

## **FIFTH MEETING**

**Wednesday, 23 January 2008, at 09:10**

**Chairman:** Dr B. SADASIVAN (Singapore)

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

**Implementation of the International Health Regulations (2005):** Item 4.5 of the Agenda (Documents EB122/8, EB122/8 Add.1 and EB122/INF.DOC./2) (continued from the third meeting)

The CHAIRMAN invited the Board to consider the revised draft resolution on implementation of the International Health Regulations (2005), which read:

The Executive Board,  
Having considered the report on the implementation of the International Health Regulations (2005),<sup>1</sup>

RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:<sup>2</sup>

The Sixty-first World Health Assembly,  
Having considered the report on the implementation of the International Health Regulations (2005);

Recalling resolution WHA58.3 on revision of the International Health Regulations, which decided that the Sixty-first World Health Assembly would consider the schedule for the submission of further reports by States Parties and the Director-General on the implementation of the International Health Regulations (2005) and the first review of their functioning, pursuant to paragraphs 1 and 2 of Article 54 of the Regulations;

Underscoring the importance of establishing a schedule to review and evaluate the functioning of Annex 2, pursuant to paragraph 3 of Article 54 of the International Health Regulations (2005);

Mindful of the request to the Director-General in resolution WHA59.2 on application of the International Health Regulations (2005) to report to the Sixtieth World Health Assembly and annually thereafter on progress achieved in providing support to Member States on compliance with, and implementation of, the International Health Regulations (2005);

Recognizing the need to rationalize reporting on all aspects of implementation of the International Health Regulations (2005) in order to facilitate the work of the Health Assembly,

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<sup>1</sup> Document EB122/8.

<sup>2</sup> See document EB122/8 Add.1 for the financial and administrative implications for the Secretariat of this resolution.

1. REAFFIRMS its commitment to the timely, ~~and~~ effective **and universal** [Paraguay] implementation of the International Health Regulations (2005);

[or]

1. **REAFFIRMS its commitment to implement fully the International Health Regulations (2005) in accordance with the purpose and scope set out in Article 2 and the principles embodied in Article 3 of the Regulations; [China]**

2. DECIDES:

- (1) in accordance with paragraph 1 of Article 54 of the International Health Regulations (2005), that States Parties and the Director-General shall report to the Health Assembly on the implementation of the Regulations biennially, with the next report to be submitted to the Sixty-third World Health Assembly;
- (2) in accordance with paragraph 2 of Article 54 of the International Health Regulations (2005), that the first review of the functioning of the Regulations shall be made by the Sixty-third World Health Assembly;
- (3) in accordance with paragraph 3 of Article 54 of the International Health Regulations (2005), that the first review and evaluation of the functioning of Annex 2 shall be submitted to the Sixty-third World Health Assembly for its consideration;

3. URGES Member States:

- (1) to ensure that the contact details of the centre that has been designated as the National IHR Focal Point are complete and up to date and to encourage relevant staff within the centre to access and use the Event Information Site on the WHO web site;
- (2) to take steps to ensure that the national core capacity requirements specified in Annex 1 to the Regulations are put in place, strengthened and maintained, in accordance with Articles 5 and 13 of the International Health Regulations (2005);
- (3) to designate an expert, if they have not already done so, for the IHR Roster of Experts, in accordance with Article 47 of the International Health Regulations (2005);
- (4) to continue to support each other and collaborate with WHO in the implementation of the International Health Regulations (2005), in accordance with resolution WHA58.3 and relevant provisions of those Regulations;

4. REQUESTS the Director-General:

- (1) to submit every two years a single report, including information provided by States Parties and about the Secretariat's activities, to the Health Assembly for its consideration, pursuant to paragraph 1 of Article 54 of the International Health Regulations (2005);
- (2) **to provide support to Member States with most vulnerable health systems in strengthening core capacity requirements for surveillance and response at airports, ports and ground crossings, paying special attention to the sub-Saharan Africa laboratory network [Malawi, on behalf of the 46 Member States of the African Region].**

Mr BURCI (Legal Counsel) said that two mutually exclusive, competing amendments for paragraph 1 of the draft decision had been proposed by Paraguay and China, respectively. If neither of the amendments was withdrawn, the Board would have to proceed to a vote on the issue. In that event, in accordance with Rule 37 of the Rules of Procedure of the Executive Board, the Board would first vote on the amendment furthest removed from the substance of the original proposal. He suggested

that the Chairman might first enquire whether either of the two delegations was prepared to withdraw its proposed amendment, or whether they were prepared to explore a compromise formulation.

Mr GAUTO (alternate to Dr Dullak Peña, Paraguay) said that his delegation maintained its proposal, considering that the word “universal” should be acceptable to all, since it was a concept that underpinned the International Health Regulations (2005). He recalled that the member for China had said that the amendment proposed by Paraguay would be acceptable to him, provided that he could add further clarifications to the text of the amendment. Since the two proposals could be complementary, he proposed, in a spirit of compromise, that they should be merged into one proposal reading: “reaffirms its commitment to the timely, effective and universal implementation of the International Health Regulations (2005) in accordance with the purpose and scope set out in Article 2 and the principles embodied in Article 3 of the Regulations”.

Dr REN Minghui (alternate to Mr Li Baodong, China) regretted that the member for Paraguay had provided a partial interpretation of the statement made the previous day by China. His Government reiterated strong support for the comprehensive draft resolution which required no amendments. The delegation of Paraguay, in introducing its proposal the day before, had attempted to bring the issue of Taiwan into the draft resolution. That politically motivated proposal, aimed at interfering in China’s domestic affairs, was totally unacceptable to China. The proposal made by China had already been adopted by consensus – including by Paraguay – in resolution WHA58.3, and would surely be accepted by the Board. He observed that China’s proposal also integrated the principle of universal application, as well as the principles of the United Nations Charter and of international law, and the sovereign right of countries to legislate and implement health legislation.

Mr GAUTO (alternate to Dr Dullak Peña, Paraguay) emphasized that Paraguay fully respected the sovereignty of China and had no desire to interfere in its internal affairs. As the International Health Regulations (2005) should be applied everywhere it was logical to introduce the word “universal”, which was simple and understandable to all. His Government had no hidden agenda. As China seemed to be merely seeking to challenge Paraguay’s viewpoint, his delegation would object to the Chinese proposal. He had no objections to a vote on the issue, if necessary, but suggested consulting other members on their views to avoid any misunderstandings.

The CHAIRMAN said that a substantive debate had already been held on the International Health Regulations (2005) and recalled that the present discussion concerned the related draft resolution. In view of the prevailing situation, he invited the Board to vote on the proposals.

Mr BURCI (Legal Counsel), explaining the voting procedure, expressed the view that, in accordance with Rule 37, the amendment proposed by China, which was furthest removed from the substance of the original proposal, should be voted on first.

Mr GAUTO (alternate to Dr Dullak Peña, Paraguay) and Dr REN Minghui (alternate to Mr Li Baodong, China) requested a roll-call vote.

Mr HOHMAN (alternate to Dr Wright, United States of America) asked whether the proposal by China would only replace the text proposed by Paraguay in paragraph 1, rather than the entire paragraph.

Mr BURCI (Legal Counsel) noted that the vote concerned the amendment proposed by China to paragraph 1 of the draft resolution.

**A vote was taken by roll-call, the names of the Member States being called in the English alphabetical order, starting with Jamaica, as determined by lot.**

**The result of the vote was as follows:**

**In favour:** Afghanistan, Azerbaijan, Bahamas, Bhutan, China, Djibouti, Indonesia, Iraq, Japan, Liberia, Madagascar, Malawi, Mali, Mexico, Namibia, New Zealand, Peru, Republic of Korea, Rwanda, Singapore, Sri Lanka, Tunisia, Turkey, United Arab Emirates, United States of America.

**Against:** El Salvador, Paraguay, Sao Tome and Principe.

**Abstaining:** Denmark, Latvia, Portugal, Slovenia, United Kingdom of Great Britain and Northern Ireland.

**Absent:** Republic of Moldova.

**The amendment was therefore approved by 25 votes to 3, with 5 abstentions.**

Mr BURCI (Legal Counsel), at the request of Mr HOHMAN (United States of America), provided clarification about the rules on explanation of vote in the Executive Board. He noted that statements in explanation of vote were explicitly allowed by the Rules of Procedure of the World Health Assembly; however, the Rules of Procedure of the Executive Board were silent in that respect. At the same time, delegations were in practice sometimes given the opportunity to explain their vote after the adoption of resolutions, without that being challenged. If there was a challenge, however, the Board would have to decide.

Mr GAUTO (alternate to Dr Dullak Peña, Paraguay) conceded that there were no explicit rules on the matter but believed in rules of courtesy.

Dr GWENIGALE (Liberia), observing that the Board had specific agenda items to discuss but that the process was being delayed by interruptions, expressed the view that countries should not speak in explanation of vote.

Turning to subparagraph 4(2), the CHAIRMAN, seeing no objection, took it that the Board endorsed the amendment proposed by Malawi on behalf of the Member States of the African Region.

**It was so agreed.**

**The resolution, as amended, was adopted.<sup>1</sup>**

**Climate change and health:** Item 4.1 of the Agenda (Document EB122/4) (continued from the fourth meeting)

The CHAIRMAN drew attention to a revised draft resolution on climate change and health, proposed by New Zealand and the United Kingdom of Great Britain and Northern Ireland, and cosponsored by Germany and the Netherlands, and associated financial and administrative implications which read:

The Executive Board,  
Having considered the report on climate change and health,<sup>2</sup>

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<sup>1</sup> Resolution EB122.R3.

<sup>2</sup> Document EB122/4.

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

The Sixty-first World Health Assembly,

Recalling resolution WHA51.29 on the protection of human health from threats related to climate change and stratospheric ozone depletion and acknowledging and welcoming the work carried out so far by WHO in pursuit of it;

Recognizing that, in the interim, the scientific evidence of the effect of the increase in atmospheric greenhouse gases, and of the potential consequences for human health, has considerably strengthened;

Noting with concern the recent findings of the Intergovernmental Panel on Climate Change that the effects of temperature increases are already being observed on some aspects of human health; that the net global effect of projected climate change on human health is expected to be negative, especially in developing countries, small island developing States and vulnerable local communities which have the least capacity to prepare for and adapt to such change, and that exposure to projected climate change could affect the health status of millions of people, through increases in malnutrition, in death, disease and injury due to extreme weather events, in the burden of diarrhoeal disease, in the frequency of cardiorespiratory diseases, and through altered distribution of some infectious disease vectors;

Noting further that climate change could jeopardize achievement of the Millennium Development Goals, including the health-related Goals, and undermine the efforts of the Secretariat and Member States to improve public health and reduce health inequalities globally;

Recognizing the importance of addressing in a timely fashion the health impacts resulting from climate change due to the cumulative effects of emissions of greenhouse gases, and further recognizing that solutions to the health impacts of climate change should be seen as a joint responsibility of all States;

Recognizing the need to assist Member States in assessing the implications of climate change for health and health systems in their country, in identifying appropriate and comprehensive strategies and measures for addressing these, in building capacity in the health sector to do so and in working with government and nongovernmental partners to raise awareness of the health impacts of climate change in their country and take action to address them;

Further recognizing that strengthening health systems to enable them to deal with both gradual changes and sudden shocks is a fundamental priority in terms of addressing the direct and indirect effects of climate change for health,

1. REQUESTS the Director-General:

(1) to continue to draw to the attention of the public and policymakers the serious threat of climate change to global health security and to the achievement of the health-related Millennium Development Goals, and to work with the United Nations Framework Convention on Climate Change secretariat, WMO, FAO, UNEP, UNDP and other appropriate organizations of the United Nations, in the context of United Nations reform initiatives, and with national and international agencies, to ensure that these health impacts and their resource implications are understood and can be taken into account in further developing national and international responses to climate change;

(2) to engage actively in the UNFCCC Nairobi Work Programme on Impacts, Vulnerability and Adaptation to Climate Change, in order to ensure its relevance to the health sector, and to keep Member States informed about the work programme in order to facilitate their participation in it as appropriate and access to the benefits of its outputs;

(3) to continue close cooperation with appropriate United Nations organizations, other agencies and funding bodies, and Member States, to develop capacity to assess the risks from climate change for human health and to implement effective response measures, by promoting further research and pilot projects in this area, including work on:

- health vulnerability to climate change and the scale and nature thereof;
- health protection strategies and measures relating to climate change and their effectiveness, including cost-effectiveness;
- the health impacts of potential adaptation and mitigation measures in other sectors such as water resources, land use, and transport, in particular where these could have positive benefits for health protection;
- decision-support and other tools, such as surveillance and monitoring, for assessing vulnerability and health impacts and targeting measures appropriately;
- assessment of the likely financial costs and other resources necessary for health protection from climate change;

(4) to consult Member States on the preparation of a workplan for scaling up WHO's technical support to Member States for assessing and addressing the implications of climate change for health and health systems, including practical tools and methodologies and mechanisms for facilitating exchange of information and best practice and coordination between Member States, and to present a draft workplan to the Executive Board at its 124th session.

## **1. Resolution** Climate change and health

### **2. Linkage to programme budget**

Strategic objective:

8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.

Organization-wide expected result:

1. Evidence-based assessments made, and norms and guidance formulated and updated on major environmental hazards to health (e.g., poor air quality, chemical substances, electromagnetic fields, radon, poor-quality drinking-water and waste-water reuse); technical support provided for the implementation of international environmental agreements and for monitoring progress towards achievement of the Millennium Development Goals.

3. Technical assistance and support provided to Member States for strengthening occupational and environmental health policy-making, planning of preventive interventions, service delivery and surveillance.

5. Health-sector leadership enhanced for creating a healthier environment and changing policies in all sectors so as to tackle the root causes of environmental threats to health, through means such as responding to emerging and re-emerging consequences of development on environmental health, climate change, and altered patterns of consumption and production and to the damaging effect of evolving technologies.

**(Briefly indicate the linkage with expected results, indicators, targets, baseline)**

Strengthened work on health protection from climate change is consistent with the expected results for strategic objective 8; full implementation of the resolution would be reflected as a specific element within the indicators and targets for the three Organization-wide expected results mentioned above.

**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)**

The first three operative paragraphs of the draft resolution are open-ended, while the remaining paragraph calls for a draft workplan to be presented to the Executive Board at its session in January 2009. On this basis, the costs are estimated only for the duration of the biennium 2008–2009.

**(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)**

Estimated costs for the current biennium are US\$ 6.4 million. For staff, we estimate the cost to be US\$ 3.4 million, of which US\$ 1.5 million will be incurred at headquarters, and US\$ 1.9 million across the six WHO regions. For activities, we estimate the cost to be US\$ 3 million, of which US\$ 1 million will be incurred at headquarters and US\$ 2 million in the regions.

**(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009?**

The total cost can be subsumed under the Programme budget 2008–2009, which was planned taking into account the increasing concern over the health effects of climate change.

**(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)**

Implementation of the global programme will be Organization-wide, with activities at global, regional and country levels. Headquarters will play a standard-setting, guidance-providing and coordination role, and will support the implementation of activities.

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

From mid-2008, we estimate that four additional staff members (full-time equivalents) will be needed at headquarters (skills profiles sought concern policy and technical development in climate change and health). Each regional office should have a full-time project officer responsible for the integration of climate change into operational programmes. This will require the addition of four staff (full-time equivalents). The required skills profiles cover project management and environmental health.

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

The current biennium.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that Italy, Latvia, Luxembourg, Republic of Korea, Romania, Slovakia and Sweden were also cosponsors of the draft resolution and should be added to the list.

Mrs VALLE ÁLVAREZ (alternate to Dr Hernández Ávila, Mexico), Professor PEREIRA MIGUEL (Portugal), Dr SINGAY (Bhutan), Mr FISKER (Denmark) and Dr ANTEZANA ARANÍBAR (Bolivia)<sup>1</sup> said that their countries also sponsored the draft resolution and asked to be added to the list.

Mr ALCÁZAR (Brazil)<sup>1</sup> reiterated his suggestion of the previous day to replace the word “threat” with “risk” wherever it appeared in the draft resolution. He was ready to support the draft resolution subject to that amendment.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), seconded by Dr DAHL-REGIS (Bahamas), proposed that the Board should consider the amendment suggested by Mr Alcázar.

**It was so agreed.**

**The resolution, as amended, was adopted.<sup>2</sup>**

**Health of migrants:** Item 4.8 of the Agenda (Document EB122/11)

The CHAIRMAN drew attention to the draft resolution on the health of migrants, proposed by Portugal and cosponsored by Austria, the Czech Republic, Denmark, Finland, Germany, Hungary, Ireland, Italy, Kenya, Latvia, Luxembourg, Mexico, Slovakia, Slovenia, Spain, Sri Lanka, and the United Kingdom of Great Britain and Northern Ireland, and the associated financial and administrative implications which read:

The Executive Board,  
Having considered the report on health of migrants,<sup>3</sup>

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

The Sixty-first World Health Assembly,  
Having considered the report on health of migrants;  
Recalling the United Nations General Assembly resolution 58/208 underlining the need for a high-level dialogue to discuss the multidimensional aspects of international migration and development (New York, 23 December 2003);  
Recalling the first plenary session of the United Nations General Assembly on migration issues and the conclusions of the High-Level Dialogue on Migration and Development (New York, 14–15 September 2006) with their focus on ways to maximize the development benefits of migration and to minimize its negative impacts;  
Recalling resolutions WHA57.19 and WHA58.17 on International migration of health personnel: a challenge for health systems in developing countries, calling for support to the strengthening of health systems, in particular human resources for health;  
Cognizant of the Bratislava Declaration on Health, Human Rights and Migration issued at the 8th Conference of European Health Ministers (Bratislava, 23 November 2007), which recognized that well-managed health measures for migrants, including

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

<sup>2</sup> Resolution EB122.R4.

<sup>3</sup> Document EB122/11.



public health measures, promote the well-being of all and can facilitate the integration and participation of migrants within the host countries;

Taking note of the Conclusions on Health and Migration in the European Union, adopted by the Council of the European Union (Brussels, 6 December 2007), which welcomed the approach to migrants' health as a powerful determinant of integration, intercultural dialogue, social cohesion, and sustainable development;

Recognizing the need for WHO to tackle the issues of health and migration as a critical part of the broader agenda on migration and development;

Recognizing that health outcomes are influenced by the multiple dimensions of migration;

Noting that people on the move experience increased health risks;

Recognizing the scarcity of information specific to migrants' health status and access to health services and the consequences thereof for health systems;

Noting that the existence of economic, political, social and environmental determinants of migrants' health underlines the need to develop intersectoral public policies that can influence both the migration process and its health consequences;

Mindful of the need for promoting mechanisms of social protection in health that can constitute instruments of inclusiveness for migrants;

Acknowledging that the health of migrants is an increasingly important public health matter both for Member States and for the work of the Secretariat;

Noting that Member States facing the challenges of migration have an increasing need to formulate and implement strategies for improving the health of migrants;

Noting that health and migration policies have to consider gender aspects and the specific needs of women and men;

Recognizing that health and migration policies can contribute to development and to achievement of the Millennium Development Goals,

1. CALLS UPON Member States:

- (1) to promote migrant-sensitive health policies;
- (2) to promote equitable access to health protection and care for migrants, subject to national laws and practice, and devise mechanisms for enhancing social protection in health for migrants;
- (3) to assess and analyse trends in migrants' health, disaggregating health information by relevant categories;
- (4) to meet migrants' health needs better by identifying gaps in service delivery;
- (5) to document best practices for meeting migrants' health needs in countries of origin or return, transit and destination, and to encourage generation of information on health issues arising from migration;
- (6) to develop and promote the sharing of data on migrants' health and knowledge of the effectiveness of interventions to improve migrants' health;
- (7) to raise health service providers' cultural and gender sensitivity to migrants' health issues;
- (8) to train health professionals to deal with the health issues associated with population movements;
- (9) to promote international cooperation on migrants' health among countries of origin or return, transit and destination;
- (10) to promote the strengthening of health systems in the countries of origin, as appropriate, within cooperation and development programmes, in order to prevent disease and ill health;
- (11) to contribute to the reduction of the global deficit of health professionals and its consequences on the sustainability of health systems and the attainment of the Millennium Development Goals;

2. REQUESTS the Director-General:
- (1) to promote migrants' health on the international health agenda;
  - (2) to explore policy options and approaches for improving the health of migrants;
  - (3) to analyse the major challenges to health associated with migration;
  - (4) to support the development of regional and national assessments of migrants' health status and access to health care;
  - (5) to promote the inclusion of migrants' health in the development of regional and national health strategies;
  - (6) to draw up guidance for filling the gaps in data on migrants' health and to document Member States' best practices and lessons learnt in dealing with migrants' health issues;
  - (7) to promote dialogue and cooperation on migrants' health among countries of origin or return, transit and destination, within the framework of the implementation of their health strategies;
  - (8) to give consideration to the health of migrants in the light of the health in all policies approach, with special emphasis on employment and social policies and those on cooperation and development;
  - (9) to promote interagency, interregional and international cooperation on migrants' health with an emphasis on developing partnerships with other organizations;
  - (10) to encourage the exchange of information through a technical network of collaborating centers, academic institutions and other key partners in order to further research into migrants' health and to enhance capacity for technical cooperation;
  - (11) to submit to the Sixty-third World Health Assembly, through the Executive Board, a report on the implementation of this resolution.

<b>1. Resolution</b> Health of migrants	
<b>2. Linkage to programme budget</b>	
Strategic objective:	Organization-wide expected result:
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.	3. Norms and standards developed, capacity built and technical support provided to Member States for assessing needs and for planning and implementing interventions during the transition and recovery phases of conflicts and disasters.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
WHO's activities in support of the health of migrants have links with strategic objectives 7, 8 and 10.	
<b>3. Financial implications</b>	
(a) <b>Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)</b>	
US\$ 2 400 000 over a period of four years.	
(b) <b>Estimated cost for the current biennium (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)</b>	
US\$ 1 200 000 at global, regional and country levels.	
(c) <b>Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the current biennium?</b>	
US\$ 586 000.	
(d) <b>For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)</b>	
Costs will be met through income from voluntary contributions aimed at supporting work in this field.	

**4. Administrative implications****(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)**

Headquarters, regional offices and, in the African and Eastern Mediterranean regions, country offices in countries facing major challenges as a result of AFRO and EMRO migration.

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

Three experts in public health and migration: one at headquarters and two based in the African and Eastern Mediterranean regions, where migration and its consequences for health are having the greatest impact.

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

Two of the public health experts will be recruited during the biennium 2008–2009, one at the global level and the other at the regional level. Technical cooperation activities will be performed over the next two bienniums. The second regional public health expert will be recruited during the biennium 2010–2011.

Mr DE SILVA (Sri Lanka) supported the draft resolution. The health of the many migrant workers from the South-East Asia Region working in the Middle East and elsewhere was a great concern. An informal working group held before the previous Health Assembly had highlighted the need to put the issue on the international health agenda.

Dr VOLJČ (Slovenia) said that he was speaking on behalf of the European Union, and that the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia, and the countries of the Stabilisation and Association Process, and potential candidates Albania, Bosnia and Herzegovina, Serbia, and the European Free Trade Association countries Iceland and Norway, members of the European Economic Area, and Ukraine and Armenia, aligned themselves with his statement. International migration was a critical matter also relevant to attainment of the Millennium Development Goals. All Member States were concerned, and the Secretariat's report summarized the important issues. He welcomed the emphasis in the draft resolution on the need for coordination, particularly between the competent United Nations agencies. Knowledge of the topic should be mapped and best practices shared. He also welcomed the support for vulnerable populations such as migrants through the promotion of non-discriminatory, comprehensive and culture- and gender-sensitive national policies. In the area of health, such an approach favoured cultural dialogue, integration and sustainable development. In view of paragraphs 17 and 21 of the report, he underlined that, in all European Union Member States, legal migrants and nationals enjoyed equal access to health services. Undocumented or irregular migrants could also use health services, at least in emergencies.

The Council of the European Union had recommended the strengthening of health systems in countries of origin through cooperation and development programmes and reducing the global deficit of health-care professionals. It had encouraged its Member States to cooperate with the relevant international organizations, WHO in particular.

Dr BIN SHAKAR (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the issue was important to the Region, as many migrants came to its higher-income countries. Those migrants often had healthy environmental conditions with provision for medical check-ups. The health statistics of those countries provided information on migrants' use of health services. Preventive care and emergency medical services were reportedly provided free. Some countries were seeking technical support from WHO in considering social insurance schemes for contracted migrant workers.

Data were lacking on a second category, internal migrants, often unskilled manual workers. They were among the poorest classes in countries beset by high levels of poverty. Those workers lacked formal health coverage, they were at high risk by the nature of their work and vulnerable because of inadequate shelter, unhealthy food and environmental hazards.

The Secretariat should provide technical support to Member States in dealing with the equitable access to health care of both categories of migrants as well as their socioeconomic conditions, for which some countries would also need financial support. WHO should concert with other international organizations such as ILO, and highlight the multidimensional issues involved in order to help countries deal with the root causes of internal migration by such means as education, employment and development projects in deprived areas.

Mrs VALLE ÁLVAREZ (alternate to Dr Hernández Ávila, Mexico), stating that her observations had the support of the delegations of El Salvador, Peru and the Bolivarian Republic of Venezuela, noted that the terms “legal” and “illegal” migrants had been used in the report, which was unacceptable and presented a negative image. People were not illegal; their actions might be. If migrants lacked the necessary documents, they could be called “undocumented” migrants in an “irregular” situation. She asked the Secretariat to revise the report in that regard.

Although several bilateral, regional and multilateral forums dealt with migration, there was still disagreement on how to reconcile the management of migration with protecting the rights of all migrants. It was important to overturn the negative perception of migrants, who made a positive contribution both to their own countries and to the economic, political, social and cultural life of receiving countries. Countries of origin and of destination should share responsibility for providing access to health services. Migrants in an “irregular” situation were vulnerable owing to low social standing, particularly concerning education and health. Bilateral and multilateral collaboration should be broadened to prevent the disability and premature death of migrants and their families. Lack of access to basic health services was a key issue. “Irregular” migrants were unable to seek medical treatment for fear of being arrested and deported. Women and girls sometimes faced sexual abuse and had no access to legal or reproductive health services. Latin American and Caribbean countries encouraged a new broad understanding of migration, and promoted its positive contribution. That approach should rest on the principle of shared responsibility, integrate the causes and effects of migration, and make the migrant central to any health policy.

She encouraged any country that had not yet done so to ratify the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, which contained useful tools for protecting the rights of migrants, including access to basic health services.

Dr SUGIURA (alternate to Dr Shinozaki, Japan) said that Japan recognized the importance of migrants’ health and endorsed a public health approach. It had no objections to the draft resolution. However, the definition of migrants in the report was too broad to enable the setting of targets for action. For example, refugees from conflict and disaster areas were distinct from migrant workers. The workplace would provide a useful point for integrated health service delivery and health promotion among migrant workers. WHO should further analyse the available data on migrants and identify suitable partners for action.

Professor PEREIRA MIGUEL (Portugal), recalling that Portugal had requested inclusion of the item on the agenda and had proposed the draft resolution, said that migrants’ health affected all WHO regions, warranted attention at all levels and should be viewed from a public health perspective. All countries, whether of origin, transit or destination of migrants, must promote migrants’ health as a key to health for all. The conclusions on health and migration adopted by the European Union in December 2007, following a high-level international conference, provided a sound basis for future action in Europe and elsewhere. The conference had focused on better health for all in an inclusive society, providing the political vision and scientific basis that would place migrants’ health on the European Union and global health agendas. WHO headquarters and the Regional Office for Europe

had provided support for the conference; the Council of Europe, the International Centre for Health and Migration and the International Organization for Migration had also contributed.

The Secretariat's report provided overview, reviewed principles for a public health approach, and suggested strategies. Issues relevant to health of migrants in the context of primary health care included provision of vaccination, care for mothers, children and the elderly, and mental and occupational health needs. The Board should progress to an active quest for solutions, and he therefore urged the adoption of the draft resolution, noting that El Salvador, Indonesia, Lithuania, Mali, Moldova, Norway, Republic of Korea, Switzerland and Turkey had indicated that they wished to be sponsors, demonstrating the widespread interest in the subject. Although there were resource limitations everywhere and health systems were struggling to cope, the actions proposed in the draft resolution seemed feasible in the short term.

Dr REN Minghui (alternate to Mr Li Baodong, China) supported a public-health approach to the health of migrants as a component of health improvements for the whole population. Paragraph 2 of the report defined migration as comprising population movements across international borders and within States. However, the remainder of the report related only to the former category. It should be made clear that management of migration within States was a matter for national governments. He supported the draft resolution in principle, although mention of European regional activities in the fourth and fifth preambular paragraphs was not appropriate and should be deleted.

Dr KANDUN (alternate to Dr Supari, Indonesia) commented that voluntary and forced population movements were increasing and were a concern at local, national and regional levels. For example, millions of Indonesians were working outside the country. Indonesia endorsed the view, expressed in paragraph 6 of the report, that migrants were generally more vulnerable to health problems and hazards than the general population in the host country, and were also subject to the stresses of new environments and re-acclimatizing on their return home. Indonesia also endorsed the principles of a public health approach for migrants set out in paragraph 5 and was pleased to sponsor the draft resolution.

Ms KENNELLY (alternate to Dr Wright, United States of America) said that, as a country of immigrants, the United States cared deeply about migrants' health and recognized its importance for WHO. Her Government's efforts included community and migrant health centres, which provided a wide range of services to uninsured, low-income families, regardless of their ability to pay. Civil society organizations also provided health care to needy populations, including migrants. All migrants, regardless of their immigration status, had access to emergency health care.

She had some concerns in respect of the report and the draft resolution. The report failed to distinguish between the many types of migrants, which might include international visitors, students, legal immigrants, refugees and undocumented immigrants – categories that needed different interventions. Further, its consideration of countries of origin and of destination oversimplified the global migration phenomenon. Most countries both sent and received migrants, and there was significant migration between developing countries. Paragraph 5 of the report referred to ensuring migrants' right to health, but there was no established right of migrants to health. The United States did not support rights-based approaches, which did little to provide practical solutions for improving health. It also opposed the idea of compulsory Government-run health care for migrants, although, as indicated, it offered governmental programmes to those in need. The report did not take into account the range of health systems in Member States. In the United States, for example, there was no national health service – the health system was privatized and migrants with health insurance had the same access to services as insured nationals. She could not agree with the suggestion made in paragraph 13 that health assessments for prospective migrants, which were necessary to protect public health and safety and, in some cases, allowed migrants to be provided with medical support on arrival, posed challenges to human rights. The Secretariat should consider those points in revising the document before its submission to the Health Assembly and in further discussions on the matter.

WHO should continue to work in areas in which it had a clear mandate and the necessary expertise, including health of migrants. However, it should not move into broader areas related to migration and development, or national migration policies in progress towards the attainment of the Millennium Development Goals. The United States wished to propose extensive amendments to the draft resolution which, in the interests of efficiency, could be discussed in an informal drafting group.

Dr DE CARVALHO (Sao Tome and Principe), speaking on behalf of the Member States of the African Region, observed that since the Alma-Ata Conference, there had been increasing recognition of the right to health, including access to integrated health services regardless of immigration status. Different strategies were needed for different categories of migrants, including refugees and undocumented migrants, who generally lacked access to health services that were culturally suited to their needs. Countries would need support in developing appropriate policies. He endorsed the strategies set out in paragraph 21 of the report and urged support for the draft resolution.

Dr MAZA BRIZUELA (El Salvador), noting that his country was a sponsor of the draft resolution, stressed the health of migrants for their integration within host countries. The health of migrants was a basic component of societal structure and emphasis should be given to the benefits of migration for development. He endorsed the comment by the member for Mexico concerning the term “illegal” in the report, which should be changed.

Dr SALANIPONI (Malawi) requested that the Secretariat, through its country offices, should support Member States in Africa in carrying out situation analyses in order to assess the health status of migrants, particularly in refugee settlements and prisons. The results would help Member States’ work on migrants’ health. He supported the draft resolution.

Mrs VALLE ÁLVAREZ (alternate to Dr Hernández Ávila, Mexico) said that all sponsors of the draft resolution could attend the meeting of the drafting group suggested by the United States of America. In the interests of clarity and transparency, she requested the member for the United States to read out her amendments to the draft resolution.

Ms KENNELLY (alternate to Dr Wright, United States of America) proposed that the fifth and sixth preambular paragraphs should be deleted. The seventh preambular paragraph should be amended to read: “Recognizing the need for additional data on health and migration”. In the eighth preambular paragraph, the word “are” should be replaced with “can be”. The ninth and tenth preambular paragraphs should be deleted. The eleventh preambular paragraph should be amended to read: “Noting the need to develop intersectoral public policies for the health of migrants”. The twelfth preambular paragraph should be deleted. As migrants’ health had always been an important public health matter, the words “increasingly important public health matter” should be deleted from the thirteenth preambular paragraph. In the modern era all States had to address migration, and the words “facing the challenges of migration” should therefore be deleted from the fourteenth preambular paragraph, as should the word “increasing”. The fifteenth preambular paragraph should be amended to read: “Noting that health policies should consider the specific needs of men and women”. The words “and migration” should be deleted from the sixteenth preambular paragraph.

Paragraph 1(4) should be amended to read: “to better identify gaps in service delivery”. In paragraph 1(5), the word “generation” should be replaced by “sharing”. The word “professional” should be added after “providers,” in paragraph 1(7). The phrase “among countries of origin or return, transit and destination” should be deleted from paragraph 1(9). Paragraph 1(10) was redundant and should be deleted. The words “where appropriate” should be added at the end of paragraph 2(5), and in paragraph 2(6) the words “draw up guidance for filling the gaps in” should be replaced with “help collect and disseminate”. The words “among countries of origin or return, transit and destination” should be deleted from paragraph 2(7), and the words “with special emphasis on employment and social policies and those on cooperation and development” should be deleted from paragraph 2(8).

Dr DAHL-REGIS (Bahamas) said that, as the health of migrants was a complex issue, it would be preferable to consider the many amendments suggested by the United States in a drafting group.

Professor PEREIRA MIGUEL (Portugal) supported the convening of an informal drafting group.

Mrs VALLE ÁLVAREZ (alternate to Dr Hernández Ávila, Mexico) requested that the drafting group should meet at a time that would enable as many sponsors as possible to attend; interpretation should be provided.

The CHAIRMAN said that he took it that the Board wished to refer the draft resolution to an informal drafting group.

**It was so agreed.**

Ms DUKE (Australia)<sup>1</sup> noted that the World Migration Report 2005, published by the International Organization for Migration, had identified migrants' health as a critical issue for policy-makers. Most countries were simultaneously countries of origin, transit and destination. About half Australia's population had either been born overseas or had at least one parent born overseas; some 5% of its population migrated. Her country's migration programme served a wide array of migrants, from refugees fleeing persecution to highly-skilled professionals. Their needs were considered in the assessment of overall health needs. Legal migrants had the same access as Australian citizens to primary health care, subsidized medication, and acute care through public hospitals.

It was important to avoid generalizations about migrants and their health issues, since needs would vary in different contexts and countries, and entitlements to public-health systems might depend upon the nature and period of the migrant's stay. The discussion required a more specific definition of the term "migrants", the contextualization of health-care needs and the identification of challenges involved. She agreed with the member for the United States that such definition issues should be considered in preparing further documentation for the Health Assembly. Health assessments for prospective migrants should not be seen as a challenge to basic human rights. In many countries, such health assessments did not necessarily preclude entry for those with health problems; their purpose was to minimize public health and safety risks. In Australia, the assessments enabled many migrants with medical problems entering for humanitarian reasons to be provided immediate medical support. She requested clarification of "securing equitable access to health services for migrants" in paragraph 17 of the report. Specifically, to what categories of health services and migrants did it refer? It would also be useful to identify underlying policy objectives.

She supported the draft resolution with improved wording. The reference to "countries of origin, transit and destination" was not specific, and the meaning of the term "migrant" should be clarified. Referring to the ninth preambular paragraph, she pointed out that not all people on the move experienced increased health risks.

Dr SOPIDA CHAVANICHKUL (Thailand)<sup>1</sup> said that, as migrants often faced health problems and also socioeconomic and employment constraints, improving their health did not lie with the health sector alone. The capacity of each Member State to deal with migrants' health should also be taken into account. He endorsed the views expressed by the member for Japan regarding the focus on health of migrants in the workplace, and on primary health care and health promotion.

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Ms WISEMAN (Canada)<sup>1</sup> strongly supported WHO's efforts to raise the profile of migrant health on the international agenda. However, the broad definition of the term "migrants" in the report did not differentiate access to health care for various subgroups of migrants and their health needs, or the locus of responsibility for the provision of health care. The definition should be clarified. She shared the concerns raised regarding paragraph 13 and some assumptions made in the report, such as the association of elevated health risks with all migrants. Canadian research had shown that immigrants were, on average, healthier than the populations in both their countries of origin and destination. Future work on health and migration should focus more on the definition of issues and links to WHO's existing initiatives. The need for WHO to collaborate with other international organizations should be reflected in the report. Canada looked forward to participating in the discussions on the draft resolution in the informal drafting group.

Dr ANTEZÁNA ARANÍBAR (Bolivia)<sup>1</sup> said that migration required a multisectoral and integrated approach at country level. Migratory flows had changed over time. Reasons for migration included poverty, the political situation and "brain-drain". Regulations were needed in order to enable developing countries to retain skilled professionals and foster development.

Migrants should not be penalized for having to abandon their country in order to escape harsh living conditions. They should have access to a full range of health services, not just emergency care. Their mental health should also be given due consideration. He supported the draft resolution, with some of the amendments suggested. The contribution by the United States was useful, and he looked forward to seeing the proposed changes in writing.

Mgr TOMASI (Holy See), speaking at the invitation of the CHAIRMAN, said that organizations worldwide sponsored by the Catholic Church offered migrants, refugees and displaced persons health care, material and legal assistance, emotional and spiritual support. The Holy See could thus observe at first hand migrants' particular vulnerability to disease and their inequitable access to preventive and curative health services. It welcomed the report's public-health approach to migrants' health, its attention to their vulnerability to occupational health hazards and preserving the integrity of migrant families. Pope Benedict XVI had remarked that, if immigrant families were not assured of real prospects of inclusion and participation, they could hardly be expected to develop harmoniously. WHO should accordingly recognize the integrity of the migrant family as a basic public health principle.

Ms WEEKERS (International Organization for Migration) said that events such as the High-level Dialogue on International Migration and Development held in September 2006 by the United Nations General Assembly attested to the recognition of migration issues and their management as key challenges for governments and agencies. Her organization promoted the physical, mental and social well-being of all types of migrants and advocated health policies and practices that encompassed all members of communities. Migration was an unstoppable process and also served to mitigate chronic population decline and labour shortages in many industrialized nations.

Addressing migrants' well-being was of long-term benefit to societies, contributing to stability and enhancing development. Conversely, discrimination, xenophobia and marginalization were exacerbated when host societies perceived migrants as vectors of disease. Her organization would continue its collaboration with WHO with a view to improving the health of migrants, along the lines of the strategies laid out in the report and highlighted in the draft resolution.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN and also on behalf of FDI World Dental Federation, the International Pharmaceutical Federation and The World Medical Association, Inc., said that the World Health Professions Alliance

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.



that they formed expressed the collective views of more than 25 million health professionals. Migrants often responded to precarious living and working conditions and traumatic experiences through a combination of stress and other symptoms that needed adequate treatment by health professionals. Their legal status was an important health determinant, especially for undocumented migrants, who faced additional barriers to access to health care. In some countries, health professionals were encouraged or even compelled to furnish the authorities with personal details of such migrants or to denounce them, thereby blatantly violating the principle of patient confidentiality. Children of undocumented migrants could start life at a disadvantage and face exclusion from access to health services such as immunization, and from schooling.

Migrant health professionals often experienced discrimination in the form of low pay, job insecurity, menial assignments and heavy workloads. The organizations for which he spoke advocated a code of ethical recruitment and equal opportunity. Almost half all migrants worldwide were women, often exposed to gender-based violence and other abuse owing to their precarious status, and encountered difficulties in accessing sexual and reproductive health-care services. Countries should develop human rights assessments, incorporating a gender perspective, in order to take account of the right of all migrants to the highest attainable standard of health, regardless of their legal and social status.

Dr ALWAN (Assistant Director-General) thanked speakers for their valuable comments especially on terminology, the need for better definitions, distinctions between the various types of migrants and review of available data. Those comments would be taken into account in revising the report and the issues raised regarding the draft resolution would be discussed during the meeting of the informal drafting group.

The CHAIRMAN took it that the Board wished to take note of the report on health of migrants, on the understanding that the informal drafting group would attempt to prepare a revised version of the relevant draft resolution for the Board's consideration.

**It was so agreed.**

(For adoption of the resolution, see summary record of the seventh meeting, section 1.)

**Health technologies:** Item 4.10 of the Agenda (Document EB122/13)

Professor SALANIPONI (Malawi), speaking on behalf of the Member States of the African Region, asked why the Secretariat's report focused specifically on medical devices, thereby failing to put forward a strategy for primary health care reflecting the scope of health technologies as defined in paragraph 2 of the document. The term "health technologies" did not just encompass medicines, vaccines and medical devices but also the delivery of health services. Despite progress with blood safety and diagnostic imaging, essential health technologies were one of the weakest components of health systems in the African Region. In 1999 a health technology strategy for the African Region had been formulated.<sup>1</sup> Blood safety policies had been developed in 42 of the 46 countries of the Region, emphasizing quality management; recruitment of blood donors and screening for transmissible infections in blood transfusions had been improved; a regional network for public health and clinical laboratories had been established; and studies on incidents in public hospitals and the private sector had been launched. Five countries of the Region were implementing national policies for the management of health technology. The main challenges faced were the multiplicity of trademarks of health and medical devices; lack of coordination among the many stakeholders in the field; cost and lack of equipment; lack of laboratory policies; low awareness among health authorities of the potential

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<sup>1</sup> Document AFR/RC49/12.

benefits of telematics; slow implementation of national policies on blood safety; blood shortages; and inadequate transfusion services. The Secretariat should work with Member States to design an appropriate health technology package for primary health care in the African Region.

Dr JAKSONS (Latvia) said that the report clearly explained what the Secretariat was doing in response to actions requested in resolution WHA60.29. At the Board's 121st session, agreement had been reached on the list of essential technologies. The Secretariat had proposed mechanisms, analytical tools and technical standards, but they would have to respond to different systems and levels of care, and address cost effectiveness and capacities and would therefore require a multidimensional approach and the involvement of experts. Data sets and appropriate guidelines would be needed for the next session of the Board. A timetable should be set to allow Member States to provide input.

Dr SINGAY (Bhutan) said that the Member States of the South-East Asia Region welcomed the Secretariat's support in choosing and making adequate use of medical technologies. Activities would include prequalification of priority medical devices and management of information on technologies.

The Member States of the Region had been assessing their needs for medical technologies, in particular, medical devices, in terms of effectiveness, quality, safety, cost, rational use, availability, access at all levels of health systems and ensuring the sustainability of operations. Effective management and strong regulatory support would ensure compliance with established standards. Establishing national institutes for health technologies and partnerships between governments, health care providers, industries, patient associations and scientific and technical organizations would optimize use of those devices.

Ms VELÁZQUEZ BERUMEN (alternate to Dr Hernández Ávila, Mexico) requested that all references to health technologies other than medical devices should be removed from the report, as resolution WHA60.29 referred specifically to those technologies. Furthermore, in paragraph 3, the wording from "on blood transfusion medicine" to the end of the paragraph should be deleted; only organizations specifically concerned with medical devices should be mentioned; and only they should serve on expert committees to set standards. Paragraph 4 should specify that assessments of needs for medical devices should be based on epidemiological data on morbidity and mortality. In paragraph 5, the reference to "the traceability of health products ... and organs for transplantation" should be replaced by a reference to harmonization of technovigilance and nomenclature systems. Paragraph 6 should include reference to the wide diversity of tools that had been developed by both the Secretariat and Member States. Nongovernmental organizations and experts in the use of medical devices were prepared to participate in the implementation of resolution WHA60.29, and to help in formulating policies.

Dr REN Minghui (alternate to Mr Li Baodong, China) said that overuse or inadequate use of medical devices affected the operation of health systems. China had assessed the use of medical devices and had standards for acquiring them. In collaboration with the Secretariat, the Ministry of Health was collecting information on the quality, safety and effectiveness of health technologies, as a basis for national policy and setting up monitoring systems. Furthermore, guidance on the use of such technologies was being provided at the grass-roots level. His country supported the establishment of collaborating centres in Member States to develop standards for assessing and monitoring medical devices. Guidance should also be given on the planning and use of high-technology products.

Dr AHMADZAI (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that challenges to health technology in the Region related to regulations, access monitoring, management and maintenance. The Regional Committee, in resolution EM/RC53/R.7, had called upon Member States to collect and update information, formulate plans and establish centres for assessing, selecting and managing medical devices. WHO should provide guidelines in order to determine which technologies were needed at various levels of health care and promote the establishment of centres of excellence.

Professor SOHN Myongsei (Republic of Korea), noting that the term “health technologies” covered a range of issues and that standard setting was one of WHO’s core functions, said that the term should also encompass certain forms of complementary, alternative or traditional medicine. In many Member States, such forms of medicine provided health services compatible with the spirit of primary health care. Therefore, norms, standards and guidelines for those types of medicine should not be neglected.

Dr JEAN LOUIS (Madagascar) presented his country’s five-year plan for ensuring health services for all, its current situation and objectives, strategies and priorities set forth in the plan.

Dr WRIGHT (United States of America) agreed with the remarks of the member for Mexico with respect to the scope of medical technology. Use of safe, high-quality health technology could make a decisive contribution. The quality, safety and efficacy of health technologies required good manufacturing and regulatory practices, which Member States should set up with the support of the Secretariat. The report presented a mix of activities and concepts from several WHO programmes that fell outside the scope of resolution WHA60.29; he requested a concise but complete explanation of how the Director-General planned to implement that resolution.

Dr ALCÁZAR (Brazil)<sup>1</sup> expressed surprise that the report only mentioned “health technologies” in the abstract, without considering the concept of public health. In the same way, the definition in paragraph 2 was only *a* definition; it was not *the* definition. If the report was to be of use when considered by the Health Assembly, it should focus on public health.

Dr ANTEZANA ARANÍBAR (Bolivia),<sup>1</sup> endorsing the comments of the previous speaker, said that the technology that had been described as “appropriate” in 1978, at the time of the Alma-Ata International Conference on Primary Health Care, had evolved subsequently. He distinguished between priorities for public health and those for health care in general, as medical technology was costly and often unavailable to whole populations.

Dr NORDSTRÖM (Assistant Director-General) said that, although the report focused on medical devices, effective use of health technologies was also important in primary health care. The emphasis, as requested in resolution WHA60.29, was on medical devices. He noted the comments made by the member for Malawi. In response to the comments of the member for Latvia, he suggested that the WHO web site should be used to communicate developments, share guidelines, report on technical support to countries and describe the results of monitoring. In response to the member for Mexico, he said that the list of partners in paragraph 3 of the document was not exhaustive; the best possible expertise and most relevant stakeholders would be sought. He thanked the members for Afghanistan, Bhutan, China and Madagascar for sharing their experiences with the Board; the Secretariat would make the best possible use of that information.

**The Board noted the report.**

**The meeting rose at 12:40.**

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.