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Progress reports[1]

Report by the Secretariat

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[1] See documents EB130/35 for reports A to C, EB130/35 Add.1 for reports M to P, and EB130/35 Add.3 for reports D to F.

G. VIRAL HEPATITIS (resolution WHA63.18)

1. 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.

2. **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.

3. 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.

4. **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, 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.

5. **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.

6. **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.

7. 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 fulfill the mandate as set out in resolution WHA63.18.

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

8. 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, at the time of writing, 26 of the 27 Member States that account for more than 85% of incident cases of multidrug-resistant tuberculosis globally had 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).

9. 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.

10. 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 will have implemented Xpert MTB/RIF technology.

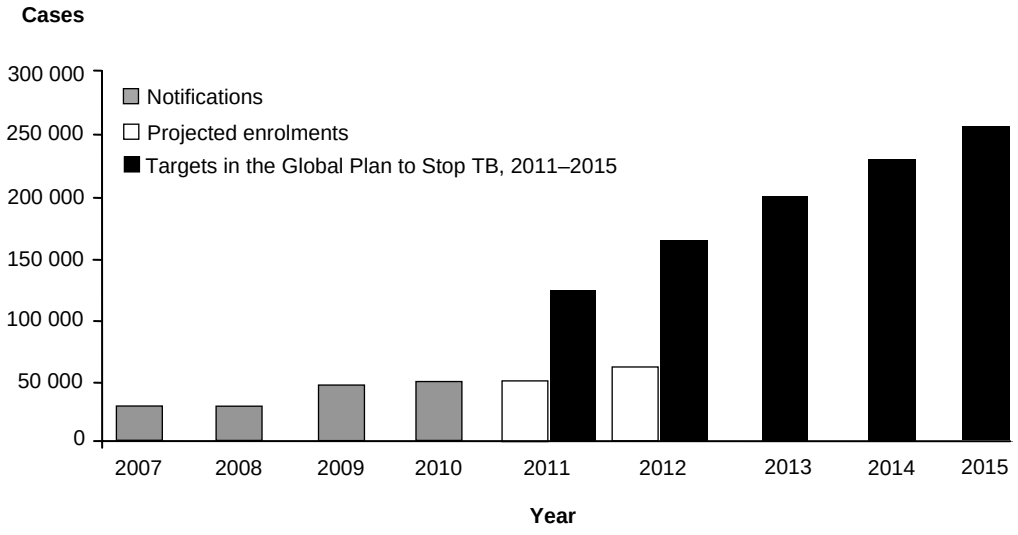
11. Earlier this year, a new global framework was launched in order to coordinate the support provided by WHO and partners to countries for expanding access to care for patients with multidrug-resistant tuberculosis. All countries are now eligible to procure quality-assured second-line antituberculosis 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.

12. 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.

13. Despite this progress, its current pace 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.

14. 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.



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

15. 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.

16. In 2010,[1] there were 317 534[2] reported cholera cases, including 7543 deaths, with a case-fatality rate of 2.38%, a 43% increase in cases when compared to 2009,[3] and an increase of 130% from 2000.[4,5] 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 October 2010.[5] 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.[5]

17. 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 Region. An innovative plan for community-led health education has been proposed for implementation in at least three high-risk countries (the locations have not yet been determined) before expansion to other high-risk areas.

18. 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.

19. A strategy for the establishment of a cholera vaccine stockpile was discussed by experts at a WHO consultation in Geneva in September 2011. A detailed plan of action for the next steps will be developed by a working group. The prequalification of a second vaccine by WHO in September 2011 was an important step towards improving the availability of cholera vaccines.

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

21. 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-

[1] Cholera, 2010; *Weekly Epidemiological Record*, 2011, **86**(31):325–340.

[2] All data considered in this report were reported to WHO through national disease surveillance systems.

[3] Cholera 2009; *Weekly Epidemiological Record*, 2010, **85**(31):293–308.

[4] Cholera 2000; *Weekly Epidemiological Record*, 2001, **76**:233–240.

[5] 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.

endemic areas. This will be raised at the 6th World Water Forum (Marseilles, 7–12 March 2012), where there will also be a session on cholera prevention and control in Africa.

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

22. 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%.

23. 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.

24. 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 case. 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.

25. 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.

26. 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.

27. 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.

28. 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)

29. 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.

30. 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.[1] 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.

31. 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,[2] 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.[3] The Regional Office for Africa is updating a regional strategy,[4] 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.[5]

32. 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

[1] http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2011/20110526_UBRAF%20Part%201_final.pdf (accessed 14 November 2011).

[2] See resolution SEA/RC64/R6.

[3] 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 (accessed 7 November 2011).

[4] Document AFR/RC56/8, HIV prevention in the African Region: a strategy for renewal and acceleration, cited in resolution AFR/RC56/R3.

[5] United Nations General Assembly resolution A/RES/65/277, http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf (accessed 7 November 2011).

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.[1] 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,[2] WHO jointly leads with UNICEF in the area of prevention of mother-to-child transmission of HIV and has been actively involved in the development of a global plan to eliminate HIV infections.[3] The "Treatment 2.0" initiative, led by WHO and UNAIDS, aims to optimize HIV treatment in order to achieve universal access by 2015.

33. The Secretariat continues to monitor the HIV pandemic and health sector response. In November 2011, WHO, UNAIDS and UNICEF jointly launched a global response to HIV/AIDS.[4] 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.

34. 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 to 48% in 2009.

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

35. 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.

36. In the 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

[1] 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.

[2] See document UNAIDS technical support division of labour: summary & rationale, Geneva, UNAIDS, 2005.

[3] 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 (accessed 7 November 2011).

[4] Global Response to HIV/AIDS: Epidemic update and progress towards Universal Access (in preparation).

partner organizations, and civil society. In addition, 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.

37. 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, 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.

38. In order to strengthen the global gonococcal antimicrobial surveillance programme, WHO has established a network of laboratories of excellence to monitor and advise on the global spread of multidrug-resistant *Neisseria gonorrhoeae*. The reference laboratories are in Australia, Canada, India, South Africa and Sweden. In addition, in order to combat antimicrobial resistance in *N. gonorrhoeae* at the global level, collaboration has been strengthened with: the Division of STD Prevention, Centers for Disease Control and Prevention (Atlanta, United States of America); the Health Protection Agency (London, United Kingdom of Great Britain and Northern Ireland); and the European Centre for Disease Prevention and Control.

39. In several regions, training was provided in order to enhance and scale up surveillance for sexually transmitted infections, including antimicrobial surveillance for gonococcal infections. 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 11 countries in the Region received comprehensive training in surveillance of sexually transmitted infections in Sri Lanka in October 2011.

40. Progress has been made towards 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 achieved 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, involving six countries in the African Region. In 2009, in the Region of the Americas 11 countries already satisfied the regional definition of elimination of congenital syphilis as a public health problem, with an incidence of below

0.5 cases per 1000 live births.[1] Twenty-two countries now have plans for elimination in place. A framework for the elimination of new paediatric HIV infections and congenital syphilis in Asia-Pacific, 2011–2015 was launched in September 2011.[2] The South-East Asia Region has identified indicators, a case definition and 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.

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[1] See PAHO, Latin American Center for Perinatology, UNICEF, World Bank. *Regional initiative for elimination of mother-to-child transmission of HIV and congenital syphilis in Latin America and the Caribbean: concept document.* Pan American Health Organization, Washington DC, PAHO, 2010 (http://new.paho.org/hq/dmdocuments/2010/Regional%20Initiative%20for%20Elimination%20Concept%20Document%20for%20the%20Caribbean.pdf, accessed 21 October 2011).

[2] 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 (http://www.unicef.org/eapro/PPTCT_CF_and_ME_guide_17Aug11.pdf, accessed 17 October 2011).