

## SEVENTH MEETING

Thursday, 24 January 2008, at 09:10

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

### 1. 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 fifth meeting)

Mr HOHMAN (alternate to Dr Wright, United States of America) recalled that he had asked for clarification during the discussion of the proposed amendments to the resolution on the implementation of the International Health Regulations (2005), adopted as resolution EB122.R3, and had been assured that the choice before the Board was between only the amendment to the original paragraph proposed by Paraguay and the alternative paragraph proposed by China, which therefore did not concern the original paragraph. He had therefore understood that, as a result of the previous day's vote on the amendments proposed to paragraph 1, there would be two paragraphs in the final text: the original paragraph 1 without the amendment proposed by Paraguay, reaffirming commitment to the "timely and effective" implementation of the International Health Regulations (2005), followed by the new paragraph proposed by China. That not being the case, he sought an explanation.

The CHAIRMAN, after consulting the Legal Counsel, said that, because China and Paraguay had proposed competing amendments to the same paragraph, accepting one amendment meant automatically excluding the other. Following a request for the proposed amendments to be presented in writing, the document discussed the previous day had shown both proposed amendments as alternatives, as they would appear in the resolution.

On occasion, he would have to seek a legal opinion and share it with members of the Board. Legal language was complex, and different interpretations could lead to misunderstandings. Unless otherwise advised by the members of the Board, he would follow and diligently apply the legal advice given.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that he would not press the matter further, but suggested that the legal advice given the previous day had been misleading. There would be another opportunity to deal with the resolution at the Health Assembly.

Mr BURCI (Legal Counsel) said that he regretted any misunderstanding over the amendments voted on, but confirmed that there had been two competing amendments to paragraph 1, which had been presented according to normal procedure: one after the other, with "or" between them. Voting to accept the proposal of China meant that the alternative proposal had lapsed and did not require a vote. It also meant that the original paragraph was replaced by the amendment adopted by the Board.

The CHAIRMAN asked whether, in the light of that clarification, the member for the United States would have voted any differently.

Mr HOHMAN (alternate to Dr Wright, United States of America) replied that his vote would not have been affected.

**International migration of health personnel: a challenge for health systems in developing countries:** Item 4.13 of the Agenda (Document EB122/16 Rev.1) (continued from the sixth meeting)

Dr REN Minghui (alternate to Mr Li Baodong, China) welcomed the efforts made by WHO since 2004 to implement resolutions WHA57.19 and WHA58.17 with a view to mitigating the impact of the international migration of health personnel on developing countries' health systems. Between 1978 and 2003, only 23.3% of medical students who had left China, mainly for developed countries, had returned after completing their studies. As a result, the Chinese health system was seriously understaffed. Appealing to WHO to raise awareness on the issue, he said that too little had been done so far. Drawing up a global code of practice, with consensus, would be useful. International awareness and dialogue should be increased by promoting cooperation between low- and high-income countries.

Mr DE SILVA (Sri Lanka) said that, although the migration of health personnel could benefit countries both of origin and of destination, it was a challenge for countries with an acute shortage of personnel and fragile health systems. He supported the Secretariat's response to resolution WHA57.19 through a global code of practice on the international recruitment of health personnel and working with the Global Health Workforce Alliance to set up a consultation process with Member States. Developing countries had become a nursery for health-care professionals in the developed world. Education was free in Sri Lanka, but, once trained, few of the best health-care professionals remained in the country. Developed countries should devise a system to ensure that health-care professionals served their own countries for at least a few years. A code of practice alone would not improve the situation since greater awareness was needed. Developing countries would be unable to meet the Millennium Development Goals without the necessary health-care professionals.

Dr VOLJČ (Slovenia) said that he was speaking on behalf of the European Union, the European Free Trade Association countries Iceland and Norway, members of the European Economic Area, and Switzerland. The candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process, and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as Ukraine, Armenia, Georgia and the Republic of Moldova, aligned themselves with his statement.

International migration of health personnel had increased significantly since the Health Assembly's consideration of the issue in 2004, resulting in a loss of human resources for countries of origin, often developing countries. That affected both the development of those countries and the quality of their national health systems. Countries of origin should invest in policies to improve working conditions, and recipient countries should reconsider their training strategies. If migrating health personnel returned to their country of origin, they could benefit themselves and their national health systems. The European Union recognized the need for comprehensive strategies in order to mitigate the adverse effects of the migration of health personnel. The Secretariat should emphasize improved statistics and information for decision-making and provide support to Member States by collating best practices. Improved health workforce planning required a global approach based on greater cooperation between key stakeholders. The Secretariat should report on the impact of the recently adopted ethical codes of practice, which was mentioned in its report to the Health Assembly in May. On that basis, WHO should prioritize elaboration of a global code of practice on the international recruitment of health personnel in order to strengthen national health systems in countries both of origin and of destination.

Dr SUGIURA (alternate to Dr Shinozaki, Japan) recognized the complexity of the issues, which involved political, economic, labour and educational aspects and depended on both national and individual decisions. The four-pillar approach developed by WHO and its cooperation with ILO and the International Organization for Migration were appreciated. There was a need for transparent coordination between countries, based on regional or global codes of practice, and prompt establishment of those codes. Collaboration between Member States and the Secretariat in collection

of data on migration of health personnel was essential. Member States must be committed to retaining their own health professionals and to empowering them through training and education.

Mr FISKER (Denmark) welcomed the information on initiatives provided in the report. Migration was provoked by a combination of “push” and “pull” factors and, despite its negative effects, its benefits should not be neglected, notably the experience acquired by migrants and the money they sent home while working abroad. He distinguished between health personnel migration and active recruitment abroad. An individual’s education should be no bar to the freedom to live and work anywhere. Given the acute shortage of health-care providers in a number of countries, however, WHO’s efforts to evolve principles for a global code of practice were appreciated.

Dr DAHL-REGIS (Bahamas) noted with appreciation the follow-up to resolution WHA57.19. She supported efforts to develop the global code of practice and requested all relevant documents, including the Commonwealth Code of Practice for the International Recruitment of Health Workers, to be considered. The problem was marked in the Caribbean and she wished to know how her country could participate in regional efforts. She asked whether a health workforce observatory had been established in her region and whether it would provide information on destination of migration and patterns of migration to and from her country.

Mr MIGUIL (Djibouti) said that the issue under consideration had been debated at the First Global Conference on Task Shifting (Addis Ababa, 8–10 January 2008). It was essential to move away from a bureaucratic approach and implement effective policies and a global code of practice. Developed countries had failed in their own training policies and were resorting to an arsenal of measures in order to recruit qualified health personnel from developing countries, at the expense of the latter’s health-care training systems and quality of health care. Time and investment devoted to training was thus wasted to the detriment of national health policies and action plans.

Migration of health personnel clearly harmed the developing world, assisted by the selective immigration policies practised by OECD countries. His Government called for an immediate end to such policies and suggested some form of financial, technical and material compensation. The discriminatory policies applied in some countries should be ended, as the same salaries and working conditions should apply to both migrant health personnel and nationals. He urged the Board to take an unequivocal position that would contribute to socioeconomic policies of the developing countries, and rapidly produce a global code of practice.

Dr ABABII (Republic of Moldova) said that half his country’s health personnel had been lost to migration in the preceding 10 years, jeopardizing the country’s ability to meet the relevant Millennium Development Goals. A unified database was needed to provide reliable information on migrating health personnel. Steps had been taken and budgeted for in Moldova in order to train health personnel. Incentives had also been introduced for young specialists to work in rural areas, and to retain highly qualified personnel. In the face of disappointing results, however, his Government had consulted developed countries to which its specialists were migrating, asking them to monitor immigration flows and observe equitable principles of international recruitment. Otherwise, compensation should be provided in respect of the training of specialists.

Developed and developing countries must work together. A global code of practice and other international cooperation agreements were vital. The statements made by previous speakers reflected the importance of the issue to the health community and the specific measures needed.

Ms KENNELLY (alternate to Dr Wright, United States of America) expressed appreciation of WHO’s work on migration of health personnel and looked forward to further research. International cooperation would be needed to find sustainable solutions to overcome shortages of health personnel, a serious concern for developing countries. Migration was influenced by various “push” and “pull” factors. The Secretariat could not cover all these, but it could support the development of national capacities to analyse and estimate human resource needs; expand local training and career

development opportunities; identify activities related to recruitment and retention of health personnel; and encourage national policies that broadened the tasks undertaken by different categories of health worker.

The United States of America was working with WHO in Ethiopia, Haiti, Malawi, Namibia, Rwanda, Uganda and Zambia through the President's Emergency Plan for AIDS Relief in order to assess clinical practice, regulatory frameworks and certification mechanisms for the realignment of tasks. In 2006, it had provided US\$ 350 million for workforce and health system development.

The Secretariat's report required some revision before submission to the Health Assembly. For example, it might include discussion of South-South migration of health workers. Further, paragraph 7 referred to OECD statistics on foreign-born workforces that included North-North migration, for example between Canada and the United States of America, which might therefore be of limited use. The report might also usefully include a balanced discussion on the benefits of migration and a reference to the right of individuals to leave their country of origin. Migration of health workers posed challenges and ethical dilemmas that distinguished it from other categories of migration. However, individuals should not be denied the right to migrate because of their chosen profession. Moreover, migration was not the primary source of shortages of health workers. Since movement of health workers could not be blocked realistically, governments, the private sector and other interested parties must concentrate on strengthening human resources in all countries.

Consultation with Member States on the proposed global code of practice for the recruitment of health personnel was essential and should take into account the wide range of health care and immigration systems. She could not agree that codes of practice for the ethical recruitment of health workers carried the weight of "soft law" as asserted in paragraph 16 of the report. A WHO code would be non-binding and would therefore not be a law of any type. Moreover, it would not "manage" migration, as mentioned in paragraph 15. Nevertheless, codes of practice could prove useful as voluntary guidelines for interested countries, particularly as fair labour practices. WHO should also encourage voluntary public-private partnerships to further strengthen health resources in developing countries. Developing countries should be encouraged to consider mechanisms to ensure that individuals trained at public expense repaid the cost of that training financially or through public service. A WHO code must not lead to discrimination against the hiring of health personnel from certain developing countries, especially those of Africa. WHO should advocate equal opportunity policies.

She requested further information on the funding of the Global Health Workers Alliance and the budgetary implications of its activities, since her delegation's questions in that regard at the Fifty-ninth World Health Assembly had not been answered.

Ms WISEMAN (Canada)<sup>1</sup> observed that there was a global shortage of health workers and their international migration posed a number of ethical concerns. A multifaceted approach was needed, which should include increased training, improved recruitment practices, and measures to retain health personnel. Canada supported WHO's efforts to improve the collection and sharing of information and frame policies for health workforce development through collaboration. Member States should develop a global code of practice for the recruitment of health personnel. Canada requested information on the proposed schedule for the guiding principles and the code.

Mr ALCÁZAR (Brazil),<sup>1</sup> endorsing the comments made by the members for Djibouti and Iraq, agreed that migration of health personnel was of particular importance for developing countries. He expressed deep disappointment at the attitude taken by the member for the United States of America. The report did not really suggest a way forward; although a global code would be useful, what was needed was a global strategy for elaborating policies, in particular to tackle the "push" factors driving

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

migration. He therefore proposed that the Secretariat should be requested to draft a global strategy for consideration at the Sixty-first World Health Assembly.

Mr DEL PICÓ (Chile)<sup>1</sup> supported further studies with technical and financial support from WHO. Information on migration of health workers should be included in national databases. WHO should consider policies regarding migration of health personnel in conjunction with its human resources policies. Member States should establish teams to monitor and analyse migration flows, to include a gender focus and devise appropriate policies.

Mgr TOMASI (Holy See), speaking at the invitation of the CHAIRMAN, welcomed the attention to better information on health worker migration and developing policy responses with a global code of practice. The Secretariat and Member States should intensify their analysis of migration flows and devise mechanisms to prevent exacerbation. Health-care workers often cited poor working conditions, low pay and inadequate clinical infrastructures as reasons for migrating. Staff in health-care facilities sponsored by religious organizations provided a substantial proportion of care in developing countries, often reaching vulnerable populations, yet they often earned less than those working in government facilities. WHO should promote the improvement of working conditions, levels of pay and access to in-service training for health workers in low-income countries. Such actions would advance progress towards Millennium Development Goals and renew emphasis on human dignity and the common good.

Ms THORSON (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN and on behalf of professional organizations in the fields of dentistry, nursing, pharmacy and medicine that were members of the World Health Professions Alliance, welcomed the progress made since the Health Assembly's first discussion of the migration of health personnel in 2004. The WHO-administered Global Health Workforce Alliance had grown into an effective body that was driving global action.

She supported the four main areas for action mentioned in the report. However, despite progress, health personnel migration had not yet changed significantly. She emphasized national action on international guidelines, policies and codes and sharing best practices. Migration was a symptom of dysfunctional health systems in sending and receiving countries. Focusing on migration alone would not be enough. The Secretariat, Member States and other stakeholders must strengthen health infrastructures and training capacities. The goal should be self-sufficiency in health human resources.

She drew attention to the Global Forum on Human Resources for Health to be held in Kampala in March 2008, and called on WHO and other interested parties to participate and encourage the retention of skilled health personnel by their countries of origin.

Dr NORDSTRÖM (Assistant Director-General) thanked speakers for their comments. The Secretariat had intensified efforts regarding migration, planning and management, and gathering and sharing of data on human resources for health. It had also established regional observatories to gather data and collaborate with countries, and he would provide the member for the Bahamas with information on the observatory in Latin America. WHO had been working closely with OECD, and the migration data available were improving and provided information on South-South, North-North and South-North migration flows. WHO was also active in the area of training and much had been learnt from the implementation of the memorandum of understanding on migration of health personnel between South Africa and the United Kingdom of Great Britain and Northern Ireland. Its success had been partly due to increased training of health personnel in the latter. Retention of skilled personnel was linked with conditions of service, socioeconomic conditions and the management of the public

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

and private health sectors. Migration could not be treated in isolation and WHO was therefore establishing partnerships with such key stakeholders as Brazil, Canada, the Global Health Workforce Alliance, and the United States President's Emergency Plan for AIDS Relief, and was focusing on action at the country level. The Alliance was included in WHO's Programme budget and funded through voluntary contributions from Norway, the United Kingdom and the Bill & Melinda Gates Foundation.

*The world health report 2006*<sup>1</sup> had raised awareness of the crisis in human resources for health. The Global Forum on Human Resources for Health in March 2008 would review and propose policies and strategies to improve the situation. There were both benefits and drawbacks of migration but the right to migrate and ethical recruitment practices were important principles to be observed.

The Secretariat had already undertaken some analyses of current migration flows and experiences with existing measures. If the Board wished the Sixty-first World Health Assembly to consider the matter, it would need to request inclusion of the item during its discussion of item 6.7 of its agenda. The Secretariat was suggesting that consultations with Member States on developing a global code of practice for the recruitment of health personnel should begin in early 2008 and that a draft code should be submitted to the Board at its 124th session in January 2009 and then, should the Board approve it, to the Sixty-second World Health Assembly in May 2009.

Professor SALANIPONI (Malawi) said that he had heard mention of both benefits and drawbacks of the migration of health personnel. As far as the countries of Africa were concerned, there were nothing but drawbacks.

**The Board noted the report.**

**Health of migrants:** Item 4.8 of the Agenda (Document EB122/11) (continued from the fifth meeting)

The CHAIRMAN drew attention to a revised draft resolution on the health of migrants, proposed by a working group, together with its financial and administrative implications, which read:

The Executive Board,  
Having considered the report on health of migrants,<sup>2</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 ~~on 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;

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<sup>1</sup> *The world health report 2006: working together for health*. Geneva, World Health Organization, 2006.

<sup>2</sup> Document EB122/11.

**Recognizing that the revised International Health Regulations (2005) include provisions relating to international passenger transport;**

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 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 consider the health needs of migrants in the framework** ~~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 **can be** ~~are~~ influenced by the multiple dimensions of migration;

Noting that some groups of migrants experience ~~people on the move may experience~~ increased health risks;

Recognizing **the need for additional data on** migrant's health and **their** access to health **care** ~~scarcity of information specific to migrants' health status and access to health services and the consequences thereof to health systems~~ **to substantiate evidence based policies for health systems;**

~~Noting that the existence of economic, political, social and environmental determinants of migrants' health underlines~~ **Taking into account the need to address determinants of migrants' health and the need to develop intersectoral public policies that can influence both the migration process and its health consequences** ~~to address health determinants and protect their migrants' health. of migrants for the health of migrants~~

**Taking into account the determinants of migrants' health in developing intersectoral policies to protect their health;**

Mindful of the ~~need for promoting mechanisms~~ **role of health in promoting social inclusion** ~~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 **policies addressing migrants' health should be sensitive** to the specific **health** ~~and migration policies should have to consider gender aspects and the specific needs of women, men and children;~~

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 **promotion** ~~protection~~ and care for migrants, subject to national laws and practice, and devise mechanisms for enhancing the health ~~social protection in health~~ for of 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 the gaps in service delivery~~ **in order to improve the health of all populations, including migrants;**
- (5) ~~to document best practices for meeting migrants' health needs in countries of origin or return, transit and destination, and to encourage generation sharing of information on health issues arising from migration;~~
- (5) **to gather, document and share information and best practices for meeting migrants' health needs in countries of origin or return, transit and destination; throughout the entire migration process, and to encourage gathering 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' and **professionals'** 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 bilateral and multilateral ~~international~~ cooperation on migrants' health among countries involved in the whole migratory process;
- (10) ~~to promote the strengthening of health systems in developing countries 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 **in collaboration with other relevant international organizations;**
- (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 **where appropriate;**
- (6) **to help collect and disseminate** ~~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 **all Member States involved in the migratory process,** ~~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 **and considering the impact of other policies;**
- (10) to encourage the exchange of information through a technical network of collaborating centres, 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.

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| <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) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)   |  |
| US\$ 2 400 000 over a period of four years.  |  |
| (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)  |  |
| US\$ 1 200 000 at global, regional and country levels.   |  |
| (c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the current biennium? US\$ 586 000.  |  |
| (d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)  |  |
| Costs will be met through income from voluntary contributions aimed at supporting work in this field.  |  |
| <b>4. Administrative implications</b>  |  |
| (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. |  |

In response to a request for clarification from Ms KENNELLY (alternate to Dr Wright, United States of America), Professor PEREIRA MIGUEL (Portugal) confirmed that the working group had agreed to use the wording “countries of origin or return, transit and destination” in paragraph 1(5). He added that the French version of paragraph 1(9) should be aligned with the English text.

Mr TINAJERO (alternate to Dr Hernández Ávila, Mexico) reiterated the importance that his country attached to ensuring migrants’ right to health. He thanked Portugal for taking the lead on the issue, and expressed support for the draft resolution.

Ms KENNELLY (alternate to Dr Wright, United States of America) said that it was the view of her Government that countries had the right to differentiate medical benefits beyond emergency care on the basis of immigration status. That consideration had not been reflected in the report.

Dr KEAN (Executive Director, Office of the Director-General) assured the member for Portugal that the French version of paragraph 1(9) would be aligned with the English text.

**The resolution was adopted.<sup>1</sup>**

**Global immunization strategy:** Item 4.11 of the Agenda (Documents EB122/14 and EB122/14 Add.1) (continued from the sixth meeting)

The CHAIRMAN drew attention to a revised draft resolution on the global immunization strategy, incorporating amendments proposed by China, Denmark, Netherlands, New Zealand, Portugal, Republic of Korea and Tunisia, together with its financial and administrative implications, which read:

The Executive Board,  
Having considered the report on the global immunization strategy,<sup>2</sup>

RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:<sup>3</sup>

The Sixty-first World Health Assembly,  
Having considered the report on the global immunization strategy;  
Applauding the remarkable investments in human and financial resources made by Member States and partner agencies in support of vaccines and immunization as well as the launch of innovative financing mechanisms such as the International Finance Facility for Immunisation, and the advance market commitment for a pneumococcal conjugate vaccine through the GAVI Alliance;

Recalling resolution WHA56.20 on reducing global measles mortality, and commending Member States’ and their partners’ success in exceeding the goal of reducing deaths worldwide due to measles by 50% by the end of 2005 compared with the 1999 level;

Commending also Member States’ and their partners’ progress in increasing the availability, affordability and uptake of hepatitis B vaccine worldwide;

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<sup>1</sup> Resolution EB122.R5.

<sup>2</sup> Document EB122/14.

<sup>3</sup> See document EB122/14 Add.1 for the financial and administrative implications for the Secretariat of the resolution.

Encouraged by the progress in molecular biology and genetics that is accelerating the discovery and development of new vaccines and by the increasing number of developing-country manufacturers producing vaccines that meet WHO requirements for vaccines of assured quality;

Alarmed that many developing countries are not on track to meet the internationally agreed target in Millennium Development Goal 4 for reducing the under-five mortality rate;

**Concerned about the failure to make available necessary resources for introduction of new vaccines especially in the middle-income countries; [Tunisia]**

Stressing the vital role that vaccine and immunization programmes can play in reducing infant mortality and in facilitating the delivery of a package of life-saving interventions,

1. URGES Member States:

- (1) to implement fully the strategy for reducing measles mortality in order to achieve the goal set in the Global Immunization Vision and Strategy 2006–2015 of a 90% reduction in the global measles mortality rate between 2000 and 2010;
- (2) to enhance efforts to improve delivery of high-quality immunization services in order to achieve the target of equitable coverage of at least 80% in all districts by 2010 set in the Global Immunization Vision and Strategy 2006–2015;
- (3) to further expand access to, and coverage of, available **and cost-beneficial [Netherlands, seconded by Denmark and Portugal]** new life-saving vaccines of assured quality, **in accordance with national priorities, [New Zealand]** for all target populations in order to accelerate the achievement of Millennium Development Goal 4;
- (4) **to develop, strengthen and/or maintain surveillance systems for vaccine-related adverse events; [Republic of Korea]**

2. REQUESTS the Director-General:

- (1) to work with Member States to sustain political commitment at all levels for achieving high immunization coverage rates with all available vaccines **that have proven to have a positive cost-benefit balance for a particular (sub)population [Netherlands, seconded by Denmark and Portugal];**
- (2) to collaborate with international partners, including UNICEF and the GAVI Alliance, in order to continue to mobilize the financial resources required to achieve this objective and in order to ensure that all Member States have access to sufficient supplies of affordable vaccines of assured quality;
- (3) **to approach international partners and donors as well as the vaccine producers to mobilize necessary resources in order to support low- and middle-income countries and to ensure that all Member States have access to sufficient supplies of affordable vaccines of assured quality; [Tunisia]**
- (4) **to take measures, as appropriate, to help developing countries to establish and strengthen the capacity of vaccine research, development and production, with the aim of ensuring vaccine supplies, reducing vaccine prices and improving access to affordable vaccines; [China]**
- (5) **to provide guidelines and technical support to Member States for the minimization of vaccine-related adverse events; [Republic of Korea]**
- (36) to facilitate scientific, technical and financial investments into the research and development of safe and effective vaccines against poverty-related and neglected diseases;
- (47) to monitor progress towards achievement of global immunization goals and report on such progress to the Sixty-fourth World Health Assembly.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that the seventh preambular paragraph, proposed by Tunisia, would be more succinct if it were amended to read: “Concerned there are insufficient resources for introduction of new vaccines, especially in low- and middle-income countries”.

Dr ABDESSELEM (Tunisia) said that he had no objection to that proposal.

Mr HOHMAN (alternate to Dr Wright, United States of America), referring to paragraph 1(3), suggested that “cost-beneficial” should be replaced with “cost-effective”.

The CHAIRMAN noted that there were no objections to that suggestion.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that the terms “particular (sub)population” and “cost-benefit balance” in paragraph 2(1) were not clear. Moreover, he was unsure whether the Director-General was in a position to determine which vaccines had proven to have a positive cost-benefit balance. He suggested that the text might be simplified by amending it to read: “to work with Member States to sustain political commitment at all levels for achieving high immunization coverage rates with all available cost-effective vaccines”.

Professor PEREIRA MIGUEL (Portugal) and Mr FISKE (Denmark) agreed to that wording.

Mr HOHMAN (alternate to Dr Wright, United States of America), referring to paragraph 2(3), wondered whether the Director-General would be in a position to ensure that all Member States had access to sufficient supplies of affordable vaccines of assured quality. He also had some concerns regarding paragraph 2(4), and would propose new wording to replace both paragraphs, to read: “to collaborate with international partners, donors, vaccine producers and other concerned parties to strengthen vaccine research, development and regulatory capacity in low- and middle-income countries, with the aim of increasing the supply of affordable vaccines of assured quality”.

Dr GWENIGALE (Liberia) pointed out that some middle-income countries would not qualify for funding from the GAVI Alliance, and required additional support in order to supply vaccines. That idea might not be conveyed if the words “to mobilize necessary resources in order to support” were deleted from paragraph 2(3).

Dr REN Minghui (alternate to Mr Li Baodong, China) said that he could not accept the amendment proposed by the member for the United States, which altered the emphasis of paragraph 2(4). The intent of that paragraph was to strengthen the vaccine research, development and production capabilities of developing countries, rather than the regulation of vaccines.

Dr ABDESSELEM (Tunisia) said that the amendment proposed by the member for the United States of America did not reflect two important elements of paragraph 2(3): the mobilization of necessary resources and access to sufficient supplies of vaccines.

Mr HOHMAN (alternate to Dr Wright, United States of America) noted that the new paragraph he had suggested referred to strengthening vaccine research and development as well as regulatory capacity. Regarding the concerns expressed by the members for Liberia and Tunisia, he pointed out that paragraph 2(2) referred to mobilization of financial resources. He suggested that the phrase “and in order to ensure that all Member States have access to sufficient supplies of affordable vaccines of assured quality” should be deleted from that paragraph, as he was unsure whether that was a feasible request to make of the Director-General.

The DIRECTOR-GENERAL said that there was duplication in the draft resolution since the issue of resource mobilization was addressed in paragraphs 2(2) and 2(3). While she would do her

utmost, she could not, in reality, ensure that all Member States had access to sufficient affordable vaccines.

The CHAIRMAN invited interested parties to consult informally with a view to formulating acceptable wording for paragraphs 2(2) to 2(4).

**It was so agreed.**

(For adoption of the resolution see section 3 below.)

## **2. STAFFING MATTERS:** Item 7 of the Agenda

**Appointment of the Regional Director for the Americas:** Item 7.1 of the Agenda (Document EB122/23)

Dr SINGAY (Bhutan), Rapporteur, read out the resolution on the appointment of the Regional Director for the Americas adopted by the Board in open session:<sup>1</sup>

The Executive Board,  
Considering the provisions of Article 52 of the Constitution of WHO;  
Considering the nomination made by the Regional Committee for the Americas at its fifty-ninth session,

1. APPOINTS Dr Mirta Roses Periago as Regional Director for the Americas as from 1 February 2008;
2. AUTHORIZES the Director-General to issue a contract to Dr Mirta Roses Periago for a period of five years as from 1 February 2008, subject to the provisions of the Staff Regulations and Staff Rules.

The CHAIRMAN congratulated Dr Roses Periago on her re-appointment and conveyed the Executive Board's best wishes for continuing success in her endeavours.

Dr ROSES PERIAGO (Regional Director for the Americas) thanked the Board and reaffirmed her commitment to the well-being of the peoples of the Region of the Americas. She accepted the appointment with humility, mindful of the values and principles that guided her in support of WHO's policies and the needs of the countries of the Americas served by PAHO. PAHO stood ready to tackle new and global public health challenges, through coordinated collective action. Preparing the countries of the Region was one of PAHO's main objectives. As health improved, inequities would be eliminated and resources freed to respond to emerging challenges such as climate change, population ageing and migration. WHO's six key objectives – promoting development; fostering health security; strengthening health systems; harnessing research, information and evidence; enhancing partnerships; and improving performance – were fundamental, as was the synergy between regional and global priorities.

She emphasized the thirtieth anniversary of the Alma-Ata conference, which had launched the WHO strategy for primary health care and the ambitious goal of health for all. That noble goal remained elusive, owing largely to social structures that perpetuated inequality and poverty. PAHO

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<sup>1</sup> Resolution EB122.R6.

was committed to the fight against inequity and social exclusion, and prioritized primary health. The Region was proud of the success of the International Conference on Health for Development: Rights, Facts and Realities, organized by Argentina with WHO and other partners.

There was great opportunity for solidarity and cooperation within the extended WHO family. For example, the European Region was launching an annual vaccination week modelled on Vaccination Week in the Americas, which was in its fifth year. Support and solidarity were exemplified by the “3 by 5” initiative on HIV/AIDS. The XVII International AIDS Conference would take place in Mexico City, the first time such a conference had been held in Latin America. She expressed appreciation for the backing not only of the Director-General and her fellow regional directors, but also of the extraordinary staff of the Regional Office. With the support of Member States and dedicated health workers, she would be able to meet the expectations of the peoples of the Americas, make the Millennium Development Goals a reality, for families and communities that were invisible to the rest of the world, and improve well-being and development of vulnerable populations.

The DIRECTOR-GENERAL recalled that when the Regional Director had taken office five years earlier, a central theme in her vision for better health in the Americas had been equity and the accountability of governments for the health of their citizens. She had prioritized strengthening of health services, and a primary health care approach as a means of fostering equity in attaining the health-related Millennium Development Goals. She had spoken of her humility. She had degrees in medicine, surgery and tropical medicine and public health, with an emphasis on infectious diseases and epidemiology. Her early work as a field epidemiologist had brought her face-to-face with suffering in many parts of Latin America, experiences that had shaped her leadership style. She defended the health interests of the poor and marginalized and insisted that “invisible” people be given a face and a voice, and the care they deserved. The people of the Americas were fortunate to have such a dedicated leader who sought fair and sustainable solutions through the primary health care approach. She looked forward to their close collaboration.

### **3. TECHNICAL AND HEALTH MATTERS (resumed)**

**Global immunization strategy:** Item 4.11 of the Agenda (Documents EB122/14 and EB122/14 Add.1) (resumed)

Mr HOHMAN (alternate to Dr Wright, United States of America) said that, following consultations with the members for China and Tunisia, informal agreement had been reached on the proposed amendments. In paragraph 2(2), the words “and in order to ensure that all Member States have access to sufficient supplies of affordable vaccines of assured quality” should be deleted. Paragraph 2(3) would read: “to collaborate with international partners and donors as well as vaccine producers to mobilize necessary resources to support low- and middle-income countries with the aim of increasing the supply of affordable vaccines of assured quality”. Paragraph 2(4) would read: “to take measures, as appropriate, to assist developing countries to establish and strengthen their capacity for vaccine research, development and regulation for the purpose of improving the output of vaccine production, with the aim of increasing the supply of affordable vaccines of assured quality”.

The CHAIRMAN said that he took it that the Board agreed with those proposals and with the amendment proposed by the member for the Republic of Korea to paragraph 2(5), which read: “to provide guidelines and technical support to Member States for the minimization of vaccine-related adverse events”.

**It was so agreed.**

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

**Monitoring of health-related Millennium Development Goals:** Item 4.14 of the Agenda (Documents EB122/33 and EB122/33 Add.1)

The CHAIRMAN, introducing the item, drew attention to a draft resolution on monitoring of the implementation of the health-related Millennium Development Goals, proposed by Slovenia and also sponsored by Austria, Belgium, Bulgaria, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Monaco, the Netherlands, Poland, Portugal, Romania, Slovakia, Spain, Sweden and the United Kingdom of Great Britain and Northern Ireland, together with its financial and administrative implications, which read:

The Executive Board,  
Having considered the report on monitoring of health-related Millennium Development Goals,<sup>2</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 monitoring of health-related Millennium Development Goals,

Recalling the 2005 World Summit Outcome and the commitments taken by the international community to implement fully the Millennium Development Goals;

Concerned by the lack of progress, especially in the sub-Saharan African countries, in the implementation of the Millennium Development Goals and, in particular, the health-related Goals 4, 5 and 6;

Recalling the General Assembly resolution 60/265 dated 12 July 2006 on follow-up to the development outcome of the 2005 World Summit, including the Millennium Development Goals and other internationally agreed development goals, and WHO's Medium-term strategic plan 2008–2013, particularly the objectives 2, 4, 7 and 12;

1. DECIDES to include regularly an item on the agenda of the Health Assembly on the monitoring of the implementation of the health-related Millennium Development Goals;
2. REQUESTS the Director-General:
  - (1) to identify major obstacles to the full implementation of the Millennium Development Goals and ways to overcome those obstacles;
  - (2) to that effect, to cooperate closely with all other United Nations and international organizations involved in the process of implementing the Millennium Development Goals;
  - (3) to submit annually a report on the status of the implementation of the health-related Millennium Development Goals, and in particular Goals 4, 5 and 6, through the Executive Board to the Health Assembly.

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<sup>1</sup> Resolution EB122.R7.

<sup>2</sup> Document EB122/33.

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| <b>1. Resolution</b> Monitoring of the implementation of the health-related Millennium Development Goals   |   |
| <b>2. Linkage to programme budget</b>  |   |
| Strategic objective:   | Organization-wide expected result:  |
| 10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.   | 5. Better knowledge and evidence for health decision-making assured through consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas, and global leadership in health research policy and coordination, including with regard to ethical conduct. |
| (Briefly indicate the linkage with expected results, indicators, targets, baseline)  |   |
| Link to production of global analytical reports.   |   |
| <b>3. Financial implications</b>   |   |
| <b>(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)</b>  |   |
| For the period 2009–2015: US\$ 700 000 at US\$ 100 000 per year. Annually, staff costs will be US\$ 75 000 and publication costs US\$ 25 000.  |   |
| <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\$ 100 000 in 2009 for production at headquarters of the report on implementation.   |   |
| <b>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the current biennium?</b>   |   |
| None.  |   |
| <b>(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)</b>   |   |
| Funding will be needed through core contributions.   |   |
| <b>4. Administrative implications</b>  |   |
| <b>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)</b>  |   |
| Headquarters.  |   |
| <b>(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant)</b>  |   |
| Two staff workers are required for three months each, representing a 0.5 full-time equivalent.   |   |
| <b>(c) Time frames (indicate broad time frames for implementation)</b>   |   |
| The first annual report will be submitted in 2009; this will continue until 2015.  |   |

Dr FORSTER (Namibia), speaking on behalf of the Member States of the African Region, said that regular monitoring of progress towards achieving the Goals was essential, and welcomed the setting up of the Global Health Observatory. Achievement of the Goals by 2015 would largely depend on progress made on the African continent. The expenditure of most African countries for health, however, fell far short of the minimum required according to the Commission on Macroeconomics



and Health, and those countries were exploring mechanisms for additional financing, such as social insurance. Those should be complemented by external funding. Monitoring and data generation in African countries should be strengthened by consensus about the indicators to be monitored and by building the necessary systems and human capacity.

He proposed adding a paragraph to the draft resolution, to become subparagraph 2(3), reading: “to provide technical assistance to Member States to strengthen national monitoring and information systems related to the Millennium Development Goals”.

Dr REN Minghui (alternate to Mr Li Baodong, China) said that the report recorded global progress, especially in reducing mortality among children under five and in improving access to treatment for HIV/AIDS. The health-related Millennium Development Goals were being met with the participation of civil society and the private sector and through new types of global partnership, but in low-income countries, weak health systems and shortages of funds were still serious obstacles. In monitoring achievement of the Goals, WHO should identify weaknesses and difficulties and take proactive measures to support Member States. In China, implementation of the Goals involved consultations with many departments in the Government; he therefore proposed that consideration of the draft resolution be postponed until the next meeting.

Dr VOLJČ (Slovenia) said that he was speaking on behalf of the European Union, European Free Trade Association member Norway, European Economic Area member Switzerland, the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, and the countries of the Stabilisation and Association Process, and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia. Armenia, the Republic of Moldova, and Ukraine, and Kenya, Madagascar, Mali and Rwanda aligned themselves with his statement. The title of the draft resolution should be amended to read “Monitoring of the achievement of the health-related Millennium Development Goals” and that the word “implementation” should be replaced by “achievement” throughout the draft resolution. He congratulated the Secretariat on the report.

In order to speed up achievement of the health-related Millennium Development Goals, he suggested that health ministers should meet annually at the time of the Health Assembly to discuss the main obstacles and possible solutions to achieving them. That would be in line with United Nations General Assembly resolution 60/265 and with objectives 2, 4, 7 and 12 of WHO’s Medium-term strategic plan 2008–2013. The activities of other agencies related to achieving the Goals should be taken into account. The proposed annual meetings would mandate WHO to intensify its support to countries in achieving the Goals.

Dr AHMADZAI (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that achieving the health-related Millennium Development Goals by 2015 would be a major challenge for several countries in his Region owing to protracted emergency situations, a lack of good health-care services and resources, and low literacy rates. Nevertheless, in his country, rates of infant and child mortality had been reduced substantially. Greater efforts to increase early and exclusive breastfeeding were needed. Six of the Region’s 10 priority countries were progressing toward the goal for improving maternal health. The Stop TB Strategy in the Region had been scaled up, and coverage of directly observed therapy was more than 95%.

The estimated prevalence of HIV infection in the general population had remained stable. However, only 6% of persons who needed antiretroviral medicines had access to them. The reported malaria figures were lower than the estimated actual figures because of poor reporting systems. Well-functioning information systems, regular health surveys and health systems research were essential for monitoring of the health-related Goals. Countries with a heavy burden of health problems often had poor information systems, and monitoring was a challenge.

He urged WHO to help to strengthen information systems for efficient monitoring of health systems. As only seven years remained before the target date for achieving the health-related Goals, the Director-General should be asked to report annually on progress to both the Executive Board and the Health Assembly.

**The meeting rose at 12:30.**