraph was unclear and its relevance was questionable. He agreed with the wording suggested by the member for India for article 4.2. The title of article 7 should read “Evidence basis for policy decisions”. He would welcome any opportunity to fine-tune the text in advance of the Health Assembly.

The CHAIRMAN asked the representative of Thailand to submit his suggestions in writing.

Dr OULD ABDI SALEM (adviser to Dr Ould Horma, Mauritania), speaking on behalf of the Member States of the African Region, said that he was open to any practical suggestion that would take into account the Region’s specificities. The draft code had been the subject of lengthy consultations with all regional committees and was a good basis for negotiation, which could take place at the next Health Assembly. He had reservations, however, about the proposal to use a web-based consultation as a tool for revising the current text.

Ms TIJTSMA (Medicus Mundi Internationalis – International Organization for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, welcomed the revised version of the draft code, with its emphasis on the roles and responsibilities of destination countries. Monitoring of the code should be a transparent process inclusive of all relevant stakeholders. Article 3 of the draft code should stress the obligation of countries both to strengthen their own health systems and to provide international cooperation and assistance; and it should call for more coherent domestic and international policies. The concept of shared responsibility should be added to article 5. Her organization urged countries that were reliant on foreign health workers to share the responsibility of supporting human resources for health in source countries.

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

The title of the draft code should be amended to include the word “ethical”. The preamble should highlight the fact that development measures for the domestic workforce and incentives offered by destination countries actually increased the international movement of health workers. The draft code should be submitted to the next Health Assembly.

Mr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN and on behalf of the International Pharmaceutical Federation, the World Dental Federation and the World Medical Association, which together formed the World Health Professional Alliance, said that balance was needed between the rights of individual health workers and the right to health of the populations of source countries. The draft code should apply to both the public and the private sector and to both permanent and temporary staff. His organization welcomed the provisions of article 4 on responsibilities, rights and recruitment practices and article 6 on national health workforce sustainability and retention. However, the term “active recruitment”, which appeared in article 5.3, was not defined, and therefore it was not clear how the proposed ban on it would be implemented.

He welcomed the provision in paragraph 9.5 that encouraged Member States to maintain a record of and monitor authorized recruiters, and the proposed system of reporting by Member States to the Secretariat (paragraph 10.1), which would allow WHO to monitor the status of migration of health workers and its impact on health systems throughout the world. He supported the revised draft, which should be submitted to the Health Assembly in May.

Mr PRASAD (adviser to Ms Sujatha Rao, India) supported the amendments proposed by the representative of Thailand.

Dr ETIENNE (Assistant Director-General) thanked participants for their valuable comments and their suggested amendments, which the Secretariat would endeavour to reflect in the draft, as it had done with the views expressed during the discussions by the regional committees.

The DIRECTOR-GENERAL asked how the Board wished to proceed. A small number of members appeared to be prepared to adopt the current draft straight away. The majority wanted more negotiations, either in a face-to-face meeting or via a web-based consultation, while a third group felt that the current draft should be submitted to the Health Assembly for negotiation and adoption by all Member States. Some had said that they would not accept any amendments proposed in the course of web-based consultations, and the latter would consequently be of limited value.

Mr DE CAMPOS (alternate to Dr Buss, Brazil) said that, if the Board sent the draft round for yet more consultations, it would be no nearer finalization than the previous year. The issue was urgent, and the draft code should be adopted as soon as possible.

The CHAIRMAN noted the remark in paragraph 10.5 of the draft that the draft code should be considered a dynamic text which would be updated as required.

Mrs NYAGURA (Zimbabwe)¹ said that a web-based procedure could be used to clarify the positions of the various parties, but the draft should not be changed.

Dr VIROJ TANGCHAROENSATHIEN (Thailand)¹ recalled that, in the previous web-based consultations held in September and October 2008, responses from professional organizations that dealt with migrant workers had far outnumbered those from the developing countries which were most affected. Views obtained via the Internet would inevitably constitute a biased sample.

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Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, said that there had already been ample opportunity for consultations and that he was not, therefore, in favour of a web-based consultation. They had a number of comments and amendments to suggest, and other parties had made suggestions during the current meeting: all of them must be reflected. It was essential that the draft code be adopted by the next Health Assembly, without further delay.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that the Board had already spent a great deal of time at the current session discussing procedural matters. It should take a decision so that it could move on to the rest of its agenda.

Dr GIMÉNEZ (Paraguay) said that his country had endorsed the draft code as it stood. The Secretariat had the tools, leadership skills and institutional authority to produce a final text that could be adopted by the Health Assembly.

Dr OMI (Japan) said that there had already been enough consultation on the text, which was not as controversial as some others. He agreed with the points raised by the representative of Thailand. The suggestions made at the current meeting should be incorporated into the draft and it should be transmitted to the Health Assembly for consideration.

Dr MOHAMED (Oman) said that the text should be checked for any errors but should otherwise be considered ready for adoption.

The DIRECTOR-GENERAL said that she would submit the draft text without any amendments to the Health Assembly.

Mr HOHMAN (United States of America)¹ said that his delegation, for one, had more substantive amendments to suggest. Comments and proposed amendments from all Member States could certainly be collected together and submitted to the Health Assembly, but would they be incorporated into the current draft, or would that go forward unchanged?

The CHAIRMAN said that the general principles behind the text appeared to be agreed. Delegations should submit their comments and amendments; they would be incorporated into the text in brackets, if that could be done easily, or submitted separately to the Health Assembly.

Dr OMI (Japan) suggested that interested delegations should discuss their proposed amendments with the Secretariat, so that consolidated agreed text could be incorporated before the document was transmitted to the Health Assembly.

Dr SADRIZADEH (Islamic Republic of Iran)¹ said that sufficient discussion had been held. The Secretariat should prepare a final revised draft for review by the Health Assembly, taking into account the points raised at the current meeting.

The DIRECTOR-GENERAL suggested that the current draft should not be changed, since it reflected the views of the regional discussions. Comments or amendments submitted by Member States would be forwarded separately to the Health Assembly for consideration.

It was so agreed.

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Replying to a question from Dr OULD ABDI SALEM (alternate to Dr Ould Horma, Mauritania), speaking on behalf of the Member States of the African Region, the DIRECTOR-GENERAL said that the comments and amendments would be summarized in a separate document, for the information of Member States.

The meeting rose at 18:10.