

## **Progress reports**

### **Report by the Secretariat**

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## **A. HEALTH SYSTEM STRENGTHENING (resolutions WHA64.9, WHA64.8, WHA63.27, WHA62.12 and WHA60.27)**

1. In adopting resolution WHA62.12 on primary health care, including health system strengthening, the Health Assembly reaffirmed Member States' commitment to the renewal of primary health care and progress towards health for all. The resolution identified four policy directions for the Organization's work to renew and strengthen primary health care, namely: moving towards universal coverage; putting people at the centre of service delivery; integrating health into broader public policy; and providing inclusive leadership and effective governance for health. Work to strengthen health systems was given further support through resolution WHA60.27 on information systems as part of national health systems, resolution WHA63.27 on strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services, resolution WHA64.8 on the strengthening of national policy dialogue to build more robust health policies, strategies and plans, and resolution WHA64.9 on sustainable health financing structures and universal coverage. The present document summarizes progress made in implementing the resolutions and the collaboration across all the levels of the Organization that has been involved, taking into account comments made by Member States when the Executive Board at its 130th session in January 2012 noted an earlier version of this progress report.<sup>1</sup>

2. The Regional Office for the Americas continues to make progress in the implementation of primary health care-based health systems according to the Montevideo Declaration (2005). It has set up a community of practice dedicated to primary health care and a virtual public health campus. It is performing a situation assessment of primary care in the Region of the Americas, measuring health system performance with a primary health care lens, integrating disease-specific programmes into the health system and implementing the health services productive management methodology.

3. The Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care was endorsed by the Regional Committee for the Western Pacific at its sixty-first session in October 2010,<sup>2</sup> after a two-year consultation process.

4. In the European Region, health system strengthening is being guided by the Secretariat's work on the clarification of concepts of public health and health systems, and on the identification of essential public health services for Europe, in line with the commitments enshrined in the Tallinn Charter: Health Systems for Health and Wealth (2008). Emphasis was placed on the technical support to countries for health financing policy with a focus on improving the performance of health financing. This was consistent with the broad policy objectives identified in WHO Europe's Health Financing Policy Paper 2008/1 *Health Financing Policy: A Guide for Decision-Makers*. Many Member States, including Estonia, Portugal and Turkey, benefited from assessing their health system performance with the technical guidance of the Secretariat.

5. In the Eastern Mediterranean Region, work is oriented by the Doha Charter and Declaration on Primary Health Care (2008). The health profile of 23 Member States has been updated to serve as the basis for policy dialogue, and a number of Member States have been provided with support in developing their national health plans. The Regional Committee adopted resolution EM/RC57/R.7, in which it urged Member States to adopt and adapt six strategic directions to improve health care financing, and requested the Regional Director to support Member States' efforts to implement the

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<sup>1</sup> See document EB130/2012/REC/2, summary record of the fourteenth meeting, section 2.

<sup>2</sup> Resolution WPR/RC61.R2.

strategic directions and expedite the move towards universal coverage. A study on the role of the private sector in providing essential health care services has been launched and a regional task force is promoting district health systems based on a family practice approach.

6. In the African and South-East Asia regions guidance is provided by, respectively, the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa (2008) and the strategic framework developed through the Regional Meeting on Health Care Reform (Bangkok, 20–22 October 2009). Regional task forces and technical working groups have provided oversight and guidance to support the translation of commitments into country cooperation strategy documents and the biennial planning exercises.

7. Globally, the Secretariat's efforts in implementing these resolutions are organized along the four tracks described below.

8. **Intensifying support to Member States in promoting inclusive leadership and effective governance for health.** Globally, 108 countries have put in place comprehensive national planning processes with varying degrees of stakeholder involvement in the national policy dialogue. The current situation regarding health workforce planning is illustrative of a trend towards more inclusive governance. Of 57 countries with severe workforce shortages, 30 reported having an intersectoral coordination mechanism (e.g. a national committee) involving relevant stakeholders. Twenty-eight reported having wider representation beyond the health ministry, whereas 24 countries had non-public sector representation (involving private sector, private-not-for-profit, community or faith-based organizations). In 29 countries, the external partners – such as bilateral or multilateral organizations – were present in the HRH committee. In 69 countries, participatory health sector reviews have been conducted and progress evaluations have been completed in respect of national health policies, strategies and plans, based on agreed health system performance assessments.<sup>1</sup> Joint assessments of national strategies were successfully conducted in 10 countries in 2011. In the Region of the Americas, regulatory frameworks and legislation have been revised and updated in 11 countries. In the European Region, six countries have completed a health system performance assessment exercise. In the Eastern Mediterranean Region, 13 countries have conducted assessment studies on the regulation of the private sector.

9. Direct support has been provided by the Secretariat to more than 60 countries for health planning and policy dialogue reviews; in 34 countries this was carried out as a joint operation by the three levels of the Organization, usually in collaboration with other agencies. Multicountry support has been provided through several intercountry workshops and further provided to countries in the context of the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance. Specific support was provided on harmonization between donors of grants for health systems strengthening and their alignment to national fiduciary and monitoring and evaluation mechanisms, as well as on the development of new health system strengthening funding proposals or direct funding of national health policies, strategies and plans following joint assessments of national strategies. A new programme aiming at strengthening long-term support to country policy dialogue processes on national health policies, strategies and plans has been launched in seven countries with support from the European Union and is set to expand in 2012. Technical support has also been provided to countries in relation to regulatory frameworks, health system performance assessment and essential public health functions. The Secretariat has targeted the improvement of national capacity for building

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<sup>1</sup> Details of the Member States concerned by this effort can be found in the information on strategic objective 10 provided in the Programme budget 2010–2011: performance assessment (document WHO/PRP/12.1) (copies available in the meeting room, in English only).

strategic intelligence through the establishment of information portals, observatories, and the organization of forums for policy debate and exchange. In support of this effort, the Organization is realigning its work on both health systems and disease-specific programmes. It has also developed dedicated tools, including a database on national health planning cycles. In addition, a global learning programme has been launched in all regions in order to build up the Organization's capacity to support policy dialogue in Member States. Seventy-five WHO country offices (617 staff) completed the first phase of this programme, and developed road maps for WHO's support to national planning cycles in their countries.

**10. Putting people at the centre of service delivery.** Common areas of concern for Member States include: ageing and the rising burden of (multiple) chronic conditions; unequal distribution of health and health care; affordability and sustainability; access to technological advances and medicines; and fragmentation, commercialization and hospital-centric systems. In many countries these problems are compounded by the fact that unregulated private providers far outnumber public or regulated private providers, in a context of high reliance on out-of-pocket payment. In all regions, but most notably in the Region of the Americas, the European Region and the Western Pacific Region, Member States have been working to achieve a more proactive steering of the health sector, paying renewed attention to primary care, care coordination and a reformulated role of hospitals.<sup>1</sup> The Secretariat has supported this effort by convening consultations with Member States and relevant stakeholders. It has put the governance of human resources and service delivery at the core of the support it provides to the national policy dialogue exercises and reviews mentioned above.

**11. Moving towards universal coverage.** Many countries still suffer from acute shortages of financial resources for health, others rely heavily on direct out-of-pocket payments to raise funds for health, preventing millions from seeking care and pushing 100 million of the people who seek care into poverty each year as a result. Every year, governments face a continual struggle to improve efficiency and to protect equity in the way resources are used. In response to resolution WHA64.9, the Secretariat has consulted widely with Member States, civil society, multilateral and bilateral partners, and across all levels of the Organization. *The world health report 2010*,<sup>2</sup> and the scaled-up research efforts that accompanied it, was one illustration of this. A plan of action has been developed that focuses on supporting Member States to review their situation in relation to universal coverage; to assess how their health financing systems can be developed further to move closer to that goal; to implement and monitor changes that are identified as necessary; and to develop strong synergies with national health plans and strategies. This reflects the fact that in the last year over 50 Member States have contacted WHO, enquiring about technical support in the area of health systems financing. The plan of action outlines how WHO will scale up its support to countries by providing information on best practices, facilitating the sharing of experiences and lessons learnt, and developing national capacities to track resources, to assess financing strategies and policies and to implement and monitor change. WHO is also strengthening its databases as requested in the resolution. In all these areas, WHO has strengthened its collaboration with bilateral and multilateral partners, academia and civil society, including the Providing for Health initiative on social health protection (P4H).

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<sup>1</sup> Rechel B et al, eds. *Investing in hospitals of the future*. Copenhagen, World Health Organization on behalf of the European Observatory on Health Systems and Policies, 2009. Saltman R, Durán A and Dubois H, eds. *Governing public hospitals. Reform strategies and the movement towards institutional autonomy*. European Observatory on Health Systems and Policies. European Observatory Studies Series No. 25, 2011.

<sup>2</sup> *The world health report 2010 – Health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

12. **Strengthening health information systems as part of national health systems.** Member States were urged, inter alia, to undertake this activity in resolution WHA60.27. In the context of the International Health Partnership and related initiatives (IHP+), WHO is working with an increasing number of countries to strengthen the monitoring, evaluation and review component of their national health strategies. This includes dealing with data gaps, improving the quality of data and strengthening capacity to conduct analyses to inform health sector reviews. There is now a growing consensus among major development agencies in respect of a rationalized set of indicators and a common monitoring and evaluation framework for assessing performance. The recommendations of the Commission on Information and Accountability for Women's and Children's Health call for stronger monitoring, review and action systems in 75 countries that are responsible for more than 95% of the burden of child and maternal mortality in the world.<sup>1</sup> This provides an additional opportunity to further strengthen health information systems and mobilize joint support for a country-led platform for information and accountability in the context of the national health strategy.

13. Although the Secretariat's support to Member States remains focused on building country capacity for maximizing and making the best use of their own resources, considerable attention has been given to improving aid effectiveness. The regional offices for Africa, the Americas, Europe, South-East Asia and the Western Pacific have focused increased attention on the coordination of donors in the health sector and the alignment of their funds and activities with national health priorities and plans. In the Eastern Mediterranean Region, an assessment on aid effectiveness and donor coordination was conducted in eight countries. It will be used to develop a regional strategy. The International Health Partnership and related initiatives (IHP+), for which WHO and the World Bank jointly serve as secretariat, has become the umbrella under which many of the collaborative efforts to strengthen health systems and enhance aid-effectiveness are regrouped. These include the Health Systems Funding Platform, the Providing for Health initiative on social health protection (P4H), the collaboration to agree on a common monitoring and evaluation framework, the Global Health Workforce Alliance, the Harmonization for Health in Africa initiative, the Innovative Results-Based Financing grant and the Catalytic Initiative to Save a Million Lives. The key focus of IHP+ is to get more partners aligned with national health strategies and plans. There are now 55 IHP+ signatories, of which 30 are developing countries (six signed up during 2011). The independent review of IHP+ conducted during 2011 has reinforced the positive dynamic generated by the meeting held in December 2010 and has confirmed the future orientations of the partnership. Sixteen countries have signed memorandums of understanding or compacts, to guide collaboration with their partners; five more such memorandums are in preparation. There are monitoring and evaluation "road maps" common to all stakeholders in eight countries. In order to ensure mutual accountability, progress in meeting commitments made by agencies as well as by countries, is monitored annually by an independent consortium, "IHP+ Results". The round of monitoring conducted in 2011 covered 10 countries and 15 donors. The inclusiveness and attention for country ownership which characterizes the IHP+ way of working is now also becoming more visible in countries that are not IHP+ signatories.

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<sup>1</sup> *Keeping promises, measuring results: Commission on information and accountability for Women's and Children's Health.* World Health Organization, 2011, in press ([http://www.everywomaneverychild.org/images/content/files/accountability\\_commission/final\\_report/Final\\_EN\\_Web.pdf](http://www.everywomaneverychild.org/images/content/files/accountability_commission/final_report/Final_EN_Web.pdf), accessed 20 March 2012).

## **B. WHO'S ROLE AND RESPONSIBILITIES IN HEALTH RESEARCH (resolution WHA63.21)**

14. At its 130th session in January 2012, the Executive Board noted an earlier version of this progress report.<sup>1</sup>

15. The present report summarizes the activities undertaken in the regional offices and headquarters in support of the implementation of the WHO strategy on research for health.

16. In the African Region the Secretariat has begun work on guidelines that draw on the Framework for the Implementation of the Algiers Declaration to Strengthen Research for Health: Narrowing the Knowledge Gap to Improve Africa's Health.

17. The Regional Committee of the Americas endorsed PAHO's policy on research for health in resolution CD49.R10.

18. The development of a strategy on research for health was discussed at the Eastern Mediterranean Regional Advisory Committee for Health Research (Cairo, 18 and 19 October 2010) and at a subsequent expert consultation (Cairo, 5 and 6 June 2011). The Regional Committee for the Eastern Mediterranean at its 58th session (Cairo, 2–5 October 2011) endorsed in resolution EM/RC58/R.3 the strategic directions for scaling up research for health in the Region and their implementation.

19. The Regional Office for the Western Pacific has concentrated on governance of research in the Region, strengthening the review of research ethics and the sharing of data to improve public health. It held a consultation of experts from the Region in order to make recommendations in these areas (Manila, 16–18 August 2011).

20. The European Region has recently, as part of its operational planning exercise for the biennium 2012–2013, given high priority to research and the use of research evidence for policy-making. Activities include a formal reconstitution of the European Advisory Committee on Health Research, initiation of work on a regional strategy on research for health, and the establishment of a regional Evidence Informed Policy Network (EVIPNet).

21. At headquarters, implementation of the strategy on research for health is harmonized with work on implementing the global strategy and plan of action on public health, innovation and intellectual property.<sup>2</sup> Main published outputs include: an overview of research activities associated with WHO, based on the results of a survey covering the period 2006–2007;<sup>3</sup> working definitions of operational research, implementation research, and health systems research in the context of research to strengthen

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<sup>1</sup> See documents EB130/35 and EB130/2012/REC/2, summary record of the thirteenth meeting, section 5.

<sup>2</sup> See document A65/26 (C).

<sup>3</sup> Terry RF, van der Rijt T. Overview of research activities associated with the World Health Organization: results of a survey covering 2006/07. *Health Research Policy and Systems* 2010, **8**:25 (<http://www.health-policy-systems.com/content/8/1/25>, accessed 23 February 2012).

health systems;<sup>1</sup> and a checklist for health research priority setting, comprising nine common themes of good practice.<sup>2</sup>

22. The Sixty-second World Health Assembly deferred consideration of the WHO strategy on research for health to the Sixty-third World Health Assembly,<sup>3</sup> which, in resolution WHA63.21, endorsed that strategy. In its draft form as well as after its endorsement, it has been used to guide the development of the research agenda in several technical areas, including influenza, foodborne diseases, radiation risks, vaccines and social determinants of health. The draft strategy was used in WHO's report on women and health to develop a six-point agenda for a gender-based approach to research.<sup>4</sup>

23. A code of good research practice for staff and research associated with WHO has been drafted and, when finalized, will be included in the WHO eManual.

24. The Secretariat has updated WHO's *Operational guidelines for ethics committees that review biomedical research*. The new publication is entitled *Standards and operational guidance for ethics review of health-related research with human participants*.<sup>5</sup>

25. The Secretariat is participating in the work of a group of major international funders of public health research that have committed themselves to working together in order to increase the availability of data emerging from their funded research. The overall aim is to accelerate advances in public health.

26. The Secretariat is developing a method that has the potential to enable more automated mapping of global health research investments through the establishment of a research classification and translation mechanism. That advance would support future efforts in mapping data on resource flows for research and development in order to facilitate identification of gaps and to contribute to planning and coordination.

27. The UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases convened meetings of disease-focused and thematic groups in order to examine needs and challenges with respect to research on neglected diseases and options for action. The first in a series of global biennial reports on infectious diseases of poverty is scheduled to be published in April 2012.

28. The concepts and frameworks set out in the strategy will be developed further in *The world health report 2012*, whose theme will be research for health.

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<sup>1</sup> Remme JHF, Adam T, Becerra-Posada F et al. Defining research to improve health systems. PLoS Medicine (November 2010) (<http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001000>, accessed 23 February 2012).

<sup>2</sup> Viergever RF, Olifson S, Ghaffar A, Terry RF. A checklist for health research priority setting: nine common themes of good practice. *Health Research Policy and Systems* 2010, **8**:36 (<http://www.health-policy-systems.com/content/8/1/36>, accessed 23 February 2012).

<sup>3</sup> Document WHA62/2009/REC/1, summary record of the first meeting of the General Committee, section 1.

<sup>4</sup> *Women and health: today's evidence tomorrow's agenda*. Geneva, World Health Organization, 2009.

<sup>5</sup> *Standards and operational guidance for ethics review of health-related research with human participants*. Geneva, World Health Organization, 2011.

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### C. GLOBAL STRATEGY AND PLAN OF ACTION ON PUBLIC HEALTH, INNOVATION AND INTELLECTUAL PROPERTY (resolution WHA61.21)

29. At its 130th session in January 2012 the Executive Board noted an earlier version of this progress report.<sup>1</sup>

30. Resolution WHA61.21 requested the Director-General, *inter alia*, to monitor performance and progress in implementing the global strategy and plan of action on public health, innovation and intellectual property, and, following submission of a report to the Sixty-third World Health Assembly,<sup>2</sup> to report to the Health Assembly every two years, through the Executive Board. The present report provides an overview of the current state of implementation.

31. In an Organization-wide collaborative effort and by engaging the external partners, the Secretariat has transformed the global strategy and plan of action into an implementable plan, with defined activities at global, regional and national levels, time frames and outputs for each of the specific actions.

32. A phased approach has been taken to implementation. Thus, a preparatory phase ended in September 2010; a pilot implementation phase is now under way and will continue until December 2012; and a broader phase of implementation will then be initiated and will continue until December 2015. In the current pilot implementation phase, the necessary relations with interested governments and other stakeholders are being established.

33. The Secretariat has concluded the mapping of relevant activities undertaken by several departments and external entities, in order to coordinate better the activities of relevant partners. An internal WHO advisory committee has been established, consisting of senior-level representatives from all major offices. In the context of the global strategy, the Secretariat has developed an assessment tool for the national assessment of innovation systems and access situations. This tool has been piloted in Kenya.

34. Implementation of the global strategy is harmonized with that of the WHO strategy on research for health<sup>3</sup> – in particular, element 1: prioritizing research and development needs; and element 2: promoting research and development. The latter strategy has been used to guide activities in a number of technical areas, including those involving influenza, foodborne diseases, vaccines and radiation risks. All six WHO regional offices have taken steps to implement that health strategy.

35. The launch of the global report on research priorities for infectious diseases of poverty is scheduled to take place on 17 April 2012 in Brussels at the conference on Innovation in Healthcare without borders.<sup>4</sup> The conference brings together researchers and governments on topics covered in the report, which was developed by the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases. Drafted by eminent global health experts, the report outlines 10 reasons to research infectious diseases of poverty; it also provides a number of “options for action” and has special chapters on the environment, health systems and innovation. The report has

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<sup>1</sup> See documents EB130/35 (C) and EB130/2012/REC/2, summary record of the thirteenth meeting, section 5.

<sup>2</sup> Document A63/6.

<sup>3</sup> See document A65/26 (B).

<sup>4</sup> The conference on Innovation in Healthcare without borders is organized by the services of the European Commission ([http://ec.europa.eu/research/health/events-13\\_en.html](http://ec.europa.eu/research/health/events-13_en.html), accessed 24 February 2012).

been developed with input from over 130 experts, organized into 10 disease-specific and thematic reference groups. The findings of their work, which has received funding from the European Union, are being published in the WHO Technical Report Series.

36. A report on the funding landscape for research and development to tackle infectious diseases of poverty is due to be published in 2012. The report is a collaborative effort involving the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, and the Council on Health Research for Development/Global Forum for Health Research and Policy Cures, with funding support from the European Union. It highlights the frameworks, priorities, strategies and policies utilized by research fund providers, particularly the differences in support for research on infectious diseases of poverty between OECD countries and countries in which diseases are endemic.

37. In the context of element 3 of the global strategy, that is, building and improving innovative capacity, WHO has published *Standards and operational guidance for ethics review of health-related research with human participants*.<sup>1</sup> These standards and operational guidance provide benchmarks to Member States on improving the quality of their research ethics systems, and strengthening research protections to communities and populations that participate in health research.

38. In addition to strengthening capacity in the area of research ethics for WHO staff at all levels, WHO has been actively working to strengthen the capacity of national ethics review committees – in close collaboration with other international organizations, the WHO Global Network of Collaborating Centres for Bioethics and national ethics committees around the world. Preparations for the 2012 Global Summit of National Ethics Committees, of which WHO provides the permanent secretariat, are currently under way (it is scheduled to take place in Tunis, in September 2012).

39. Improving transparency in health research activities is a responsibility shared by many stakeholders within the global community, namely: researchers, sponsors, policy-makers and international organizations. The establishment of the International Clinical Trials Registry Platform by WHO in 2005 illustrates the commitment to this goal. Over the last two years, many initiatives have been taken at national and international levels to establish primary registries and increase the quality of information available. The Pan African Clinical Trial Alliance, in which more than 20 sub-Saharan African countries are represented, is an example of a joint effort to improve the oversight of clinical trials. On 14 September 2011, the European Union Clinical Trials Register became the 14th member of the Primary Registry Network of the International Clinical Trials Registry Platform. In February 2012 the European Union Clinical Trials Register will become a data provider to the International Clinical Trials Registry Platform search portal by adding 38 000 records of clinical trials. Furthermore, the International Clinical Trials Registry Platform is part of an initiative known as the OPEN project (To Overcome failure to Publish nEgative fiNDings), which is commissioned by the European Union.

40. A clinical career development fellowship programme run by the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases has trained 18 scientists from low- and middle-income countries with experience in good clinical practice and project management within a pharmaceutical development setting.

41. Within the context of element 4 of the global strategy, that is, transfer of technology, WHO has completed the initial stage of a project supported by the European Union in partnership with

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<sup>1</sup>*Standards and operational guidance for ethics review of health-related research with human participants*. Geneva, World Health Organization, 2011.

UNCTAD and the International Centre for Trade and Sustainable Development. As part of the project, extensive background work has been undertaken on the challenges and barriers to local production and related technology transfer in the areas of pharmaceuticals, diagnostics and vaccines. A series of reports have combined the existing body of evidence to develop a framework document that is guiding the activities of the second phase of this project.<sup>1</sup>

42. The Secretariat has conducted a landscape analysis of all technology transfer experiences in the field of vaccines in order to identify emerging trends and conditions supportive of technology transfer. The project on the transfer of pandemic influenza vaccine technology to developing countries, initiated in 2006, has now provided funding and technology transfer to 13 developing countries, four of which have succeeded in obtaining licences for locally produced pandemic influenza vaccine, and the others are on their way to achieving such approval. In addition, WHO has negotiated, on behalf of developing countries, a royalty-free licence for a technology involving live attenuated influenza virus and has made this technology available to three manufacturers in developing countries, one of which has already achieved approval of the product and local sales. As part of the same effort, WHO facilitated the establishment of a centre of excellence at the University of Lausanne, Switzerland, that focuses on training and technology transfer of advanced adjuvant technology – this centre has now completed the training of two developing country vaccine manufacturers, one of which has already begun producing adjuvant.

43. In its implementation work on element 5 of the global strategy (application and management of intellectual property to contribute to innovation and promote public health), WHO has engaged in a number of activities aimed at strengthening the capacity of developing countries to apply and manage intellectual property in a manner that maximizes health-related innovation and promotes access to health products.

44. As part of their trilateral cooperation, WHO, WIPO and WTO have initiated a series of joint technical symposia on issues concerning public health, intellectual property and trade. Two symposia have now been held, one in 2010 and the other in 2011.<sup>2</sup> In addition, the three organizations are preparing a joint study entitled “Promoting access and medical innovation: intersections between public health, intellectual property and trade”.<sup>3</sup>

45. In further collaborative activities, WHO, together with UNDP and UNAIDS, has published a policy brief on using the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) to improve access to HIV/AIDS treatment.<sup>4</sup> In addition, in collaboration with WIPO, WHO is developing a global patent landscape on patenting trends in the field of vaccines.

46. Element 6 of the global strategy, improving delivery and access, called for the strengthening of the WHO prequalification programme. Prequalification of selected active pharmaceutical ingredients and of products for neglected tropical diseases was initiated and research conducted into the benefits and impacts of prequalification. Between January 2010 and December 2011, WHO prequalified

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<sup>1</sup> See [http://www.who.int/phi/publications/local\\_production/en/index.html](http://www.who.int/phi/publications/local_production/en/index.html) (accessed 24 February 2012).

<sup>2</sup> Additional information, including programmes and summary reports, is available at: <http://www.who.int/phi/> (accessed 24 February 2012).

<sup>3</sup> See also [http://www.who.int/phi/news/promoting\\_access\\_medical\\_innovation/en/index.html](http://www.who.int/phi/news/promoting_access_medical_innovation/en/index.html) (accessed 24 February 2012).

<sup>4</sup> UNAIDS, WHO, UNDP. *Using TRIPS flexibilities to improve access to HIV treatment: policy brief*. Geneva, World Health Organization, 2011 ([http://www.who.int/phi/phi\\_trips\\_policybrief\\_en.pdf](http://www.who.int/phi/phi_trips_policybrief_en.pdf), accessed 24 February 2012).

42 medicinal products (28 products for the treatment of HIV/AIDS, 7 anti-tuberculosis products, 1 antimalarial, 1 influenza-specific antiviral and 5 reproductive health products), 2 active pharmaceutical ingredients (for antimalarials), 35 vaccines, 2 malaria rapid diagnostic tests, 3 HIV rapid diagnostic tests, 5 HIV viral load tests and 1 CD4 technology and 9 quality-control laboratories (one each in Belgium, Bolivia (Plurinational State of), Canada, India, Peru, United Republic of Tanzania and Uruguay, and two in Ukraine).

47. In 2010, WHO prequalified for the first time artesunate powder for injection (the first prequalified sterile product made in China); it also prequalified the first combination of tenofovir/lamivudine and the first generic emtricitabine.

48. Regulatory collaboration, harmonization and capacity building continued to be key components of WHO prequalification programmes. In 2011 the Chinese national regulatory authority was assessed as functional by WHO, making possible the prequalification of vaccines produced in that country. In 2010, following a joint assessment with the East African Community, simultaneous prequalification was completed for three African countries (Kenya, Uganda and the United Republic of Tanzania). Surveys of manufacturers have shown that capacity building by the programme is greatly appreciated.

49. In the context of element 7, promoting sustainable financing mechanisms, the Secretariat is facilitating the work of the Consultative Expert Working Group on Research and Development: Financing and Coordination.<sup>1</sup>

50. In 2010, PAHO's 50th Directing Council adopted a resolution on strengthening national regulatory authorities for medicines and biologicals<sup>2</sup> to safeguard the quality, safety and efficacy of these products. The resolution defines the necessary tools and mechanisms for strengthening the regulation and oversight of public health functions and urges countries to evaluate and strengthen their essential regulatory functions. Based on the results of the evaluations, the national regulatory authority can establish an institutional development plan or can be designate regulatory authority of regional reference once it reaches the highest level in the assessment. Several countries of the Region of the Americas are participating in this initiative; currently, four national regulatory authorities are considered regional reference under this mechanism (Argentina, Brazil, Colombia and Cuba).

51. In response to the requirements of element 8, establishing monitoring and reporting systems, in coordination with the Regional Office for the Americas, WHO is developing a web-based platform to monitor and report on the progress of the implementation of the global strategy. The global innovation and access platform will be built on the PAHO Regional Platform for Access and Innovation for Health and its beta version will be presented at the World Health Assembly in May 2012.

52. In the Regional Office of the Americas, the PAHO Regional Platform for Access and Innovation for Health will be launched in May 2012. In the South-East Asia Region, the first consultation has been held to develop the regional framework for the global strategy and plan of action (New Delhi, 5 and 6 April 2011) and Member States agreed, inter alia, to strengthen their engagement in the promotion of research and development for health, to share information on intellectual property-related issues, to develop their capacity to negotiate in the area of public health and intellectual property, and to promote domestic industries in order to enhance their capacity to meet the need for affordable medicines and medical technologies.

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<sup>1</sup> See also document EB130/23.

<sup>2</sup> Resolution CD50.R9.

53. Regional and national networks for innovation are vital components for ensuring the implementation of the global strategy and plan of action on public health, innovation and intellectual property. The African Network for Drugs and Diagnostics Innovation was established as an African-led innovation network. The development of the Network has been supported by WHO, the United Nations Economic Commission for Africa, the African Development Bank, the European Commission, and the African Union. The African Network for Drugs and Diagnostics Innovation, which was initiated by the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, is now hosted by the United Nations Economic Commission for Africa in Addis Ababa. Similar networks for Asia and the Americas are also being developed.

#### **D. SMALLPOX ERADICATION: DESTRUCTION OF VARIOLA VIRUS STOCKS (resolution WHA60.1)**

54. At its 130th session in January 2012 the Executive Board noted an earlier version of this progress report.<sup>1</sup>

55. This document summarizes the outcome of the thirteenth meeting of the WHO Advisory Committee on Variola Virus Research (Geneva, 31 October and 1 November 2011).

56. The Committee recalled the provisions for research referred to in resolution WHA60.1, in which the Health Assembly noted that “authorization was granted to permit essential research for global public-health purposes, including further international research into antiviral agents and improved and safer vaccines”.

57. The Advisory Committee received reports at its thirteenth meeting from the two authorized repositories of variola virus (VECTOR – the State Research Centre for Virology and Biotechnology (Koltsovo, Russian Federation) and the Centers for Disease Control and Prevention (Atlanta, Georgia, United States of America)) on the virus collection that they hold. No research involving the use of live virus had been done in the former in 2011. At the latter, secure databases have been created to track the use of live virus.

58. All WHO’s archives of its Smallpox Eradication Programme have been digitized and uploaded into a dedicated database. The collection includes some 730 000 paper documents as well as maps, photographs and other records. Plans are in place to make the archives available on the Internet.

59. The Advisory Committee noted that two excellent candidate antiviral drugs (ST-246, (tecovirimat) and CMX001 (hexadecyloxypropylcidifovir)) were in advanced stages of development. Pharmacokinetics from animal studies were being used to determine proposed human doses.

60. Further, two live attenuated smallpox vaccines (LC16m8 and MVA) showed good safety profiles in human beings and protected against disease induced by several orthopoxviruses in animal models.

61. Diagnostic tests based on polymerase chain reactions and developed by researchers in the variola virus repositories in the Russian Federation and the United States of America have proved to be accurate and sensitive. They could detect variola virus DNA and distinguish it from DNA of other orthopoxviruses pathogenic for human beings.

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<sup>1</sup> See document EB130/2012/REC/2, summary record of the fourteenth meeting, section 2.

62. The Advisory Committee recommended the further development of the smallpox laboratory network in collaboration and coordination with the Emerging and Dangerous Pathogens Laboratory Network recently launched by WHO.

63. Remaining objectives of the research programme were to improve the reproducibility of the non-human primate model for variola virus infection so that additional data on the effectiveness of antiviral agents and vaccines could be generated. Such data would help regulatory agencies to have greater confidence in the effectiveness of these drugs and vaccines against variola virus and therefore help their progress to licensure. The Committee recommended continuation of this work.

64. WHO biosafety inspection visits are planned to the authorized repositories in the Russian Federation and the United States of America. The visit to the containment facilities in the Centers for Disease Control and Prevention is due to take place in May 2012 and that to VECTOR in October 2012. In a WHO meeting held in Oslo from 31 January to 3 February 2012, both repository sites had an opportunity to review the inspection process. It has been agreed that the inspections will follow the framework of the European Committee for Standardization's Laboratory biorisk management standard, CWA 15793:2011.

65. The Advisory Committee recommended that the Ad Hoc Committee on Orthopoxviruses be reconvened to discuss an emergency response to a possible future outbreak of smallpox.

66. The Advisory Committee was informed that the membership of the scientific subcommittee had been renewed.

#### **E. ERADICATION OF DRACUNCULIASIS (resolution WHA64.16)**

67. At its 130th session in January 2012 the Executive Board noted an earlier version of this progress report.<sup>1</sup>

68. In May 2011, the Health Assembly in resolution WHA64.16 called for intensified eradication efforts and requested the Director-General to closely monitor the implementation of the resolution and report every year until eradication of dracunculiasis is certified.

69. Member States where dracunculiasis is endemic have continued to make steady progress towards eradication. During 2011 only 1058 new cases were reported from four countries (Chad, Ethiopia, Mali and South Sudan<sup>2</sup>), 41% fewer than in 2010, and the number of villages that reported cases was 483, a decrease of 38% over 2010. Ghana has reported no case since May 2010, indicating that transmission has been interrupted, and this country is now in the pre-certification phase.

70. All countries where the disease is endemic or which are in the pre-certification stage (except Kenya) reported to WHO monthly, even when there was no case to report. Schemes to reward reporting of dracunculiasis cases are in place in all endemic or formerly endemic countries except South Sudan.

71. On the recommendation of the eighth meeting of the International Commission for the Certification of Dracunculiasis Eradication (Geneva, 29 November to 1 December 2011) five more

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<sup>1</sup> See document EB130/2012/REC/2, summary record of the fourteenth meeting, section 2

<sup>2</sup> To be read as southern Sudan until 9 July 2011.

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countries (Burkina Faso and Togo – countries in which dracunculiasis was formerly endemic; and Bosnia and Herzegovina, Brunei Darussalam and Eritrea – where the disease has not, or has not recently, been endemic) were certified as being free of dracunculiasis. By the end of 2011, 192 countries and territories had been certified free of dracunculiasis.

72. The challenge for the eradication of dracunculiasis remains the interruption of disease transmission in the following four countries.

73. **Chad.** Ten years after the country reported its last case, 10 indigenous cases were reported from eight villages in 2010, and none of these cases was contained. In 2011, ten cases were reported from nine villages, and only four cases were contained. Detailed investigation suggests that cases in recent years had been missed, leading to continued transmission. Measures to interrupt transmission are being implemented. However, the lack of access to some areas at risk of disease transmission because of insecurity is a major constraint. WHO and The Carter Center have provided technical and financial assistance to reinvigorate the eradication programme and strengthen surveillance.

74. **Ethiopia.** As a result of intensified surveillance and case-containment activities, Ethiopia reported eight cases from five villages in 2011, 62% fewer than in 2010. Of the eight, six were indigenous cases; the two others were imported from South Sudan. Seven of the cases concerned were contained. Dracunculiasis surveillance has been expanded nationwide through the national Integrated Disease Surveillance and Response system and health education.

75. **Mali** was the only country in West Africa where dracunculiasis transmission was still continuing. During 2011, 12 cases were reported compared with 57 in 2010; only 5 (42%) of the 12 cases were reportedly contained. These cases were reported from 6 villages.

76. **South Sudan** accounted for 97% of all new cases reported in 2011. In 2011, 463 villages reported a total of 1028 new cases – 39% fewer than in 2010 – and 74% of them were contained; 775 cases (75%), however, were from the Eastern Equatoria State, which reported significantly more cases in 2011 than in 2010. Kapoeta East county accounted for 76% of the total cases reported in the Eastern Equatoria State in 2011. The probable reasons for the increase in the number of cases in Kapoeta East county (from 478 cases in 2010 to 590 cases in 2011) are that in 2010 only 67% of the cases were contained, only 52% of its endemic villages applied vector control to unsafe water sources and only 6% of endemic villages had at least one safe water source. However, the disease trend since June 2011 is showing an encouraging decline compared with the same period of 2010 and 80% of cases in the county in 2011 were reportedly contained.

77. Other challenges are the lack of safe drinking-water supply and maintaining effective nationwide surveillance of dracunculiasis, including in dracunculiasis-free areas. Of the 483 villages that reported cases in 2011, 388 (80%) did not have at least one safe source of drinking-water. There is an urgent need to supply adequate safe drinking-water to communities in which the disease is endemic.

78. WHO and The Carter Center estimated a funding gap of US\$ 62 million for the period 2011–2015. The Government of the United Kingdom of Great Britain and Northern Ireland has pledged an amount of up to £20 million, the Bill & Melinda Gates Foundation has confirmed additional support of US\$ 23.3 million and the remaining funds will be provided by the Government of the United Arab Emirates (US\$ 10 million) and the Children's Investment Fund Foundation, which has pledged US\$ 6.7 million. These figures include approximately US\$ 8 million towards contingencies.

**F. CHAGAS DISEASE: CONTROL AND ELIMINATION (resolution WHA63.20)**

79. At its 130th session in January 2012 the Executive Board noted an earlier version of this progress report.<sup>1</sup>

80. Control and elimination of Chagas disease are achievable. The incidence of Chagas disease in the Region of the Americas – the most severely affected of WHO's regions – has been substantially reduced through efforts in vector control and systematic blood screening. The estimated number of new cases has declined by 32%, from 41 000 in 2006 to 28 000 in 2010. The objective of interrupting intra-domiciliary vector-borne transmission has been achieved in seven countries where the disease is endemic and in specific areas of endemicity in seven more countries. Universal blood screening has been implemented in 20 of 21 disease-endemic countries. As a result, the prevalence in younger age groups has decreased, and the number of people at risk globally has declined by 40%, from 108 million in 2006 to 65 million in 2010.

81. Continued vector control efforts have led to: (i) certified interruption of vector-borne transmission of *Trypanosoma cruzi* by *Rhodnius prolixus* in all disease-endemic Central American countries (Costa Rica, El Salvador, Guatemala, Honduras and Nicaragua) and in Mexico, with support from Canada, Japan and Spain; (ii) certified interruption of transmission by *Triatoma infestans* in the Moquegua and Tacna regions of Peru, with support from Canada and Spain, and in La Paz (the Plurinational State of Bolivia); and (iii) significant vector control in the Catamarca, La Rioja, Misiones, San Luis and Santa Fe provinces of Argentina, with support from Spain, which may soon lead to confirmed interruption of transmission in Misiones and Santa Fe provinces.

82. Strengthening of diagnosis and treatment has had several results. Through subregional initiatives in the Americas supported by WHO and PAHO case detection has increased and access to treatment has broadened, from fewer than 50 treatments with nifurtimox in 2005 to more than 1500 in 2010. Demand for benznidazole has increased, with more than 7000 people now being treated each year. Better diagnosis and treatment have led to increased detection of cases and identification of areas with active transmission (the Chaco region of South America, Amazonia, and the border between El Salvador and Guatemala), and to increased detection and better management of cases resulting from congenital transmission (in Argentina the number of pregnant women screened rose from 50 000 in 1997 to 130 000 in 2010) and transmission through blood transfusions, accidents and oral procedures, as well as cases of coinfection (with HIV and *T. cruzi*). As part of these strengthening measures, diagnosis and treatment protocols continue to be harmonized, and systems for treatment monitoring and detection of drug-resistance are in place in four countries.

83. Seroepidemiological surveys have been completed by a team led by WHO and PAHO in eight disease-endemic countries in order to determine the status of transmission and certify vector-borne interruption.

84. Measures to address the social determinants of Chagas disease include replacement or improvement of dwellings and peridomiciliary structures in 11 countries and interventions focusing on social and community participation in 18 countries.

85. Partnerships are in place to improve Chagas disease control. The Drugs for Neglected Diseases initiative has been collaborating with the pharmaceutical company producing benznidazole in Brazil,

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<sup>1</sup> See document EB130/2012/REC/2, summary record of the fourteenth meeting, section 2.

and as a result a paediatric formulation will be available soon. Collaboration between the initiative and PAHO resulted in a software application that Member States can use to estimate their need for benznidazole. Argentina and Colombia have committed resources for research on improved laboratory techniques for diagnosis and treatment monitoring. The UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases is assisting with capacity building and research on improved diagnostic tools and vector control. Collaborating centres in the Americas are working on several initiatives.

86. Access to high-quality nifurtimox is ensured until 2017 through donations from the pharmaceutical company Bayer AG. Access to benznidazole remains a challenge, and discussions are under way with the manufacturer to meet concerns about supply and manufacture.

87. Two networks were created in the European Region and the Western Pacific Region in order to strengthen data collection and standardize norms for Chagas disease control (prevention, control of transmission and health care). In addition, countries that are not endemic for the disease are strengthening surveillance, responding to the risk of transmission through blood transfusion and organ transplantation, and enhancing control of congenital disease.

#### **G. VIRAL HEPATITIS (resolution WHA63.18)**

88. At its 130th session in January 2012 the Executive Board noted an earlier version of this progress report.<sup>1</sup>

89. In 2010, the Health Assembly adopted resolution WHA63.18, which refers to the need for a comprehensive approach to the prevention and control of viral hepatitis. In order to respond to the requests made in the resolution, the Secretariat is taking a broad approach, including scaling up successful interventions, strengthening health systems and developing new approaches, at the same time mobilizing much-needed resources. The Secretariat's work is following four strategic axes.

90. **Strategic axis 1: raising awareness and mobilizing resources.** Activities focus on increasing awareness about viral hepatitis among policy-makers, health professionals and the public; strengthening prevention and control measures; and removing discrimination against those who are infected.

91. On 28 July 2011, WHO sponsored its first official World Hepatitis Day. Using the theme, "This is Hepatitis ... Know it. Confront it. Hepatitis affects everyone, everywhere," WHO supported activities through collaboration with civil society. Campaign materials – produced in a number of different languages – included technical fact sheets, web notifications, news updates, press releases, a video statement by the Director-General, campaign posters, social media and a variety of audio-visual products. The mass media were widely engaged, increasing the visibility of both the problems caused by viral hepatitis and the solutions available for confronting the different diseases concerned.

92. **Strategic axis 2: data for policy and action.** WHO is updating estimates of the global prevalence and burden of viral hepatitis. Efforts are currently being made to communicate results and develop tools in order to enable governments to produce evidence-based and cost-effective policies and plans. Guidelines and standards for disease surveillance are being finalized so that countries can better prioritize resources and select appropriate interventions, from immunization to antiviral therapy,

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<sup>1</sup> See document EB130/2012/REC/2, summary record of the fourteenth meeting, section 2.

and from screening the blood supply to ensuring safe health-care environments and practices. Guidance on serological surveys is also being issued as a way of monitoring trends in viral hepatitis and evaluating the impact of prevention efforts.

93. **Strategic axis 3: prevention of transmission.** Successful prevention efforts are being adapted in response to growing populations, changing epidemiology and new economic constraints. WHO is re-examining policies on immunization such as those relating to immunization schedules, the protection of neonates and health-care workers (especially against infection with hepatitis B virus), expanded roles for existing hepatitis A vaccines, new hepatitis E vaccines, and innovative approaches for the future. Just as the advent of the HIV/AIDS epidemic in the 1980s led to campaigns that successfully changed many behaviours, continued health promotion must focus on behaviours that put people at risk of infection and that can be altered. Key messages for the prevention of hepatitis include infection control, safer sex and the formulation of strategies for countries on safe blood products, injections, food and water.

94. **Strategic axis 4: screening, care and treatment.** Over the past decade, rapid advances have been recorded in the area of therapeutic agents for hepatitis B and C. As a result, hepatitis C can often be cured and chronic hepatitis B can be controlled for the long term. It will be of utmost importance to provide guidelines for screening patients with hepatitis B and C, for increasing their access to care and for managing drug resistance. Particular attention will need to be paid to those in resource-constrained settings. The Secretariat is therefore developing a package of resources that includes the provision of appropriate pre- and post-test counselling, as part of a framework for care and treatment and for the provision of support to countries to make treatments more accessible and affordable.

95. WHO has established a dedicated hepatitis team at headquarters with focal points in the regional offices who will coordinate work with partners and Member States in order to develop tools and products to advance the important work along each of these axes. This effort will develop and take forward a country-level operational framework to fulfil the mandate as set out in resolution WHA63.18.

96. In order to permit Member States and the Secretariat to follow closely progress towards the full implementation of resolution WHA63.18, tools are being developed for the country assessment of comprehensive hepatitis prevention and control, and work has begun on a second set of reports on country surveys of policies and implementation.

## **H. PREVENTION AND CONTROL OF MULTIDRUG-RESISTANT TUBERCULOSIS AND EXTENSIVELY DRUG-RESISTANT TUBERCULOSIS (resolution WHA62.15)**

97. In resolution WHA62.15 the Health Assembly urged Member States to achieve universal access to diagnosis and treatment of multidrug-resistant and extensively drug-resistant tuberculosis and requested WHO to support the process. Considerable progress has been made and 26 of the 27 Member States that account for more than 85% of incident cases of multidrug-resistant tuberculosis globally currently have plans to expand access to care. In September 2011, the Regional Committee for Europe adopted the Consolidated action plan to prevent and combat multidrug- and extensively drug-resistant tuberculosis in the WHO European Region 2011–2015 (resolution EUR/RC61/R7).

98. Partly to prevent the development of drug-resistant tuberculosis, all 22 countries with a high burden of tuberculosis have adopted WHO-recommended strategies to engage relevant care providers in tuberculosis control through public–private collaboration. In 2011, between 20% and 40% of notifications of cases of tuberculosis were reported by health-care providers outside national

tuberculosis programmes in 20 countries (including 10 with a high burden of tuberculosis) in areas implementing mixed public–private approaches. As quality-assured medicines are essential to prevent and treat drug-resistant tuberculosis, WHO has provided technical assistance and strategic advice on quality standards and regulatory issues to manufacturers and regulatory authorities in more than 70 countries.

99. Between 2008 and 2011, WHO introduced new policies on programmatic management of drug-resistant tuberculosis and new laboratory diagnostic tools, and endorsed six additional drug-susceptibility testing technologies, including the Xpert MTB/RIF assay, a new molecular technique to diagnose both tuberculosis and resistance to rifampicin in less than two hours. WHO has produced guidance for countries on the use of these tests and is coordinating the Expanding Access to New Diagnostics for TB project which aims at improving access to drug-susceptibility testing in 27 priority countries. Technology transfer is complete or under way in 18 of these countries. By the end of 2011, 40 developing countries had implemented Xpert MTB/RIF technology.

100. In 2011, a new global framework was launched in order to coordinate the support provided by WHO and partners to countries for expanding access to care for patients with multidrug-resistant tuberculosis. All countries are now eligible to procure quality-assured second-line antituberculosis medicines directly through the Global Drug Facility (the WHO-supported procurement mechanism), but their cost remains too high. Two new antituberculosis medicines are expected to enter into clinical use around 2013, and WHO is working on a policy for their rational introduction and use.

101. WHO provides support to countries in monitoring access to care for multidrug-resistant tuberculosis and in modernizing information technology systems in use for this purpose. Some 21 countries with a high burden of tuberculosis are using or planning to adopt electronic systems for the management of data, and 10 are planning, have recently started or have completed surveys of drug resistance in order to improve the accuracy of information available.

102. Despite this progress, the current pace of improvements will not lead to achievement of the targets set in resolution WHA62.15. Globally, only about 6% of basic health care units providing care for tuberculosis patients also provide care for those with multidrug-resistant disease. Overall notification of cases of multidrug-resistant tuberculosis increased from 29 000 in 2008 to about 53 000 in 2010, but it remains well below target (see Figure). About 290 000 multidrug-resistant tuberculosis cases could be detected each year if all notified tuberculosis patients could be tested for drug susceptibility, but only about 46 000 patients with multidrug-resistant tuberculosis (16% of the estimated total) were reported to have been enrolled in treatment programmes in 2010 and of these only 13 000 are being treated according to WHO standards.

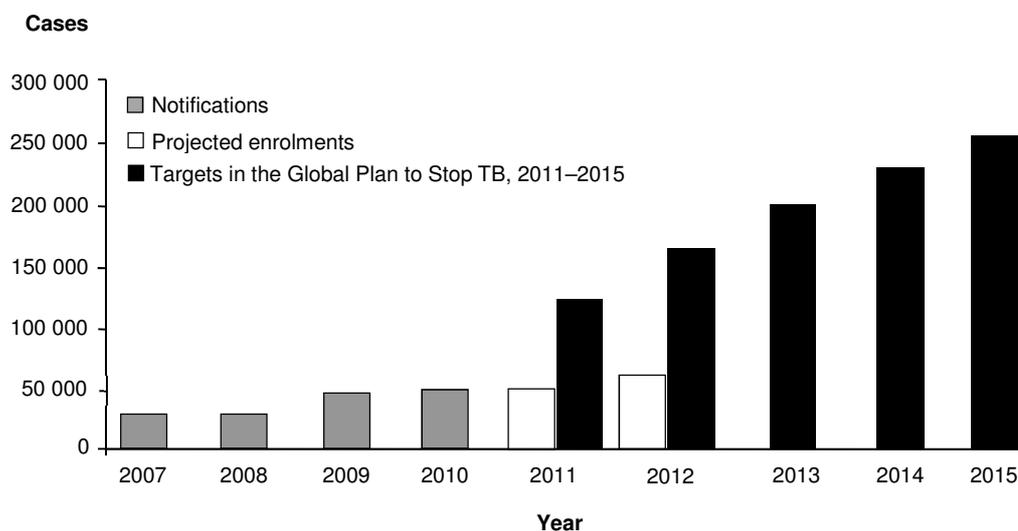
103. Countries must urgently commit more funding to tuberculosis programmes, increase access to affordable rapid diagnostics, and treat more of their drug-resistant tuberculosis patients. The costs of treatment must be lowered and the production capacity of quality-assured second-line medicines increased. Programmatic capacity for managing tuberculosis patients must also be strengthened through implementation of the policy set out in resolution WHA62.15.

104. At its 130th session in January 2012 the Executive Board noted an earlier version of this progress report;<sup>1</sup> during the discussions, reference was made to the need for Member States to intensify the response to multidrug-resistant tuberculosis. A recent study of people in India infected by

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<sup>1</sup> See document EB130/2012/REC/2, summary record of the fourteenth meeting, section 2.

forms of virtually untreatable, multidrug-resistant tuberculosis<sup>1</sup> gives an indication of the risks to which countries could be exposed if implementation of resolution WHA62.15 is not accelerated.



## I. CHOLERA: MECHANISMS FOR CONTROL AND PREVENTION (resolution WHA64.15)

105. This report provides an update on the global situation and an evaluation of efforts made in cholera prevention methods and cholera control, in response to the request made by the World Health Assembly in resolution WHA64.15 on cholera: mechanisms for control and prevention. At its 130th session in January 2012 the Executive Board noted an earlier version of this report.<sup>2</sup>

106. In 2010,<sup>3</sup> there were 317 534<sup>4</sup> reported cholera cases, including 7543 deaths, with a case-fatality rate of 2.38%, a 43% increase in cases when compared with 2009,<sup>5</sup> and an increase of 130% from 2000.<sup>6,7</sup> Cases were reported from 48 countries. For the first time since 1995, the proportion of cases reported to WHO from the African continent declined from a level of more than 90% of the worldwide total to a level of less than 50%, as a consequence of the large outbreak in Haiti which began in

<sup>1</sup> Udhwadia Z et al. Correspondence: Totally Drug-Resistant Tuberculosis in India. *Clinical Infectious Diseases*. doi:10.1093/cid/cir889 (published online December 21, 2011).

<sup>2</sup> See document EB130/2012/REC/2, summary record of the fourteenth meeting, section 2.

<sup>3</sup> Cholera, 2010; *Weekly Epidemiological Record*, 2011, **86**(31):325–340.

<sup>4</sup> All data considered in this report were reported to WHO through national disease surveillance systems.

<sup>5</sup> Cholera 2009; *Weekly Epidemiological Record*, 2010, **85**(31):293–308.

<sup>6</sup> Cholera 2000; *Weekly Epidemiological Record*, 2001, **76**:233–240.

<sup>7</sup> Trends and levels in reported cases and deaths are affected by the notification rates of national surveillance systems and of the number of reporting countries.

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October 2010.<sup>1</sup> Three outbreaks, which affected the Lake Chad Basin in Central Africa, the Dominican Republic and Haiti in the Caribbean, and Papua New Guinea in Oceania, accounted for 79% of the global cases and 89% of the global cholera deaths.<sup>1</sup>

107. Efforts to scale up control measures continued throughout the year. For example, Kenya developed a comprehensive national action plan, which is being implemented, and which will serve as an example for other countries in the African Region. An innovative plan for community-led health education has been proposed for piloting.

108. Experts at an ad hoc meeting convened by WHO in Geneva in May 2011, reviewed the principles of an integrated outbreak response plan for large-scale humanitarian crises. Firm consensus was achieved to use cholera vaccines reactively during outbreaks to reduce mortality in those areas where other interventions cannot be delivered effectively. It is important that such vaccination campaigns do not disrupt other high-priority interventions.

109. A strategy for the establishment of a cholera vaccine stockpile was discussed by experts at a WHO consultation in Geneva in September 2011. A funding proposal has been submitted for a project in which a working group will identify the next steps to be taken. The prequalification of a second vaccine by WHO in September 2011 was an important step towards improving the availability of cholera vaccines.

110. Countries are making major efforts to improve the control of cholera in disease-endemic areas, but progress has been impeded by the increased number of people living in unsanitary conditions, higher levels of migration, failing infrastructure, the impact of climate change, and competing public health priorities.

111. On 11 January 2012, on the second anniversary of the earthquake in Haiti, the international community – including PAHO, UNICEF and the Centers for Disease Control and Prevention (Atlanta, Georgia, United States of America) – launched the Call to Action: A Cholera-Free Hispaniola. The aim of this initiative was to move from cholera control to cholera elimination by means of essential investments in water, sanitation and hygiene infrastructure as these are considered to be the only long-term measures for controlling cholera.

112. The International Network to Promote Household Water Treatment and Safe Storage is now formally co-hosted by WHO and UNICEF. Efforts will be intensified to promote activities in cholera-endemic areas. This matter was raised at the 6th World Water Forum (Marseille, 7–12 March 2012), where there was also a session on cholera prevention and control in Africa.

## **J. CONTROL OF HUMAN AFRICAN TRYPANOSOMIASIS (resolution WHA57.2)**

113. At its 130th session in January 2012 the Executive Board noted an earlier version of this progress report.<sup>2</sup>

114. The number of new cases of human African trypanosomiasis reported has dropped below 10 000 for the first time in 50 years, with 9878 new cases reported in 2009 and 7139 in 2010. The number of cases reported during the period 2001–2010 fell by 73.4%.

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<sup>1</sup> Cholera 2000; *Weekly Epidemiological Record*, 2001, **76**:233–240.

<sup>2</sup> See document EB130/2012/REC/2, summary record of the fourteenth meeting, section 2.

115. The chronic form of the disease, caused by *Trypanosoma brucei gambiense*, is endemic in 24 countries. During 2009 and 2010, 11 countries (Benin, Burkina Faso, Gambia, Ghana, Guinea-Bissau, Liberia, Mali, Niger, Senegal, Sierra Leone and Togo) reported no case and eight (Cameroon, Congo, Côte d'Ivoire, Equatorial Guinea, Gabon, Guinea, Nigeria and Uganda) reported an average of fewer than 100 new cases annually. Angola, Central African Republic, Chad and Sudan reported between 100 and 1000 new cases annually. The Democratic Republic of the Congo is the most affected country, reporting more than 1000 new cases each year.

116. The acute form of human African trypanosomiasis caused by *T. b. rhodesiense* is endemic in 13 countries. During the same period Botswana, Burundi, Ethiopia, Mozambique, Namibia, Rwanda and Swaziland reported no cases. Kenya and Zimbabwe reported sporadic cases; Malawi, United Republic of Tanzania and Zambia reported fewer than 100 new cases each year and Uganda reported between 100 and 1000 new cases annually.

117. Public-private partnerships have allowed countries in which human African trypanosomiasis is endemic to use the best available treatment options. In April 2009 the combination of eflornithine and nifurtimox received approval by the Expert Committee on the Selection and Use of Essential Medicines for the treatment of second-stage disease due to *T. b. gambiense*. This combination reduces the duration of drug treatment and facilitates its administration, while maintaining the same level of efficacy as treatment with eflornithine alone. Thanks to this new therapeutic option, in 2010 only 12% of the cases reported were treated using the toxic melarsoprol, compared with 86% of the cases reported in 2008. This success is attributed to capacity building and the free distribution of a kit that includes all the materials needed to administer the combination of drugs.

118. Despite the encouraging results and exciting perspectives, the process remains fragile and human African trypanosomiasis continues to be a threat in Africa. With this in mind, countries in which the disease is endemic should be supported to strengthen control activities through the identification of isolated pockets of disease transmission and the improvement of surveillance and reporting. In order to achieve this, an integrated approach should be adopted, in which surveillance and control activities are undertaken within reinforced and operational health systems.

119. The fall in the number of cases of human African trypanosomiasis reported has contributed to a lack of interest in bilateral cooperation, and among nongovernmental organizations and donors, as well as a decline in awareness of the threat that the disease represents for development and public health in countries in which it is endemic. This trend is being reinforced by the setting of other public health priorities. There is therefore a risk that control and surveillance may stagnate – something that occurred in the late 1960s and that led ultimately to the return of the disease. In order to ensure that history does not repeat itself, awareness about the disease should be maintained through a redoubled advocacy effort. The aim should be to make sure that the disease is accorded priority on the health agendas of both the countries in which it is endemic and donors. Control and surveillance in the field need to be strengthened and research accelerated into tools to support the development of new strategies for involving health systems in the cost-effective and sustainable control and surveillance of human African trypanosomiasis.

120. In the fight against the disease, WHO continues to collaborate with the African Union Commission within the framework of the Pan African Tsetse and Trypanosomiasis Eradication Campaign and with FAO within the framework of the multi-institutional Programme Against African Trypanosomiasis.

## **K. GLOBAL HEALTH SECTOR STRATEGY ON HIV/AIDS, 2011–2015 (resolution WHA64.14)**

121. The Health Assembly endorsed in resolution WHA64.14 the global health sector strategy on HIV/AIDS, 2011–2015. This report responds to the request in the resolution that the Director-General report progress in implementing the strategy. At its 130th session in January 2012 the Executive Board noted an earlier version of this progress report.<sup>1</sup>

122. An operational plan was developed, which details major WHO outputs in support of implementing the strategy. The plan is aligned with the UNAIDS 2012–2015 unified budget, results and accountability framework.<sup>2</sup> The Department of HIV completed a strategic realignment process in July 2011 to optimize its structure and staffing for strategy implementation in a limited resources context.

123. On 20 June 2011, consultations were held in Geneva with Member States, UNAIDS, development partners, civil society and cosponsors on how to translate the global strategy into country action. Regional adaptation of the global strategy has progressed. In October 2010, in resolution EM/RC57/R.5, the Regional Committee for the Eastern Mediterranean endorsed the regional strategy. In September 2011, a resolution of the Regional Committee for South-East Asia welcomed the Health Assembly's endorsement of the strategy,<sup>3</sup> and in October 2011, the Regional Committee for Europe in resolution EUR/RC61/R8 adopted an action plan. PAHO's regional plan for 2006–2015 will be reviewed in the first half of 2012.<sup>4</sup> The Regional Office for Africa is updating a regional strategy,<sup>5</sup> which will be considered by the Regional Committee for Africa in 2012. The global strategy was noted in the Political Declaration on HIV/AIDS by the United Nations General Assembly on 10 June 2011.<sup>6</sup>

124. Priorities have been identified for the biennium 2012–2013. New research on the preventive benefits of antiretroviral therapy, the broader health benefits of earlier initiation of antiretroviral therapy, the effectiveness of pre-exposure prophylaxis of HIV with antiretroviral medicines and the use of vaginal microbicides were discussed at a consultation on the strategic use of antiretroviral medicines for HIV prevention and treatment.<sup>7</sup> One of the outcomes is a set of guidelines, now in preparation, on the prioritized use of antiretroviral drugs. Within the UNAIDS division of labour,<sup>8</sup> WHO jointly leads with UNICEF in the area of prevention of mother-to-child transmission of HIV and

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<sup>1</sup> See document EB130/2012/REC/2, summary record of the fourteenth meeting, section 2.

<sup>2</sup> [http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2011/20110526\\_UBRAF%20Part%201\\_final.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2011/20110526_UBRAF%20Part%201_final.pdf) (accessed 21 February 2012).

<sup>3</sup> See resolution SEA/RC64/R6.

<sup>4</sup> Regional HIV/STI Plan for the Health Sector 2006–2015, PAHO, 2005, [http://www.paho.org/english/ad/fch/ai/HIV\\_Regional\\_Plan\\_2006-2015\\_ENGLISH.pdf](http://www.paho.org/english/ad/fch/ai/HIV_Regional_Plan_2006-2015_ENGLISH.pdf) (accessed 21 February 2012).

<sup>5</sup> Document AFR/RC56/8, HIV prevention in the African Region: a strategy for renewal and acceleration.

<sup>6</sup> United Nations General Assembly resolution 65/277, [http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610\\_UN\\_A-RES-65-277\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf) (accessed 21 February 2012).

<sup>7</sup> This was an informal WHO consultation on the strategic use of antiretroviral drugs, Geneva, 14–16 November 2011, and included Member States, researchers, development partners, civil society and programme developers.

<sup>8</sup> See document UNAIDS technical support division of labour: summary & rationale, Geneva, UNAIDS, 2005.

has been actively involved in the development of a global plan to eliminate HIV infections.<sup>1</sup> The “Treatment 2.0” initiative, led by WHO and UNAIDS, aims to optimize HIV treatment in order to achieve universal access by 2015.

125. The Secretariat continues to monitor the HIV pandemic and health sector response. In November 2011, WHO, UNAIDS and UNICEF jointly launched a report on the global response to HIV/AIDS.<sup>2</sup> New data show that the global incidence of HIV has decreased, with an estimated 2.7 million (2.4 million – 2.9 million) new HIV infections in 2010, 15% less than the 3.1 million (3 million – 3.3 million) people newly infected in 2001. Annual AIDS-related deaths have decreased from a peak of 2.2 million (2.1 million – 2.5 million) in 2005 to an estimated 1.8 million (1.6 million – 1.9 million) in 2010. However, there is substantial regional variation.

126. Significant progress has been made in the health sector response to HIV. Medical male circumcision programmes for HIV prevention have been expanded in 13 high-burden countries in sub-Saharan Africa. In 2010, 410 000 operations were performed, but that figure reflects only 2% of the estimated need. More people know their HIV status as a result of a 22% increase in the number of health facilities providing HIV testing and counselling services in 2010 compared with 2009. However, HIV services for populations at greater risk, including injecting drug users, sex workers, men who have sex with men and transgender people, remain limited. The successful expansion of HIV treatment continues, with 6.6 million people receiving antiretroviral therapy in low- and middle-income countries at the end of 2010, a 27% increase from the end of 2009. Access to antiretroviral medicines for preventing mother-to-child transmission of HIV has also increased, with 59% of HIV-positive pregnant women having access to such treatment in 2010 compared with 48% in 2009.

#### **L. PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED INFECTIONS: GLOBAL STRATEGY (resolution WHA59.19)**

127. The present report provides an update on progress made in implementing the Global Strategy for the Prevention and Control of Sexually Transmitted Infections, which was endorsed by the Health Assembly in resolution WHA59.19. At its 130th session in January 2012 the Executive Board noted an earlier version of this progress report.<sup>3</sup>

128. In the WHO European Region a regional framework for implementing the Global Strategy was elaborated; it was then reviewed by representatives of Member States in the Region, international partner organizations and civil society. Missions were undertaken to Kyrgyzstan, Tajikistan and Ukraine to provide technical support for strengthening interventions for the prevention and control of sexually transmitted infections. In September 2011, during the 26th Europe Congress of the International Union against Sexually Transmitted Infections (Riga, 8–10 September 2011), WHO organized a symposium that catalysed commitment by countries in the Region.

129. In the Western Pacific Region a meeting was held to conduct a mid-term review of the Regional Strategic Action Plan for the Prevention and Control of Sexually Transmitted Infections (Ulaanbaatar,

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<sup>1</sup> Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive, 2011–2015, [http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609\\_JC2137\\_Global-Plan-Elimination-HIV-Children\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf) (accessed 21 February 2012).

<sup>2</sup> *Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011*. Geneva, World Health Organization, 2011.

<sup>3</sup> See document EB130/2012/REC/2, summary record of the fourteenth meeting, section 2.

18–20 October 2010). The meeting heard of progress in implementation of the Action Plan, with reports of decreasing sexually transmitted infections and HIV rates, together with the maintenance of low levels of HIV prevalence in Cambodia, Lao People's Democratic Republic, Mongolia, Philippines and Viet Nam. In Cambodia, prevalence among sex workers of sexually transmitted infections and HIV has been reduced by means of a comprehensive targeted intervention consisting of outreach and peer education, condom promotion, the "100% condom use" programme and provision of regular services for sexually transmitted infections. In the Lao People's Democratic Republic, the Philippines and Viet Nam, rates of sexually transmitted infections have decreased among sex workers through periodic presumptive treatment, in addition to other targeted interventions.

130. In the Region of the Americas, guidance on the integration of services and programmes for sexual and reproductive health with activities for the prevention of HIV and sexually transmitted infections has been developed and disseminated. In the Caribbean, the Secretariat provided support to Guyana for the development of the national strategy on sexually transmitted infections. A meeting with the Centers for Disease Control and Prevention (Atlanta, Georgia, United States of America) and other stakeholders was held in 2010, focusing on the management and monitoring of sexually transmitted infections in the Caribbean. Eight countries were evaluated on prevention and control of such infections in the context of the health systems' response to HIV in the period 2008–2011. Prevention of sexually transmitted diseases has also been a prominent component of regional efforts to advance comprehensive sexuality education and promotion of sexual health, as stated in the Mexico City Ministerial Declaration: "Preventing through education" (2008).

131. In the South-East Asia Region, the Secretariat has advocated for an integrated approach to sexually transmitted infections and HIV, based on the Regional Strategy for the Prevention and Control of Sexually Transmitted Infections 2007–2015. Member States have been encouraged to include control of sexually transmitted infections in their proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria, with the Secretariat providing technical support for the development of proposals. Regional guidelines for the management of sexually transmitted infections were developed in 2011 by the Regional Office for South-East Asia and shared with countries. The Secretariat also provided technical support for the updating of national guidelines on sexually transmitted infections in Indonesia, Maldives, Myanmar and Sri Lanka. Technical missions were undertaken to Myanmar to develop and implement surveys of the prevalence of sexually transmitted infections among most-at-risk populations. In addition, two staff members of the national health laboratory in Yangon were supported to receive training in Bangkok on polymerase chain reaction technology for the diagnosis of sexually transmitted infections, while in Myanmar all laboratory staff of clinics for such infections were provided with national training in diagnosis. An assessment of the programme on sexually transmitted infections was conducted in Indonesia as part of the external review of the health sector response to HIV. In India, Sri Lanka and Thailand rates of sexually transmitted infections have continued to decrease among sex workers thanks to the use of syndromic and etiologic management of these infections, condom promotion and other interventions. The Regional Office also gave impetus to the implementation of strategies towards the expansion of monitoring gonococcal antimicrobial resistance.

132. In the African Region, the true prevalence of sexually transmitted infections is not clearly known, largely owing to a lack of data. In response to this, most countries in the Region have included prevention and control of sexually transmitted infections as an integral part of programmes on HIV prevention, and sexual and reproductive health. In addition, the Southern African Development Community Member States have developed a framework for the prevention and control of sexually transmitted infections. The framework, which is in line with the Global Strategy for the Prevention and Control of Sexually Transmitted Infections, was endorsed in 2010. Following this, many of the countries concerned have updated national guidelines for the prevention and control of such infections.

Data on two indicators related to sexually transmitted infections have been collected from countries as part of reporting on progress of implementing the framework: (1) the number of service delivery points providing sexually transmitted infection services for sex workers per 1000 sex workers; and (2) the prevalence of syphilis infection among those attending antenatal care clinics. In 2009, nine countries reported on the first indicator and 28 on the second. Results from the reporting countries varied widely, as the number of service delivery points for sex workers ranged from 0.5 per 1000 sex workers in Guinea to 14.4 per 1000 sex workers in Sao Tome and Principe. The prevalence of syphilis among antenatal care attendees also varied, and countries such as Chad, Ghana, Madagascar, Mozambique and Zambia reported syphilis infection exceeding 5%. Cervical cancer screening using visual inspection with acetic acid and cryotherapy are being scaled up in Madagascar, Malawi, Nigeria, Rwanda, Uganda, United Republic of Tanzania and Zambia.

133. In the Eastern Mediterranean Region the annual regional reviews of surveillance activities for HIV and sexually transmitted infections have been conducted and recommendations developed and disseminated to health ministries and partner agencies. The regional stakeholders meeting for implementation of the regional strategy for prevention and control of sexually transmitted infections 2009–2015 (Hammamet, Tunisia, 8–11 June 2009) set priorities, targets, timeframes and performance indicators for implementing the regional strategy. Three countries – Iran (Islamic Republic of), Syrian Arab Republic and Yemen – were provided with support to develop and integrate their national action plan for sexually transmitted infections into the national operational plans against HIV. Technical support has been provided to Iran (Islamic Republic of), Iraq, Morocco, Oman, Somalia, South Sudan, Sudan, Tunisia, Yemen and West Bank and Gaza Strip on the surveillance of HIV and sexually transmitted infections, including an in-depth review of the relevant surveillance systems.

134. In line with WHO's leading role in driving global coordination and action on antimicrobial resistance, the Secretariat has elaborated a global action plan to control the spread and impact of antimicrobial resistance in *Neisseria gonorrhoeae* with the goal of enhancing prevention, diagnosis and control of infection at the global level, and of mitigating the health impact of antimicrobial resistance, through improved, sustained, evidence-based and collaborative multisectoral action. WHO has established a network of laboratories of excellence to monitor and advise on the global spread of multidrug-resistant *N. gonorrhoeae*. The reference laboratories concerned are in Australia, Canada, India, South Africa and Sweden. In addition, collaboration has been strengthened with the Division of STD Prevention, Centers for Disease Control and Prevention (Atlanta, Georgia, United States of America); the Health Protection Agency (United Kingdom of Great Britain and Northern Ireland); and the European Centre for Disease Prevention and Control in order to combat antimicrobial resistance in *N. gonorrhoeae* at the global level. Data collected to date show that multidrug-resistant gonococcal strains are circulating, mainly in the Western Pacific Region, characterized by combined resistance to oral cephalosporins, quinolones, penicillins and tetracyclines. Gonococci exhibiting decreased susceptibility to antibiotics in laboratory tests and, more recently, manifesting clinical resistance as treatment failures, have emerged in Japan – a matter of global concern. Gonococci with reduced susceptibility and resistance to oral cephalosporins are spreading within the Asia-Pacific region and emerging in other regions of the world. It is also noteworthy that surveillance programmes based in the United Kingdom and the United States of America have reported a trend towards decreased susceptibility among gonococci to both oral cephalosporins and ceftriaxone, mirroring what was observed with penicillin and tetracycline in the 1940s and 1950s. In South Africa, antimicrobial resistance surveys have been completed in various parts of the country. These surveys have confirmed widespread ciprofloxacin resistance among gonococci but, to date, no evidence of resistance to either cefixime or ceftriaxone. In Namibia, following a similar survey, the reported prevalence of ciprofloxacin resistance was found to be 24% overall. As a result, the Ministry of Health and Social Services revised the national treatment guidelines in 2008 and replaced ciprofloxacin with cefixime for the treatment of presumptive gonococcal infection. In Morocco, national guidelines on sexually

transmitted infections were also revised and a national network for monitoring drug resistance in *N. gonorrhoeae* was established with technical support from the Secretariat.

135. In several regions, training has been conducted in order to enhance and scale up surveillance for sexually transmitted infections, including antimicrobial surveillance for gonococcal infections. In November 2010, a workshop – organized by the University of Saskatchewan (Saskatoon, Canada) – was held to revitalize the Gonococcal Antimicrobial Susceptibility Surveillance Program in Latin America and the Caribbean. Currently, PAHO is strengthening the monitoring of the sensitivity of *N. gonorrhoeae*, through an institutionalized network within health ministries. National reference laboratories will be part of this network. In the African Region, 23 Zimbabwean nurses and three laboratory technicians were trained in Harare in October 2010, two biologists from Madagascar were trained at the reference laboratory in South Africa in March 2011, and three laboratory technicians from the United Republic of Tanzania were trained in South Africa in June 2011. In the South-East Asia Region, a training workshop for four laboratory technicians from Bhutan was conducted at the reference laboratory in India in June 2010. In December 2010, one microbiologist from Bhutan, nine from India and one from Sri Lanka were trained at the same centre. Some 20 programme managers from the 11 countries of the South-East Asia Region received comprehensive training in surveillance of sexually transmitted infections in Sri Lanka in October 2011.

136. Progress has been recorded by the WHO's initiative on the global elimination of congenital syphilis. A monitoring system was established within the reporting system for WHO's activities to achieve the goal of universal access to HIV prevention, treatment and support. By 2010, 16 low- and middle-income countries had reached the global elimination target for 2015 of screening for syphilis at first visit at least 90% of antenatal care attendees aged 15–24. In June 2011, a pilot initiative was launched on the dual elimination of mother-to-child transmission of syphilis and HIV through strengthened antenatal care services, involving six countries in the African Region: Central African Republic, Ghana, Madagascar, Mozambique, United Republic of Tanzania and Zambia. In 2009, in the Region of the Americas 11 countries presented data indicating that they may have achieved the target of elimination of congenital syphilis as a public health problem, with an incidence of below 0.5 cases per 1000 live births. In November 2009, PAHO and UNICEF launched the Regional Initiative for the Elimination of Mother-to-Child Transmission of HIV and Syphilis in Latin America and the Caribbean (the Elimination Initiative).<sup>1</sup> The Elimination Initiative was endorsed by key regional mechanisms, including the Chief Medical Officers of the Caribbean and the CARICOM Caucus of Ministers Responsible for Health, and the Meeting of the Ministers of Health of the Andean Region in 2010.<sup>2</sup> In September 2010, PAHO's Directing Council endorsed the Strategy and approved the Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis by 2015,<sup>3</sup> and 22 countries have plans for elimination in place. In Asia-Pacific, a framework for the elimination of new paediatric HIV infections and congenital syphilis 2011–2015 was launched in September 2011.<sup>4</sup> The South-East Asia Region has identified indicators, a case definition and

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<sup>1</sup> See *2010 Situation analysis: elimination of mother-to-child transmission of HIV and congenital syphilis in the Americas*. Washington DC, PAHO, 2011.

<sup>2</sup> REMSA. Eliminación de la sífilis congénita, de la transmisión vertical del VIH y disminución del VIH pediátrico. Resolución REMSA XXIV/3. Caracas, 2010.

<sup>3</sup> Resolution CD50.R12.

<sup>4</sup> See *Elimination of new paediatric HIV infections and congenital syphilis in Asia-Pacific, 2011-2015*. United Nations Children's Fund East Asia and Pacific Regional Office, Bangkok, 2011 (available online at [http://www.unicef.org/eapro/PPTCT\\_CF\\_and\\_ME\\_guide\\_17Aug11.pdf](http://www.unicef.org/eapro/PPTCT_CF_and_ME_guide_17Aug11.pdf), accessed 22 February 2012).

targets for elimination. Finally, in the Western Pacific Region, the “one-stop shop” approach in Mongolia has succeeded in decreasing trends of reported congenital syphilis.

137. In order to tackle existing gaps in strategic information on sexually transmitted infections, estimates have been made of global and regional prevalence and incidence in adults between 15 and 49 years of age of four treatable sexually transmitted infections, namely: *Chlamydia trachomatis*, *N. gonorrhoeae*, *Treponema pallidum* and *Trichomonas vaginalis*. The estimates indicate that the total number of new cases per year for 2005 was 448 million. Work has continued to bring the estimates up to date by analysing data between 2005 and 2008. Based on this continuing analysis, it is estimated that in 2008 there were over 498 million incident cases of the four infections.

#### **M. REPRODUCTIVE HEALTH: STRATEGY TO ACCELERATE PROGRESS TOWARDS THE ATTAINMENT OF INTERNATIONAL DEVELOPMENT GOALS AND TARGETS (resolution WHA57.12)**

138. At its 130th session in January 2012 the Executive Board noted an earlier version of this progress report.<sup>1</sup>

139. In resolution WHA57.12, the Health Assembly requested the Director-General to devote sufficient organizational priority, commitment and resources to supporting effective promotion and implementation of the reproductive health strategy; to provide support to Member States in ensuring reproductive health commodity security; and report at least biennially. In September 2010, the United Nations Secretary-General launched the Global Strategy for Women’s and Children’s Health, refocusing attention on the critical role of reproductive health in the overall health of women and children, and re-emphasizing the need to accelerate progress.

140. The Secretariat continues to collaborate with Member States in efforts to achieve universal access to and quality of sexual and reproductive health care. Regional work includes support to policy frameworks and acceleration plans on improving reproductive health and contributing to ministerial and parliamentary summit outcome documents on reproductive health and development. Technical support is being provided in a number of areas, including health-care financing, policy dialogue, human resources, and in strengthening capacity for service delivery needs in the key components of sexual and reproductive health.

141. A WHO questionnaire was administered in 2011 among Member States to assess implementation of the global reproductive health strategy. The results indicate that progress has been made. Among the 58 Member States that responded to the survey, progress had been facilitated by:

- strengthening partnerships aimed at improving health-system capacity, training and retaining skilled health workers, and increasing access to emergency obstetric care;
- updating legislative and regulatory frameworks aligned with national strategic plans;
- gaining political commitment through demonstrating the vital connection between improved reproductive health and development;

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<sup>1</sup> See document EB130/2012/REC/2, summary record of the fourteenth meeting, section 2.

- strengthening monitoring, evaluation and accountability to improve the evidence base for priority setting; and
- allocating national resources for reproductive health: over 50% of the countries surveyed had procedures in place to monitor resource flows.

142. The results of the survey also show that increasingly interventions developed by WHO to reduce maternal mortality and improve reproductive health were being put into practice. More than 85% of countries that responded indicated that targeted antenatal care had been integrated into reproductive/maternal health programmes; in 95%, magnesium sulphate is registered for use in reducing deaths from eclampsia, which is a significant improvement compared with findings of the survey conducted in 2009; and in more than 95%, reproductive health essential medicines were in the national essential medicines list. Only about two thirds, however, included emergency contraception among contraceptive methods provided through public health programmes; and only three quarters reported screening for early detection of cervical cancer. Screening for congenital syphilis during pregnancy was still not universal.

143. At the same time, Member States identified barriers to the improvement of reproductive health services. These barriers include: political instability or crisis; poor quality of care; poor coordination of efforts; insufficient human resources and poorly motivated staff; lack of funds and commodities; poverty; low levels of community engagement; and sociocultural factors.

144. Such barriers also contribute to uneven progress and account for the observed disparities in reproductive health outcomes, including the varied rates of reducing maternal mortality across regions. Globally, the annual reduction in the maternal mortality ratio was 2.3% between 1990 and 2008. In the South-East Asia Region and Western Pacific Region, the estimated decline in the annual maternal mortality ratio was 5%. It was 1.7% and 1.5% in the African Region and the Eastern Mediterranean Region, respectively. The slower progress in reducing maternal mortality in sub-Saharan Africa relative to Asia, together with an increasing number of births, has resulted in a major regional shift in the burden of maternal mortality. In 1990, around 58% of global maternal deaths occurred in Asia and 36% in sub-Saharan Africa; in 2008, this trend had reversed, with an estimated 39% of global maternal deaths occurring in Asia and 57% in sub-Saharan Africa.

145. Access to care through pregnancy and childbirth is crucial for reducing maternal deaths and improving maternal health. The proportion of childbirths attended by skilled health personnel increased from 61% in the 1990s to 66% in the 2000s, globally. Despite the dramatic progress made in many regions, coverage (i.e. the proportion of childbirths where skilled attendants are present) remains low in the South-East Asia Region and the African Region, where the majority of maternal deaths occur. Inequities exist according to place of residence: in recent years, the median value for the proportion of births attended by a skilled health professional is 63% in rural areas compared with 89% in urban areas.

146. Family planning is a key component of sexual and reproductive health and can prevent up to one third of maternal deaths.<sup>1</sup> Although contraceptive use among women who are married or in union is over 60% globally, large differences are seen across regions. Women in sub-Saharan Africa have the lowest levels of contraceptive use (22% in 2008). The unmet need for family planning, that is, the gap between women who wish to delay or stop childbearing and those who do not use any contraceptive

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<sup>1</sup> Cleland J, et al. Family planning: the unfinished agenda. *The Lancet*, 2006; 368:1810–1827.

method, has been unchanged in sub-Saharan Africa since 1990: 26% in 1990, and 25% in 2008.<sup>1</sup> Within countries, the unmet need is associated with household wealth, with poorer women having a higher unmet need.<sup>2</sup>

147. Pregnancy presents a risk of adverse health and social consequences for adolescents, especially as they are less likely to have access to reproductive health services.<sup>2</sup> Data for 22 countries in sub-Saharan Africa for 1998–2008 show that women aged 15–19 years who are married or in a union have much lower levels of contraceptive use than all women of reproductive age who are married or in a union (10% and 21%, respectively), and similar levels of unmet need for contraception (around 25%). Thus, the proportion of adolescents having their demand met for contraception is much lower than that of their older counterparts (29% compared with 45%).

148. Adolescent boys and men are also in need of sexual and reproductive health services and information. Less than 40% of young men in developing regions know that two ways of avoiding sexually transmitted infections are condom use and either abstinence or having only one, uninfected partner. The proportion of young men reporting that they had used a condom at last high-risk sex varies from 38% in southern Asia to 56% in the Caribbean.<sup>3</sup> Sexuality education programmes have been shown to have a significant effect on reducing high-risk sexual behaviours.<sup>4</sup>

## **N. ADVANCING FOOD SAFETY INITIATIVES (resolution WHA63.3)**

149. At its 130th session in January 2012 the Executive Board noted an earlier version of this progress report.<sup>5</sup>

150. Recent foodborne disease outbreaks, such as the event in western Europe in 2011 involving *Escherichia coli* O104:H4 and the radioactive contamination of certain food items following the emergency at the Fukushima nuclear plant in Japan, have highlighted the need for consolidated global actions to ensure the safety of food for all Member States at all levels.

151. Resolution WHA63.3 recognizes the importance of full engagement on the part of the health sector, in collaboration with other sectors, in order to ensure sound food safety management, and requests Member States and the Director-General to undertake key actions needed to advance food safety initiatives. An update on the Secretariat's work in the relevant areas is provided below.

152. **International Food Safety Authorities Network (INFOSAN).** The Network has become a joint programme that has been co-managed by FAO and WHO since June 2010. This partnership has increased the availability of information for food authorities and improved overall management. It has

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<sup>1</sup> The Millennium Development Goals Report 2011. United Nations, New York, 2011, p. 33, [http://www.un.org/millenniumgoals/11\\_MDG%20Report\\_EN.pdf](http://www.un.org/millenniumgoals/11_MDG%20Report_EN.pdf) (accessed 1 March 2012).

<sup>2</sup> See document EB130/12 for a more detailed discussion about the birth rate among adolescents, which remains high in sub-Saharan Africa (122 births per 1000 women aged 15–19 years). Despite a decline in total fertility in Latin America, the Caribbean and southern Asia, adolescent fertility continues to be high in these regions.

<sup>3</sup> The Millennium Development Goals Report 2011 – Statistical Annex. United Nations, New York, 2011, p. 12, <http://mdgs.un.org/unsd/mdg/Resources/Static/Data/2011%20Stat%20Annex.pdf> (accessed 1 March 2012).

<sup>4</sup> Wellings K, Collumbien M, Slaymaker E, et al. Sexual behaviour in context: a global perspective. *The Lancet*, 2006; 368: 1706–1728.

<sup>5</sup> See document EB130/2012/REC/2, summary record of the fourteenth meeting, section 2.

also increased the level of interaction between relevant initiatives in both organizations, ensuring synergy between them, and has provided momentum for further development of the Network.

153. The First Global Meeting of INFOSAN, held from 14 to 16 December 2010 in Abu Dhabi, gave focal points and emergency contact points the opportunity to identify practical recommendations for enhancing communication and collaboration. The activities of the INFOSAN secretariat have focused on: strengthening capacities at country and regional levels to promote participation in INFOSAN, linking with ongoing efforts to develop country core capacities to implement the International Health Regulations (2005); and assuring the continued provision of technical support.

154. During a number of food contamination events and foodborne disease outbreaks, the INFOSAN secretariat has collected and verified important information before sharing it with INFOSAN members.

155. In various WHO regions, the capacity of countries both to collaborate with INFOSAN and to detect, assess and manage food safety incidents and emergencies at a national level has been developed through workshops and technical support.

156. **Tools for information exchange.** Creating links between the various sources of food safety data and improving access to them can help Member States to manage food safety nationally. With this end in mind, a user-friendly, interactive online tool has been designed to integrate relevant data and information. The tool, named FOSCOLLAB, should improve data-sharing to support risk assessment and decision-making in food safety. A detailed business plan for the tool has been developed following consultation with countries.

157. **Assessment of the burden of foodborne diseases.** WHO's Foodborne Disease Burden Epidemiology Reference Group has continued to assess the global burden of foodborne diseases from all causes (whether microbiological, parasitic or chemical). Pilot country-level burden assessments have started in four countries (Albania, Japan, Thailand and Uganda). In addition, guidance has been developed on translating scientific evidence into policy-making and practice.

158. **Continued support to the work of the Codex Alimentarius Commission.** WHO has continued providing financial and technical support to the work of the Codex Alimentarius Commission and its subsidiary bodies. In addition, 10 scientific expert meetings were held in the last biennium to evaluate chemical and biological hazards in food, largely as a basis for scientific advice for the relevant committees of the Commission.

159. The FAO/WHO Project and Fund for Enhanced Participation in Codex (the Codex Trust Fund) has provided increased support to Member States to enhance the participation of developing countries in the work of the Codex Alimentarius Commission. By the end of 2010, the Codex Trust Fund had provided support to enable 1423 participants from 132 countries to attend Codex meetings and participate in task forces and working groups. A further 336 participants have received support to participate in Codex training courses and workshops.

160. **Zoonotic diseases at the human–animal interface.** Collaboration with FAO and OIE is being intensified in support of the provision of policy guidance to tackle health risks at the human–animal–ecosystem interface. In support of this effort, the three agencies are sharing responsibilities and coordinating activities jointly, and have published details of their collaboration in a tripartite concept

note.<sup>1</sup> A tripartite joint action plan that translates the policy guidance into concrete actions is being implemented, taking account of ongoing successful activities. The latter include the collaboration on the Global Early Warning System for Major Animal Diseases, including Zoonoses, which builds on the added value of combining and coordinating the three agencies' early warning and response capacity against animal disease threats.

161. **Capacity building.** In addition to activities carried out through the Codex Trust Fund, training workshops have been conducted in the areas of risk assessment of food contaminants, antimicrobial resistance due to antibiotic use in agriculture, and laboratory capacity. These were generally organized through the WHO regional offices.

162. **Raising awareness and promoting healthy behaviours.** Public information and health promotion materials in the area of food safety have been further developed, translated into various languages, field-tested and disseminated. In this respect, the Secretariat has continued to support Member States in developing and maintaining sustainable preventive measures, including food-safety education programmes based on the Five Keys to Safer Food concept.

163. The Regional Office for the Western Pacific has developed a draft Western Pacific Regional Food Safety Strategy (2011–2015), covering major themes requiring action by Member States to ensure food safety. The Strategy was submitted for consideration by the Regional Committee for the Western Pacific at its sixty-second session in October 2011.<sup>2</sup> The Committee subsequently endorsed the Strategy in resolution WPR/RC62.R5. The Regional Office for South-East Asia is in the process of finalizing a similar strategy. Technical activities in all WHO regions have included capacity building for food safety management, enhancement of laboratory capacities, support to strengthening systems for response to food safety emergencies, and guidance on food safety legislation.

## **O. CLIMATE CHANGE AND HEALTH (resolutions EB124.R5 and WHA61.19)**

164. At its 130th session in January 2012, the Executive Board noted an earlier version of this progress report.<sup>3</sup>

165. The present report responds to resolution EB124.R5, in which the Executive Board requested the Director-General to report on progress in implementing resolution WHA61.19 and the workplan on climate change and health. The report also updates the information provided to the Health Assembly in May 2011.<sup>4</sup>

166. **Promoting and supporting the generation of scientific evidence.** The Secretariat has worked closely with WMO, holding a consultation meeting and providing technical input to the health component of the new Global Framework for Climate Services. WHO staff continue to contribute to

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<sup>1</sup> FAO, OIE, WHO. *The FAO-OIE-WHO collaboration: sharing responsibilities and coordinating global activities to address health risks at the animal-human-ecosystems interfaces. A tripartite concept note.* Food and Agriculture Organization of the United Nations, Office International des Épidémiologies, World Health Organization, 2010. (Available online at <http://www.fao.org/docrep/012/ak736e/ak736e00.pdf>, accessed 21 February 2012).

<sup>2</sup> See document WPR/RC62/7.

<sup>3</sup> See documents EB130/35 Add.1 and EB130/2012/REC/2, summary record of the fourteenth meeting.

<sup>4</sup> Document A64/26.

the Intergovernmental Panel on Climate Change Special Report on extreme events<sup>1</sup> and to the forthcoming Fifth Assessment Report. The Secretariat continues to work to identify the likely health benefits of strategies to reduce greenhouse gas emissions from key sectors assessed by the Panel, and has published reports on the housing<sup>2</sup> and transport<sup>3</sup> sectors. WHO has produced new technical reports and guidance on subjects that include vulnerability and adaptation assessment<sup>4</sup> and gender, climate change and health.<sup>5</sup> A guidance package on health responses to heatwaves has also been published.<sup>6</sup>

**167. Advocacy and awareness raising.** The Secretariat has worked with Member States to emphasize the importance of health in climate change policy, and the linkages between climate change and other environmental and social determinants of health. This effort has included events at the Sixty-third World Health Assembly, the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19–21 October 2011) and the 17th Conference of the Parties to the United Nations Framework Convention on Climate Change (Durban, South Africa, 28 November–9 December 2011). The Secretariat coordinates a contact group of national delegates to the Framework Convention in order to promote consideration of health within the negotiations, and has established a consultation group of health-professional associations and nongovernmental organizations in order to generate and disseminate information for health advocacy. The Secretariat has also updated an audit of the carbon footprint of selected WHO offices as part of the United Nations “Greening the Blue” initiative, and is now considering policy proposals to reduce emissions.

**168. Strengthening health systems to protect populations from the adverse impacts of climate change on health.** WHO has gained ministerial endorsement for new frameworks for protecting health from climate change in the African Region and in the Region of the Americas, which will guide national health systems’ adaptation plans. The Secretariat has completed assessments of health vulnerability and consequent adaptation needs in over 30 countries. A seven-country global pilot project on public health adaptation to climate change (involving Barbados, Bhutan, China, Fiji, Jordan, Kenya and Uzbekistan) has run its first year. In addition, the Regional Office for Europe has completed the second year of a health systems adaptation project that it is coordinating in central Asia and eastern Europe (covering Albania, Kazakhstan, Kyrgyzstan, the Russian Federation, Tajikistan, the former Yugoslav Republic of Macedonia and Uzbekistan), while work on the health components of United Nations country team projects in China, Jordan and the Philippines is also entering its third year. Finally, WHO has initiated a new large-scale project on climate change and vector-borne disease in the Western Pacific Region.

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<sup>1</sup> Intergovernmental Panel on Climate Change. WMO. UNEP. Special report: Managing the risks of extreme events and disasters to advance climate change adaptation (<http://ipcc-wg2.gov/SREX/>, accessed 23 February 2012).

<sup>2</sup> *Health in the green economy: health co-benefits of climate change mitigation – housing sector*. Geneva, World Health Organization, 2011 ([http://whqlibdoc.who.int/publications/2011/9789241501712\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241501712_eng.pdf), accessed 23 February 2012).

<sup>3</sup> Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH. WHO. *Urban transport and health: sustainable transport: a sourcebook for policy-makers in developing cities*. Geneva, World Health Organization, 2011 and commissioned by the Federal Ministry for Economic Cooperation and Development (BMZ) (Germany) ([http://whqlibdoc.who.int/publications/2011/9789241502443\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241502443_eng.pdf), accessed 23 February 2012).

<sup>4</sup> Protecting health from climate change. Vulnerability and adaptation assessment. Draft for discussion. World Health Organization, Pan American Health Organization, 2010 ([http://www.who.int/globalchange/VA\\_Guidance\\_Discussion.pdf](http://www.who.int/globalchange/VA_Guidance_Discussion.pdf), accessed 23 February 2012).

<sup>5</sup> *Gender, climate change and health*. Geneva, World Health Organization, 2011 (<http://www.who.int/globalchange/GenderClimateChangeHealthfinal.pdf>, accessed 23 February 2012).

<sup>6</sup> *Public health advice on preventing health effects of heat*. Copenhagen, WHO Regional Office for Europe, 2011 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0007/147265/Heat\\_information\\_sheet.pdf](http://www.euro.who.int/__data/assets/pdf_file/0007/147265/Heat_information_sheet.pdf), accessed 23 February 2012).

169. **Partnership with organizations of the United Nations system and other parties.** WHO has contributed the health perspective to the response of different United Nations bodies to climate change, including the following: the United Nations System Chief Executives Board for Coordination; the United Nations High-Level Committee on Programmes; the Conference of the Parties to the United Nations Framework Convention on Climate Change and its associated policy and technical meetings; and the High-Level Committee on Programmes Task Team on the Social Dimensions of Climate Change, which WHO co-organizes. The Organization also leads activities to design regional frameworks on climate change and health, and convenes intersectoral steering committees to implement national climate and health projects. As a result, health is now recognized as one of the core sectors in global adaptation efforts.

170. The Secretariat supports these activities through a capacity-building programme including training materials, a database of national expertise, guidance on access to funding sources, a toolkit for programme managers on public health adaptation, and a clearing house of existing public health systems' adaptation projects.

## **P. PARTNERSHIPS (resolution WHA63.10)<sup>1</sup>**

171. In 2010, the Health Assembly in resolution WHA63.10 requested the Director-General to create an operational framework for WHO's hosting of formal partnerships and to apply the policy on WHO's engagement with global health partnerships and hosting arrangements to current hosting arrangements with a view to ensuring their compliance with the principles embodied in the policy. The resolution further requested the Director-General to submit to the Executive Board any proposals for WHO to host formal partnerships for its review and decision. The present document reports on progress in implementing resolution WHA63.10, and on the various actions taken by the Secretariat in relation to partnerships in implementing the policy. At its 130th session in January 2012 the Executive Board noted an earlier version of this progress report.<sup>2</sup>

172. **New formal partnerships.** During the past five years, there has been no new formal partnership. WHO currently hosts 13 formal health partnerships and special programmes.<sup>3</sup>

173. **Status of selected hosted partnerships.** Since 2009, the status has changed for four formal partnerships, reflecting the fluid nature of WHO's relationship with any partnership. The Global Fund to Fight AIDS, Tuberculosis and Malaria separated from WHO in 2009, becoming a fully independent foundation under Swiss law. The Water Supply and Sanitation Collaborative Council moved from

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<sup>1</sup> Document A63/44, paragraph 1, footnote 2, provides a definition of the term "global health partnership" as often referring to "a collaborative and formal relationship among multiple organizations in which risks and benefits are shared in pursuit of a shared goal. Such partnerships have their own, separate governance body." Within WHO, these partnerships do not have a separate legal identity. In the policy on WHO engagement with global health partnerships and hosting arrangements (document WHA63/2010/REC/1, Annex 1), paragraph 6 states: "the term 'formal partnerships' refers to those partnerships with or without a separate legal personality but with a governance structure (for example, a board or steering committee) that takes decisions on direction, workplans and budgets".

<sup>2</sup> See document EB130/2012/REC/2, summary record of the fourteenth meeting, section 2.

<sup>3</sup> These include the following: Roll Back Malaria Partnership; Stop TB Partnership; Partnership for Maternal, Newborn and Child Health; Health Metrics Network; Alliance for Health Policy and Systems Research; Global Health Workforce Alliance; International Drug Purchase Facility (UNITAID); United Nations Standing Committee on Nutrition; African Programme for Onchocerciasis Control; European Observatory on Health Systems and Policies; WHO Framework Convention on Tobacco Control; UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases; and the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction.

WHO to the United Nations Office for Project Services in 2009, given the better fit between the latter and the Council's work. In 2010, the Intergovernmental Forum on Chemical Safety ended and the secretariat of the Strategic Approach to International Chemicals Management was established (not hosted by WHO). In 2011, the Health and Nutrition Tracking Service was reintegrated into WHO, with the completion of the Service's original mission and in view of its compatibility with a new reinforced team on epidemiological surveillance in humanitarian situations within the new WHO Polio, Emergencies and Country Support cluster.

174. **WHO operational framework.** Since the inception of WHO-hosted partnerships, all such partnerships have been expected to comply fully with WHO Rules and Regulations.<sup>1</sup> In 2011, the Secretariat further developed an internal operational framework document that summarizes and communicates the requirements for hosting a partnership and its secretariat. In addition, a section on hosted partnerships has been included in the revised WHO e-Manual. These enhancements have been guided by the new "policy on WHO engagement with global health partnerships and hosting arrangements", which was endorsed by resolution WHA63.10,<sup>2</sup> by the current WHO Rules and Regulations, and by best practice within WHO, where appropriate.

175. **Partnership staffing and resources.** As at 31 December 2011, there were some 424 staff members on long-term and temporary appointments working for WHO-hosted partnerships, special programmes and the secretariat of the WHO Framework Convention on Tobacco Control. Recorded income for these entities during the biennium 2010–2011 was about US\$ 1055 million, of which UNITAID and the African Programme for Onchocerciasis Control accounted for US\$ 650 million. In line with the policy on engagement with partnerships, WHO has developed an approach to ensure it is "reimbursed for all administrative and technical support costs incurred in providing hosting functions for partnerships and implementing or supporting their activities",<sup>3</sup> taking into consideration existing programme support costs and post-occupancy charge retentions.

176. **International Public Sector Accounting Standards.** As from 1 January 2012, the Standards have been fully applied to the Organization's financial reporting. With the exception of UNITAID, the African Programme for Onchocerciasis Control, UNAIDS, the International Computing Centre and IARC, hosted partnerships will continue to be consolidated in WHO's financial report in line with the requirements of the Standards.

177. **Evaluations of partnership secretariats.** In November 2010, the Office of Internal Oversight Services evaluated the Organization's engagement with selected partnerships. In 2011, the Independent Expert Oversight Advisory Committee began reviewing WHO's hosting arrangements for partnerships. Both bodies reviewed the hosting relationship between WHO and the partnerships, and supported the need for partnerships to comply with WHO's Rules and Regulations. Whereas some partnerships commission their own independent evaluations, the Secretariat is developing a simple, standard approach to monitoring and evaluating the effectiveness, synergy and concurrence of partnership secretariats with WHO Rules and Regulations.

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<sup>1</sup> These refer to the WHO Constitution, WHO's Financial Regulations and Financial Rules, Staff Regulations and Staff Rules, and other administrative rules, policies, procedures, practices and guidelines, including WHO technical norms, guidelines and procedures, and any relevant resolutions of WHO's governing bodies.

<sup>2</sup> See document WHA63/2010/REC/1, Annex 1.

<sup>3</sup> See document WHA63/2010/REC/1, Annex 1, paragraph 23.

178. **Other forms of partnering.** In addition to formal partnerships, WHO continues to engage with diverse United Nations organizations and non-State stakeholders in its implementation of the Medium-term strategic plan 2008–2013. Some of these actions are recorded in the report by the Secretariat on collaboration,<sup>1</sup> which was noted by the Sixty-fourth World Health Assembly,<sup>2</sup> and in the annual reports of the Standing Committee on Nongovernmental Organizations to the Executive Board. WHO's management of more than 60 networks and alliances (those that lack their own governance arrangements) allows the Organization to convene stakeholders and facilitate the attainment of goals, including: the promotion of health outcomes; the assurance that there is optimal coordination of field-level activities; and the reassurance that services are delivered in a coherent and effective way. Examples of successful alliances include the International Health Partnership (WHO–World Bank joint secretariat), the Global Polio Eradication Initiative, and the Harmonization for Health in Africa initiative.

## **Q. MULTILINGUALISM: IMPLEMENTATION OF ACTION PLAN (resolution WHA61.12)**

### **Staff language skills database**

179. In 2008, the Health Assembly, in resolution WHA61.12, requested the Director-General, *inter alia*, to ensure the establishment of a database of the official languages of the Organization in which staff members in the professional category were fluent. This request was fulfilled by the creation of a database that members of staff can access through the WHO Intranet in order to edit and update their language profiles. The database, which has been available to all staff in the Organization since September 2011, was enhanced to permit the reporting of language skills other than fluency. The addition of a search function has also allowed staff members to identify colleagues with skills in a particular language.

180. As at 17 February 2012, more than 1000 staff members, whose locations cover headquarters, the regional offices and some country offices, have entered their language data. Of these, almost half are staff members in the professional and higher categories. The data entered so far show that: 12% of respondents are fluent in Arabic, 2% in Chinese, 96% in English, 53% in French, 5% in Russian and 15% in Spanish. In addition, staff members report having some level of competency in more than 160 languages other than the official languages.

### **Exhibition on multilingualism**

181. On 13 May 2011, the Secretariat launched a library exhibition on multilingualism, aiming to promote language diversity and raise awareness about the role of multilingualism in achieving WHO's global health objectives. The exhibition featured a series of 17 posters, a quiz to guess the language of 16 WHO books, and a video showing testimonials from end-users of WHO's multilingual information in the Western Pacific Region. As at May 2011, WHO's publications had been translated into more than 77 different languages, and many examples were displayed at the exhibition.

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<sup>1</sup> Document A64/42.

<sup>2</sup> See the summary record of the Sixty-fourth World Health Assembly, fourth meeting of Committee B, section 3.

## **The WHO web site**

182. A new web page on multilingualism on the WHO web site<sup>1</sup> promotes multilingual communication as a tool for improving global health.

183. The multilingual team of web editors prioritizes content for the official languages on the basis of statistics for texts being accessed on the web site in the six official languages, direct feedback from web users, and the thematic priorities of the Organization. The team has been functioning without dedicated editors for some official languages, making it difficult to sustain the current workload.

## **Institutional Repository for Information Sharing**

184. The Institutional Repository for Information Sharing is a digital library providing open and online access to all WHO's published material, through a multilingual interface.<sup>2</sup> In November 2011, at the special session of the Executive Board on WHO reform, this effort gained further impetus with a number of Member States requesting that WHO make governing bodies documentation more broadly accessible in a full-text, searchable, digital library, in order to facilitate rapid retrieval.<sup>3</sup> The Institutional Repository was demonstrated to Member States in a side event at the 130th session of the Executive Board in January 2012. The documents it contains are searchable in official languages by any keywords, and are enriched with full descriptions (metadata) and subject headings (controlled vocabularies) in order to allow for better integration within topical WHO web sites and to ensure that they can be found through Internet search engines.

## **Language services**

185. Language services are the main multilingual resource of the Organization. Recent increases in the number of sessions of the governing bodies and in the volume of associated documentation have made the interpretation and translation workload heavier. At the same time, however, the need for high-quality translation of technical documents continues. In 2011, interpretation was provided for 108 meetings over 216 calendar days, totalling 2870 interpreter-days of work, and, given resource constraints, the freelance market is a strategically important source of services. WHO is the lead agency for the United Nations System Chief Executives Board for Coordination in renegotiating the agreement with the International Association of Conference Translators, and is actively involved in the renegotiation of the parallel agreement with the International Association of Conference Interpreters. The aim is to assure quality and ensure continuity of service from external contractors in the future.

186. The Regional Office for Europe has produced localized versions of the English style guide in French, German and Russian. Similarly, the Regional Office for the Eastern Mediterranean has produced a version in Arabic.

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<sup>1</sup> Available at <http://www.who.int/about/multilingualism/en/index.html> (accessed 23 February 2012).

<sup>2</sup> The proposal for an institutional repository is described in document EB121/6, which was noted by the Executive Board at its 121st session (see document EB121/2007/REC/1, summary record of the thirteenth meeting, section 4).

<sup>3</sup> See document EBSS/2/2011/REC/1, summary record of the third meeting.

## **Report of the United Nations Joint Inspection Unit**

187. In June 2010, WHO contributed to the preparation of the report of the Joint Inspection Unit of the United Nations system on multilingualism in United Nations System Organizations, which is currently being finalized.

### **Language learning**

188. Language training continues to be offered to staff members free of charge. During the biennium 2010–2011, enrolments in language courses at headquarters totalled 1844: 84 were for Arabic, 24 for Chinese, 225 for English, 1109 for French, 49 for Russian and 353 for Spanish.

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