

## **Progress reports**

### **Report by the Secretariat**

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## Communicable diseases

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

1. In resolution WHA64.14, the Health Assembly endorsed the global health sector strategy on HIV/AIDS, 2011–2015 and requested the Director-General to report on its implementation.

2. Since the launch of the strategy, the number of new HIV infections in low- and middle-income countries has declined, falling from 2.7 million in 2010 to 2.3 million in 2012, with an overall decline of 33% recorded since 2001. Expanded coverage of services for the prevention of mother-to-child transmission of HIV resulted in a 36% drop in the number of new infections in children in 2012 compared with 2009. By the end of 2012, 9.7 million people in low- and middle-income countries were receiving antiretroviral therapy, 1.6 million more than at the end of 2011 – the fastest growth in access to antiretroviral therapy in any single year, making the target of 15 million people receiving the therapy by 2015 achievable. Access to antiretroviral therapy contributed to a decline in annual AIDS-related deaths from 1.8 million in 2010 to 1.6 million in 2012, with an estimated 5.2 million deaths averted between 1996 and 2012. Expanded access to antiretroviral therapy has also reduced the number of deaths from tuberculosis, with an estimated increase in lives saved from 50 000 in 2005 to 400 000 in 2011. However, expansion of services and their quality has been uneven across regions, countries and different population groups.

3. In June 2013, WHO launched its *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*,<sup>1</sup> which include new recommendations on: community-based HIV testing and counselling; earlier initiation of antiretroviral therapy; treatment of all children under five years and all pregnant and breastfeeding women; harmonization of antiretroviral regimens across different populations; use of simpler and safer regimens; improved patient monitoring and task shifting; decentralization; and service integration. The guidelines place emphasis on: improving the quality of interventions and services across the continuum of HIV care, including expanding HIV testing and counselling; linking people into care and treatment; maximizing adherence to antiretroviral treatment; retaining people in care; and preventing and managing major co-morbidities. WHO has conducted workshops in all regions to facilitate the rapid adoption and adaptation of the guidelines and is monitoring their impact on national policies and practices related to the use of antiretroviral medicines.

4. In order to be effective, the health-sector response to HIV should be focused on populations and settings with an increased risk of transmission, morbidity and mortality. Key populations at greatest risk, including people who inject drugs, sex workers, males who have sex with males, transgender women and prisoners, often do not have access to HIV services. For example, data gathered in 2011 from 21 countries in Europe indicate that 59% of people eligible for antiretroviral therapy acquired HIV through injecting drug use, yet injecting drug users represented only 21% of those receiving antiretroviral therapy. In 2014, WHO will consolidate the guidance on comprehensive HIV health services for these key populations in order to promote health equity and human rights. The Organization is also supporting efforts to reach other vulnerable populations, including through the preparation of two sets of guidelines on HIV services for adolescents and preventing gender-based

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<sup>1</sup> Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization; 2013 ([http://apps.who.int/iris/bitstream/10665/85321/1/9789241505727\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/85321/1/9789241505727_eng.pdf), accessed 25 October 2013).

violence. WHO has prequalified a male circumcision device in order to scale up voluntary male medical circumcision for prevention of HIV by reaching vulnerable men in high-prevalence settings.

5. The *Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*<sup>1</sup> advocates stronger links between programmes on HIV, maternal and child health and family planning. Under the plan, WHO has supported antiretroviral programmes for preventing mother-to-child transmission of HIV in 22 countries with a high prevalence, increasing coverage from 57% in 2011 to 63% in 2012. However, only 34% of children eligible for antiretroviral therapy in countries with the heaviest disease burden were receiving treatment in 2012 compared with 68% of eligible adults. Existing collaboration between tuberculosis and HIV programmes provides a model for an integrated approach, as described in the *WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders*.<sup>2</sup>

6. WHO is focusing its HIV programmes on emerging priorities, such as the prevention and management of co-morbidities. It has provided new guidance on hepatitis B and hepatitis C prevention and management, with emphasis placed on hepatitis and HIV coinfection. The prevalence of noncommunicable diseases among people living with HIV is increasing and there is a need for care services that are integrated and adapted to chronic conditions. In response to this, in 2014 WHO will assess the relative burden of noncommunicable diseases among people living with HIV and will decide on the clinical and programmatic guidance that is required for comprehensive care.

7. The Secretariat will continue to work with Member States and partners to monitor implementation of the global health sector strategy on HIV/AIDS, 2011–2015.

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

8. In response to the request in resolution WHA64.16 to report on progress annually, this report provides an update on the eradication of dracunculiasis.

9. Currently, 192 countries, territories and areas have been certified free of dracunculiasis transmission. As at 30 August 2013, 14 Member States remain to be certified: four countries in which the disease is endemic (Chad, Ethiopia, Mali and South Sudan), six countries in the pre-certification phase (Côte d'Ivoire, Ghana, Kenya, Niger, Nigeria and Sudan) and four countries that have not reported any recent history of the disease (Angola, Democratic Republic of the Congo, Somalia and South Africa). The ninth meeting of the International Commission for the Certification of Dracunculiasis Eradication is scheduled to be held on 3–5 December 2013. At the 17th Review Meeting of National Dracunculiasis Eradication Programmes, held in Ougadougou in April 2013, the progress made in 2012 was reviewed and plans for 2013 were drawn up. During the Sixty-sixth World Health Assembly, an informal meeting of health ministers of countries where dracunculiasis is endemic was held in order to strengthen commitment to eradication.

10. Between January and August 2013, the number of reported new cases of dracunculiasis fell by 77% to 115 cases compared with 499 reported during the same period in 2012. The cases occurred in 86 villages, whereas in 2012 the reported cases involved 263 villages. This was mainly due to an 80%

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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. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2011.

<sup>2</sup> WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders. Geneva: WHO; 2012 ([http://whqlibdoc.who.int/publications/2012/9789241503006\\_eng.pdf](http://whqlibdoc.who.int/publications/2012/9789241503006_eng.pdf), accessed 22 October 2013).

reduction in the number of new cases reported in South Sudan in the period January–August, which fell from 485 in 2012 to 96 in 2013. Indigenous transmission is now localized in a few zones in the countries concerned.

11. The outbreak in Chad continued into its fourth year with eight new cases being reported between January and August 2013, involving eight villages; seven of the cases were contained and more than 700 villages were kept under active surveillance with the assistance of The Carter Center. Worms that are morphologically indistinguishable from those found in humans have been discovered in dogs in the same at-risk area in the past year and specimens are undergoing epidemiological investigation. The Secretariat has been providing technical support to Chad in strengthening dracunculiasis surveillance and raising awareness on the reward beyond the villages under active surveillance. However, further support is needed for these activities and for case containment.

12. In Ethiopia, low intensity transmission continued in the Gambella region. Between January and August 2013, six new cases were reported in four villages compared with three cases in 2012. Four of the new cases were contained. Support is needed for strengthening surveillance and raising awareness of the reward scheme, especially along the border with South Sudan. The Secretariat is working to link dracunculiasis surveillance with ongoing large-scale interventions, such as mapping of neglected tropical diseases and community-based distribution of medicines. However, a determined and concerted response from local authorities is also needed to ensure that all rumours are investigated and new cases contained.

13. Mali is the only West African country where dracunculiasis transmission continues. Between January and August 2013, four new cases were reported in three villages in two districts. One case was contained. The same number of cases were reported in 2012. Since March 2012, security concerns in the north of the country have interrupted the national eradication programme, although United Nations humanitarian groups facilitated intermittent surveillance. A recent improvement in security has allowed surveillance to be strengthened. Surveillance has also been intensified in the Malian refugee camps in Burkina Faso, Mauritania and Niger in order to prevent further spread of the disease. As part of this effort, the Secretariat has provided technical and financial support for capacity building among health staff, and has been conducting a countrywide programme to create awareness among communities of the cash reward scheme in order to increase the sensitivity of the surveillance system. However, additional support is needed for reinstating or heightening surveillance as the security situation improves, and to advertise the reward scheme more widely.

14. South Sudan accounted for 83% of all dracunculiasis cases reported between January and August 2013. Seventy villages reported a total of 96 new cases, of which 68% were contained. There were 80% fewer cases than during the same period in 2012 when 485 cases were reported. WHO, UNICEF and The Carter Center are supporting the national programme to interrupt transmission and are providing technical support for strengthening dracunculiasis surveillance, including capacity building, strengthening of supervision, investigation of rumours of cases and health education and coordination. However, support is needed for further enhancing case containment and surveillance, including in areas bordering Sudan, and for strengthening surveillance through voluntary reporting of cases with the introduction of a reward scheme.

15. In June 2013, a case of dracunculiasis was reported during a poliomyelitis eradication campaign in the southern Darfur region of Sudan, bordering South Sudan. It was later laboratory confirmed as *Dracunculus medinensis*. The last indigenous case in Sudan was reported in 2002 and the last imported case in 2007. The Secretariat is providing technical and financial support to Sudan in strengthening dracunculiasis surveillance through the strengthening of integrated disease surveillance and response, using a house-to-house search approach during the vaccination campaign against

poliomyelitis and raising awareness in the community of the cash reward for the voluntary reporting of cases. However, additional support is needed for strengthening surveillance and raising awareness of the reward scheme, including in areas that are hard to access, such as those bordering South Sudan and Chad.

16. WHO-supported surveillance continued in areas that are dracunculiasis-free in the four remaining countries endemic for the disease and in the six pre-certification countries, and was supplemented by a reward scheme for voluntary reporting of information leading to confirmation of cases of dracunculiasis. In addition, the house-to-house surveys used during national immunization days and mass drug administration campaigns were employed in dracunculiasis case searches. Information sharing and cross-border surveillance by countries endemic for the disease and neighbouring countries that are dracunculiasis-free have been streamlined and intensified.

17. All countries in which the disease is endemic, and those in the pre-certification stage, submitted monthly reports to WHO. Among the 10 countries that are either endemic for the disease or in the pre-certification stage, 87% of districts reported monthly between January and August 2013. During the same period, a total of 2532 rumours were reported, of which 2105 (83%) were investigated within 24 hours of notification. Countries are encouraged to report on the degree to which individuals are aware of the reward offered for voluntary reporting.

18. Among countries in the post-certification stage, Benin, Burkina Faso, Cameroon, Central African Republic, Senegal, and Togo submitted quarterly reports in 2013. Countries in the post-certification stage should continue their surveillance through community-based and health surveillance systems and respond immediately to any suspected case or rumour.

## **Noncommunicable diseases**

### **C. CHILD INJURY PREVENTION (resolution WHA64.27)**

19. In resolution WHA64.27 the Health Assembly requested the Director-General, *inter alia*, to provide normative and technical support, to develop capacities among individuals and institutions relevant to child injury prevention and control, and to increase science-based policies and programmes for preventing and mitigating the consequences of child injury. It also requested the Director-General to establish a network to ensure effective coordination and implementation of activities for child injury prevention in low- and middle-income countries.

20. WHO has canvassed stakeholders for a child injury network through electronic means, followed by a consultation involving UNICEF, technical partners, nongovernmental organizations and academics. This consultation gave strong support to the desirability of such a network, and achieved consensus on three priorities for it: raising the visibility of child injury, providing a forum for technical exchange, and capacity building. Terms of reference have been finalized, and through a consultative process, strategic objectives are being identified for the network to achieve in its first two years.

21. Development of institutional and individual capacities has been a strategic focus of work. WHO has developed a number of training resources specific to child injury prevention, including an online training course on the subject within the TEACH-VIP E-Learning curriculum; a new series of lessons addressing child injury within TEACH-VIP 2, the latest iteration of a comprehensive training curriculum currently in use in over 100 countries; and a three-day short course on the prevention of child injury. Emergency care and rehabilitation services that are relevant for injured children also

receive attention in two additional VIP short courses; one addressing trauma care systems planning and management, and another addressing trauma care systems quality improvement.

22. The training resources mentioned above address knowledge transfer. WHO has additionally prioritized skill-building in the area of child injury prevention through MENTOR-VIP, a global mentoring programme coordinated by the Secretariat. This distance-mentoring programme has established mentorships which have addressed child injury-related programming, data collection, or research, in Nigeria, Pakistan, Philippines and United Republic of Tanzania.

23. Regional capacity-building workshops addressing child injury topics have been conducted so far in all regions except the Region of the Americas. The workshops have focused on improving the knowledge base of national injury focal persons, policy-makers, and personnel from relevant institutions and nongovernmental organizations.

24. Progress has been made on science-based programming and policies, for example with a small but important number of countries adopting child restraint laws. More countries need to do so and enforcement of those laws must be improved globally. The *Global status report on road safety 2013*<sup>1</sup> drew attention to this issue and provided guidance and support to Member States to adopt and enforce child restraint laws.

25. In terms of the integration of child injury prevention within broader child health programming, there has been collaboration to develop the strategic framework for child and adolescent injury prevention in the Eastern Mediterranean Region by staff from headquarters and the Regional Office. The framework aims to support the efforts of health ministries, in partnership with other key sectors, to prevent child and adolescent injuries and implement the recommendations of the *World report on child injury prevention*.<sup>2</sup>

26. Similarly, the Regional Office for the Western Pacific has integrated child injury prevention into a life course approach to primary health care delivery resources and is pilot testing this in the Lao People's Democratic Republic and the Philippines. In the South-East Asia Region, headquarters and regional personnel have been actively supporting the integration of child injury prevention within maternal and child health programming in Sri Lanka, drawing upon the successful experience of this in Thailand.

### **Promoting health through the life course**

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

27. As part of technical support to countries in implementing the reproductive health strategy, the Secretariat has collaborated with UNFPA on its global survey to review progress made in achieving the aims of the International Conference on Population and Development, and by participating in regional conferences at which the survey results were considered.

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<sup>1</sup> Global status report on road safety: supporting a decade of action. Geneva: World Health Organization; 2013.

<sup>2</sup> World report on child injury prevention. Geneva: World Health Organization; 2008.

28. The survey indicated that significant progress has been made. Most of the 176 countries that responded reported having implemented a range of regulations and strategies to strengthen sexual and reproductive health and people's related rights. These included: national strategies on reproductive, maternal and newborn health and family planning; inclusion of sexual and reproductive health in social programmes; early detection and primary prevention of cervical and breast cancer; prevention and control of HIV/AIDS and sexually-transmitted infections; prevention of unintended pregnancy and unsafe abortion; and improving young people's sexual and reproductive health.

29. However, countries reported that the following areas required further attention: access to comprehensive sexual and reproductive health services for adolescents and young people, vulnerable groups and persons with disabilities; integration of sexual and reproductive health and HIV/AIDS services; prevention and management of the consequences of unsafe abortion; maternal mortality; gender inequality; violence against women; cancers related to reproduction; and participation of men. The Secretariat continued to provide support to strengthen response to remaining gaps. For example, clinical and policy guidelines were issued on preventing early pregnancies; on responding to intimate partner violence and sexual violence against women; and on safe abortion.

30. Variable and uneven progress is also seen in reproductive health outcomes. This is the case for maternal mortality across the regions. Between 1990 and 2010, the annual decline in the global maternal mortality ratio was 3.1%. In the South-East Asia and Western Pacific regions, the estimated decline was 5.2%, whereas in the African and Eastern Mediterranean regions it was 2.7% and 2.6%, respectively. In 1990, about 43% of global maternal deaths occurred in southern Asia and 35% in sub-Saharan Africa; in 2010, the situation was reversed, with an estimated 29% of global maternal deaths occurring in southern Asia and 56% in sub-Saharan Africa.

31. Access to pregnancy and delivery care is crucial in reducing maternal deaths and improving maternal health. According to the latest available data, the proportion of deliveries attended by a skilled health professional has increased globally, rising from 61% in the 1990s<sup>1</sup> to 70% between 2005 and 2012.<sup>2</sup> Inequities can be linked to place of residence: the median value for the proportion of births attended by a skilled health professional is 61% in rural areas compared with 88% in urban areas.<sup>2</sup>

32. Reducing the unmet need for family planning and improving access to contraception can prevent up to one third of maternal deaths.<sup>3</sup> Contraceptive use increased globally from 55% in 1990 to over 60% in 2010.<sup>4</sup> Nevertheless, among women aged between 15 and 49 years (both married women and those living in a consensual union) some 146 million who wished to delay or stop childbearing did not have access to any form of family planning, and 222 million did not have access to modern contraceptives. Addressing family planning needs contributes to both women's empowerment and gender equality by enhancing opportunities for economic participation. Ensuring security of contraceptive commodities is among the key elements of the global strategy for dealing with unmet contraceptive needs. The Secretariat, among others, has actively supported implementation of the

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<sup>1</sup> World health statistics 2010. Geneva: World Health Organization; 2010.

<sup>2</sup> World health statistics 2013. Geneva: World Health Organization; 2013.

<sup>3</sup> Cleland J, Bernstein S, Ezeh A, Faundes A, Glasier A, Innis J. Family planning: the unfinished agenda. *The Lancet*. 2006;368:1810–1827.

<sup>4</sup> Alkema L, Kantorova V, Menozzi C, Biddlecom A. National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis. *The Lancet*. 2013;381:1642–1652.

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recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children.

33. Adolescents constitute a population group that is particularly vulnerable to adverse health and social consequences. The birth rate for adolescents remains high in sub-Saharan Africa (118 births per 1000 women between 15 and 19 years);<sup>1</sup> the same is true for Latin America and the Caribbean and for southern Asia (79 and 46 births per 1000 women between 15 and 19 years, respectively).<sup>1</sup> In order to sustain efforts to reduce high adolescent fertility, the Secretariat is actively supporting Member States in implementing its guidelines to prevent early pregnancy and poor reproductive outcomes.<sup>2</sup>

34. Improving adolescents' knowledge and understanding of sexual and reproductive health, including of HIV/AIDS, and building their life skills to enable them to manage their own health, are crucial steps in both meeting their health needs and fulfilling their rights. Currently, less than 40% of young men in developing regions are aware that condom use and either abstinence or having a single uninfected partner are effective ways of avoiding sexually-transmitted infections. The proportion of young men who reported using a condom at last high-risk sex varied between 37.2% in southern Asia and 76.2% in the Caucasus and central Asia. Sexuality education programmes were shown to be effective in reducing risky sexual behaviours.<sup>3</sup> The Secretariat has developed case studies of successful examples in scaling up sexuality education for enabling South–South exchange of these best practices.

35. In addition to specific activities mentioned above, at the London Summit on Family Planning, held in July 2012, the Secretariat expressed its commitment to the objectives of the Summit, namely: to strengthen the evidence base and norms for effective policy and programme actions in order to expand access to quality services. As part of this commitment, guidelines are being prepared for ensuring a human rights-based approach to family planning programmes, as contraceptive services are scaled up.

## **E. FEMALE GENITAL MUTILATION (resolution WHA61.16)**

36. In response to resolution WHA61.16, the Secretariat is working with Member States and international, regional and national partners to eliminate the practice of female genital mutilation. This report highlights the progress made since 2011.

37. Recent analyses suggest that the prevalence of female genital mutilation has declined,<sup>4</sup> particularly in the Central African Republic and Kenya among women between 15 and 49 years. However, work needs to be intensified in the many countries where prevalence rates remain high. The total number of girls and women who have undergone female genital mutilation in the African and

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<sup>1</sup> The Millennium Development Goals Report 2013. Statistical Annex. New York: United Nations; 2013.

<sup>2</sup> WHO guidelines on preventing early pregnancy and poor reproductive health outcomes among adolescents in developing countries. Geneva: World Health Organization; 2011.

<sup>3</sup> Wellings K, Collumbien M, Slaymaker E, Singh S, Hodges Z, Patel D, Bajos N. Sexual behaviour in context: a global perspective. *The Lancet* 2006;368:1706–1728.

<sup>4</sup> Female genital mutilation/cutting: a statistical overview and exploration of the dynamics of change. New York: United Nations Children's Fund; July 2013.

Eastern Mediterranean regions is estimated to be more than 125 million.<sup>1</sup> In the European Union, rates vary between countries.<sup>2</sup>

38. By September 2013, a total of 24 countries in the African and Eastern Mediterranean regions had made the practice a criminal offence.<sup>3</sup> Legislation criminalizing female genital mutilation was passed in Guinea-Bissau and Kenya in 2011, and in Somalia in 2012. In 2011, 141 cases were brought to court in Burkina Faso, Eritrea, Ethiopia, Kenya, Senegal, Sudan and Uganda.<sup>4</sup> Gambia and Mauritania have submitted draft legislation criminalizing the practice to their respective legislatures.

39. Since the last progress report in 2011, programmes initiated by Member States to tackle female genital mutilation include an initiative to protect newborn girls in Sudan, and inclusion of female genital mutilation in the national school curriculum in Senegal. The International Day of Zero Tolerance to Female Genital Mutilation, held annually on 6 February, provides an opportunity for countries to become actively involved in raising awareness about the practice.<sup>5</sup>

40. Since 2010, thousands of communities throughout Africa have publicly declared their decision to abandon female genital mutilation.<sup>4</sup> Community-sponsored alternative rites of passage designed to influence the abandonment of the practice have been introduced in Gambia, Kenya, Somalia, Uganda and United Republic of Tanzania. Support for ending female genital mutilation has also increased among religious leaders. In 2011, religious leaders from eight west African countries, Egypt and Sudan condemned the practice.<sup>4</sup> In 2012, some 4178 religious and traditional leaders in 15 African countries<sup>6</sup> publicly opposed female genital mutilation,<sup>7</sup> and 730 religious leaders in eight African countries<sup>8</sup> denounced any link between female genital mutilation and religion.<sup>7</sup>

41. In 2012, the joint UNFPA–UNICEF programme on female genital mutilation supported the training of 2690 health professionals in the management of complications arising from the practice.<sup>7</sup> In addition, the Council of the European Union adopted the EU Strategic Framework and Action Plan on Human Rights and Democracy, which covers female genital mutilation.

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<sup>1</sup> Female genital mutilation/cutting: a statistical overview and exploration of the dynamics of change. New York: United Nations Children's Fund; July 2013.

<sup>2</sup> Female genital mutilation in the European Union and Croatia. Report. Vilnius: European Institute for Gender Equality; 2013.

<sup>3</sup> Countries with laws and/or decrees against female genital mutilation/cutting where the practice is concentrated include Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mauritania, Nigeria, Niger, Senegal, Somalia, Sudan, Togo, Uganda, United Republic of Tanzania and Yemen. Cameroon, Gambia, Mali and Sierra Leone have no laws against female genital mutilation/cutting.

<sup>4</sup> UNFPA–UNICEF Joint Programme on Female Genital Mutilation/Cutting. Accelerating change. Annual report, 2011. New York: United Nations Children's Fund; 2012.

<sup>5</sup> The International Day is observed by the following countries: Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Senegal, Somalia, Sudan and Uganda.

<sup>6</sup> Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Senegal, Somalia, Sudan and Uganda.

<sup>7</sup> UNFPA–UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating change. Scaling up a comprehensive approach to abandonment in 15 African countries. Annual Report, 2012. New York: United Nations Children's Fund.

<sup>8</sup> Djibouti, Eritrea, Ethiopia, Gambia, Guinea-Bissau, Kenya, Mauritania and Senegal.

42. The Secretariat has continued to lead and support national and international efforts to eliminate female genital mutilation, particularly in the areas of policy dialogue, strengthening information systems to monitor progress, advocacy and research, including, in Ethiopia and Nigeria, research on the psychological consequences of female genital mutilation, and, in Sierra Leone, research on the relationship between fistula and female genital mutilation. The Secretariat has also reviewed different approaches for (i) bringing about the abandonment of the practice,<sup>1</sup> and (ii) ensuring its measurement,<sup>2</sup> and has synthesized the evidence. WHO, in collaboration with UNFPA and other partners, supported the establishment of the African Coordinating Centre for Abandonment of Female Genital Mutilation, hosted by the University of Nairobi.

43. The Secretariat is providing technical support to Sudan for the implementation of a multi-year initiative to tackle female genital mutilation in cooperation with the Government of the United Kingdom of Great Britain and Northern Ireland. In 2012, the Secretariat was also instrumental in the adoption by the United Nations General Assembly of a resolution to intensify global efforts to eliminate female genital mutilation.<sup>3</sup>

## **F. YOUTH AND HEALTH RISKS (resolution WHA64.28)**

44. The leading causes of death among people aged between 10 and 19 years are suicide, road injury, AIDS, diarrhoeal diseases and maternal conditions.<sup>4</sup> Survey results for 13–15 year olds<sup>5</sup> show that the prevalence of underage alcohol drinking and heavy episodic drinking are on the rise, with prevalence of alcohol use in the last 30 days reaching 60% in some countries. Overweight and obesity are increasing in low- and middle-income countries, particularly in urban settings, with obesity prevalence in 13–15 year olds reaching 30% in some settings. Prevalence of current cigarette smoking in 13–15 year olds is as high as 44%,<sup>6</sup> while 41% of people in this age group are regularly exposed to second-hand smoke.<sup>7</sup> There is also reportedly a high exposure to bullying, with up to 70% in some settings that can be associated with psychiatric morbidity in adulthood. Worldwide, two risk factors drive morbidity among adolescent girls: unsafe sex, leading to sexually transmitted infections including HIV, and lack of contraception, leading to high-risk pregnancy. The consequences of early marriage and the needs of adolescents living with HIV are also now being recognized.

45. These issues are reflected in the health policies of many Member States, with the majority addressing principally reproductive health and HIV/AIDS.<sup>8</sup> Globally, 169 countries have implemented

<sup>1</sup> Johansen REB, Nafissatou JD, Laverack G, Leye L. What works and what does not: a discussion of popular approaches for the abandonment of female genital mutilation. *Obstet Gynecol Int.* 2013; 2013:348248.

<sup>2</sup> Yoder PS, Wang S, Johansen E. Estimates of female genital mutilation/cutting in 27 African countries and Yemen. *Stud Fam Plann.* 2013; 44(2):189–204.

<sup>3</sup> United Nations General Assembly resolution 67/146.

<sup>4</sup> Global Health Observatory (GHO) [website]. Geneva: World Health Organization; 2013 ([www.who.int/gho](http://www.who.int/gho), accessed 21 October 2013).

<sup>5</sup> Global school-based student health survey (GSHS) [website]. Geneva: World Health Organization; 2013 (<http://www.who.int/chp/gshs/en/>, accessed 21 October 2013).

<sup>6</sup> Global Youth Tobacco Survey (GYTS) – Country Reports. Geneva: World Health Organization; 2013 ([http://www.who.int/tobacco/surveillance/country\\_reports/en/](http://www.who.int/tobacco/surveillance/country_reports/en/), accessed 21 October 2013).

<sup>7</sup> Global estimate of the burden of disease from second-hand smoke. Geneva: World Health Organization; 2011.

<sup>8</sup> Some 84% of national health policy documents contained in the WHO Country Planning Cycle Database contain a reference to adolescents ([http://www.who.int/nationalpolicies/resources/resources\\_database/en/](http://www.who.int/nationalpolicies/resources/resources_database/en/), accessed 21 October 2013).

at least one of the tobacco demand-reduction measures. Data regarding national tobacco policies indicate that worldwide, 16% of adolescents are protected by comprehensive smoke-free laws, and 10% are protected by bans on advertising, promotion and sponsorship.<sup>1</sup> The majority of countries in the European Region have partially or fully implemented policies restricting the marketing of food and beverages to children and adolescents.<sup>2</sup> Setting lower blood alcohol concentration limits (of  $\leq 0.02\text{g/dl}$ ) is an effective means of reducing crashes related to drink-driving among this group, and is a policy that has been applied to date in 42 countries (23%).<sup>3</sup> The vaccination of adolescents against tetanus, meningococcus, rubella and measles varies among countries; the introduction of the human papilloma virus vaccine has increased awareness of the need for adolescent immunization.

46. The importance of early intervention in the prevention of suicide among young people was highlighted in the comprehensive mental health action plan 2013–2020, which was adopted by the Sixty-sixth World Health Assembly, as was the global monitoring framework for the prevention and control of noncommunicable diseases. The framework includes specific indicators on adolescent alcohol and tobacco use, physical activity, overweight and obesity. Technical guidance has been developed, in collaboration with United Nations partners, civil society and young people. For example, WHO has produced guidance on: preventing early pregnancy and poor reproductive outcomes among adolescents; HIV testing and counselling, and care for adolescents living with HIV; and the management of conditions specifically related to stress, including several recommendations on adolescents. The implementation of existing strategies as they apply to young people will be addressed in global reports on alcohol, suicide, violence prevention, and in a report entitled *Health for the world's adolescents*, all to be published by WHO in 2014.

47. Current mechanisms for the coordination of activities related to the health of young people across the Organization are inadequate. A shortage of both financial and human resources has had a particularly negative impact on the provision of systematic support to countries in the implementation of existing strategies. The Regional Office for Africa has addressed this issue by recently recruiting an adviser on adolescent health, who can support countries. References to the health of young people appear in several categories of the Programme budget 2014–2015 (which also contains an indicator on adolescent birth rates), which was approved at the Sixty-sixth World Health Assembly.

## **G. IMPLEMENTATION OF THE RECOMMENDATIONS OF THE UNITED NATIONS COMMISSION ON LIFE-SAVING COMMODITIES FOR WOMEN AND CHILDREN (resolution WHA66.7)**

48. In response to resolution WHA66.7, the report summarizes the progress made in following up the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children. It describes the work that WHO – in collaboration with other organizations in the United Nations system, national, regional and international regulators and other partners – is undertaking in order to ensure that vulnerable women and children have access to safe, high-quality commodities.

49. In close coordination with UNICEF and UNFPA, WHO continued to support the preparation of evidence-based, needs-driven plans in the area of reproductive, maternal, newborn and child health in

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<sup>1</sup> WHO report on the global tobacco epidemic, 2013. Geneva: World Health Organization; 2013.

<sup>2</sup> Marketing of foods high in fat, salt and sugar to children: update 2012–2013. Copenhagen: WHO Regional Office for Europe; 2013.

<sup>3</sup> Global status report on road safety 2013. Geneva: World Health Organization; 2013.

order to support implementation of the recommendations of the Commission in eight pathfinder countries.<sup>1</sup> The results of this work include the development by Nigeria of, among other things, a comprehensive framework for providing access to life-saving commodities that establishes amoxicillin as the unambiguous first-line treatment for pneumonia; includes the use of all relevant neonatal commodities in the Task Shifting Policy; updates Federal and State Essential Medicines Lists; and develops harmonized training programmes.

50. Activities to improve access to life-saving commodities involve the provision of policy, regulatory and technical support. The WHO Model List of Essential Medicines was updated and includes (i) clarifications on the use of chlorhexidine and (ii) a listing of antenatal corticosteroids. Treatment guidelines on newborn care were updated to support health care workers in ensuring safe and effective treatments using the life-saving commodities and a guideline compendium was prepared to improve access to critical information. Country support strategies are in place to adapt this information and support evidence-based reviews of national policies in Member States.

51. In June, the Secretariat organized country collaboration processes in order to develop specifications for paediatric products and medical devices, and define the relevant quality-control and regulatory pathway. Where approvals from stringent regulatory systems were not available, Expert Review Panels convened to ensure quality and facilitate rapid procurement for key reproductive health commodities. Surveys are in process to establish the regulatory and quality status of targeted commodities. Products on local markets were sampled in order to provide a focus for technical assistance, market-shaping efforts and risk-based approaches. Technical support was provided to manufacturers producing zinc, oral rehydration salts and amoxicillin to help them secure the approval of stringent regulators.

52. At the global level, WHO has played an active role in the formation and continued shaping of a steering committee on reproductive, maternal, newborn and child health.<sup>2</sup> The steering committee is an informal group whose aim is to align and harmonize global financing streams for reproductive, maternal, newborn and child health in order to provide a better response to the demands of countries and plug existing gaps, including by leveraging complementary funding streams for “one country plan”, and by ensuring that global initiatives are tailored to fit country plans. To that end, a time-limited task team is reviewing country engagement processes for leveraging funding streams, such as the Health Results Innovation Trust Fund, the H4+ initiative and the newly established RMNCH Trust Fund.

53. In support of the recommendations of the United Nations Commission on Information and Accountability for Women’s and Children’s Health, WHO and its partners are also working to better streamline the measurement of results and accountability for the various initiatives under the United Nations Secretary-General’s Global Strategy for Women’s and Children’s Health, using the seven principles of the International Health Partnership and related initiatives (IHP+). As part of its support

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<sup>1</sup> Democratic Republic of the Congo, Ethiopia, Malawi, Nigeria, Senegal, Sierra Leone, Uganda and United Republic of Tanzania.

<sup>2</sup> The steering committee members are representatives of the donor and recipient countries Canada, Ethiopia, France, Nigeria, Norway, Senegal, Sweden, United Republic of Tanzania, and of the United Nations Executive Office of the Secretary-General, UNICEF, UNFPA, the World Bank, the Office of the United Nations Secretary-General’s Special Envoy for Financing the Health Millennium Development Goals and for Malaria, the United Nations Foundation, the Partnership for Maternal and Child Health, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance, the Bill & Melinda Gates Foundation, the United States Agency for International Development and the Clinton Health Access Initiative.

to the independent Expert Review Group, WHO submits information on progress towards the recommendations of the United Nations Commission on Life-Saving Commodities.

## **H. CLIMATE CHANGE AND HEALTH (resolutions EB124R.5 and WHA61.19)**

54. The report complies with the request by the Executive Board in resolution EB124.R5 for an annual report on the progress made in implementing resolution WHA61.19 and the WHO work plan on climate change and health.

55. The Secretariat has focused its awareness-raising efforts on making health systems more resilient; on safeguarding the environmental determinants of health, such as water and sanitation services; and on reducing the disease burden resulting from air pollution, while simultaneously cutting greenhouse gas emissions. Occasions used for drawing attention to the link between the different elements have included: regional health and environment ministerial meetings and their preparatory sessions; ministerial-level events such as (i) the meeting on health, air pollution and climate change, held during the Sixty-sixth World Health Assembly, and (ii) the meeting on improving health resilience to climate change organized at the nineteenth session of the Conference of the Parties to the United Nations Framework Convention on Climate Change, for which WHO offered training and sponsored health representatives to participate in the negotiations. The Secretariat also collaborated in the organization of a summit of nongovernmental organizations working on health and climate change.<sup>1</sup>

56. WHO has continued to lead the health component of the United Nations' response to climate change through the negotiating process of the United Nations Framework Convention on Climate Change, regional coordination mechanisms, and as the lead agency for health in United Nations country teams. Its main partners include the United Nations Framework Convention on Climate Change secretariat, UNDP, WMO and UNEP, regional and subregional agencies and bodies (for example, the United Nations Economic and Social Commission for Western Asia, the League of Arab States and the European Union), bilateral development agencies and WHO collaborating centres. The partnerships support a range of programme areas, including the application of information on climate change in health-related activities with WMO, the designing of training materials with the United Nations Institute for Training and Research, and the implementation of country projects with UNDP. WHO has also joined the Climate and Clean Air Coalition to Reduce Short-Lived Climate Pollutants.

57. The Secretariat contributed to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change and has represented the health sector in the work programme on loss and damage established by the United Nations Framework Convention on Climate Change, as well as in the UNFCCC Nairobi Work Programme on Impacts, Vulnerability and Adaptation to Climate Change. The Secretariat has also published guidance on assessing economic damage and adaptation costs,<sup>2</sup> and on mainstreaming gender in health adaptation programmes,<sup>3</sup> together with a review of the effect of

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<sup>1</sup> <http://www.climateandhealthalliance.org/summit/climate-and-health-summit>, accessed on 13 November 2013.

<sup>2</sup> Climate change and health: a tool to estimate health and adaptation costs. Copenhagen: WHO Regional Office for Europe; 2013.

<sup>3</sup> Mainstreaming gender in health adaptation to climate change programmes: user's guide: discussion draft. Geneva: World Health Organization; 2012.

floods on health and prevention measures in the European Region.<sup>1</sup> A new WHO initiative aims to identify research priorities in line with paragraph 2 of resolution WHA61.19. It has also updated estimates of the burden of disease attributable to air pollution; reviewed the link between household energy, health and climate change; and devised health impact assessment methods for estimating the health benefits of reduced air pollution associated with more sustainable transport.

58. The Secretariat has monitored and supported implementation of resolution WHA61.19 and of associated regional frameworks for action through the provision of technical guidance on developing the health component of national adaptation plans, and through workshops including countries throughout the regions (all 58 Member States in the African and South-East Asia regions, 32 in the Region of the Americas, 12 in the European Region, 8 in the Eastern Mediterranean Region and 14 in the Western Pacific Region). New training materials, including for specific focal areas, for example, climate change, water resources and health, are also being made available.

59. With the support of the Governments of Germany, Norway, the Republic of Korea and the United Kingdom of Great Britain and Northern Ireland, together with the Global Environment Facility and the Millennium Development Goals Achievement Fund, the Secretariat has coordinated large-scale pilot projects on health adaptation to climate change in Albania, Bangladesh, Barbados, Bhutan, Cambodia, China, Ethiopia, Fiji, Jordan, Kazakhstan, Kenya, Kyrgyzstan, Malawi, Mongolia, Nepal, Papua New Guinea, Philippines, the Russian Federation, Tajikistan, the United Republic of Tanzania, the former Yugoslav Republic of Macedonia and Uzbekistan.

## Health systems

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

60. The global strategy and plan of action on public health, innovation and intellectual property was adopted by the Health Assembly in resolutions WHA61.21 and WHA62.16. The global strategy and plan of action comprises eight elements that are designed, inter alia, to promote and prioritize research and development, build innovation capacity, promote transfer of technology and manage intellectual property so as to meet the research and development needs of developing countries, with particular regard to the diseases disproportionately affecting those countries.

61. Implementation of the global strategy, in particular element 1 (Prioritizing research and development needs) and element 2 (Promoting research and development), is harmonized with implementation of the WHO strategy on research for health. WHO regional offices have been involved in the mapping of research efforts and in supporting the identification of public health priorities. *The world health report 2013* focused on the importance of research in achieving universal health coverage.<sup>2</sup>

62. The UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases plays a key role in the implementation of the global strategy. Among the activities carried out by the Special Programme to promote research and development for the most-needed

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<sup>1</sup> Floods in the WHO European Region: health effects and their prevention. Copenhagen: WHO Regional Office for Europe; 2013.

<sup>2</sup> The world health report 2013: research for universal health coverage. Geneva: World Health Organization; 2013.

medical products and technologies in developing countries are: the establishment of a consortium to prepare new guidelines on predicting, detecting and managing outbreaks of dengue; finalization of preparations for new research on the impact of climate change on vector-borne diseases in Africa; and publication of the *Global report for research on infectious diseases of poverty 2012*,<sup>1</sup> undertaken with the Council on Health Research for Development/Global Forum for Health Research and Policy Cures.

63. By expanding the number of countries participating in the International Clinical Trials Registry Platform, WHO continues to ensure that all those involved in health-care decision-making have a complete view of the research in order to improve transparency and strengthen the validity and value of the scientific evidence base.

64. In the context of element 3 of the global strategy (Building and improving innovative capacity) and element 4 (Transfer of technology), WHO is leading a project funded by the European Union to broaden access to medical products in developing countries by building capacity for local production and related technology transfer.

65. The Secretariat has identified biotherapeutics as an area where technology transfer and local production can have an impact on price and access. In order to facilitate such activities, it is establishing a technology transfer hub in the Netherlands. In addition, technology transfer for the local production of anti-rabies monoclonal antibodies continues. Of the three developing country institutes that received technology transfers, one has completed early clinical evaluations; and of the 14 manufacturers involved in the ongoing project on technology transfer for manufacturing pandemic influenza vaccines in developing countries, five have now registered locally produced influenza vaccines, adding 300 million pandemic influenza vaccine doses to the global capacity.

66. As part of the process of implementing element 5 of the global strategy (Application and management of intellectual property to contribute to innovation and promote public health), WHO, WIPO and WTO published a study, *Promoting access to medical technologies and innovation: intersections between public health, intellectual property and trade*,<sup>2</sup> for policy-makers, legislators, government officials, international organizations, nongovernmental organizations and researchers. In collaboration with WHO, WIPO conducted a patent landscape survey of selected vaccines<sup>3</sup> in order to identify where research is being conducted into those vaccines and where intellectual property may create barriers to the production of new vaccines.<sup>4</sup>

67. WHO, in collaboration with the Government of Brazil, UNAIDS, UNITAID, WIPO, WTO, and the nongovernmental organization, the Medicines Patent Pool, organized a consultation on access to HIV medicines in middle-income countries with a focus on broadening access to antiretroviral treatment (Brasília, 10–12 June 2013).

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<sup>1</sup> Global report for research on infectious diseases of poverty 2012. Geneva: World Health Organization; 2012.

<sup>2</sup> World Health Organization, World Intellectual Property Organization and World Trade Organization. Promoting access to medical technologies and innovation: intersections between public health, intellectual property and trade. Geneva: World Health Organization; 2012.

<sup>3</sup> Human pneumococcal conjugate vaccines, human conjugate typhoid vaccines and human influenza vaccines.

<sup>4</sup> Patent landscape report on vaccines for selected infectious diseases. Geneva: World Intellectual Property Organization; 2012.

68. In response to element 6 of the global strategy (Improving delivery and access), which calls for the WHO prequalification programme to be strengthened, WHO has streamlined the prequalification of diagnostics, medicines and vaccines into a single unit located within its Department of Essential Medicines and Health Products. As at 30 June 2013, WHO had prequalified 347 medicinal products (of which 38 since 2012: 19 products for treating HIV/AIDS; 14 anti-tuberculosis products; and three antimalarial and two reproductive health medicines), 48 active pharmaceutical ingredients, 129 vaccines, 25 diagnostic products (including an adult male circumcision device and a test for early diagnosis of HIV in infants) and 27 medicine quality-control laboratories covering all WHO regions (five since 2012).

69. The Secretariat's work on strengthening regulatory authority capacity has focused on:

- developing a consolidated tool for all products (including diagnostics and devices), with finalization expected in 2014;
- assessing pharmacovigilance and post-marketing activities in the field of pharmaceuticals in sub-Saharan countries; and
- preparing national institutional development plans in order to strengthen national regulatory authorities, national control laboratories and pharmacovigilance centres engaged in vaccine regulation.

The Secretariat focused its attention on providing support to Brazil, China, Russian Federation, India and South Africa for carrying out assessments, follow-up activities and training. Thirty-five out of 44 producer countries continued their operations; it is estimated that 97% of the global vaccine supply is currently of assured quality.

70. The next report of the Alliance for Health Policy and Systems Research, produced in collaboration with the Department of Essential Medicines and Health Products for issue in 2014, will focus on access to medicines and their affordability and appropriate use. The report will contain information on innovative interventions, including provision of medicines as part of universal health coverage and interventions in private markets or within patient communities.

71. In the context of element 7 (Promoting sustainable financing mechanisms), the Secretariat facilitated the work of the Consultative Expert Working Group on Research and Development: Financing and Coordination in preparing its report for submission to the Sixty-fifth World Health Assembly in 2012.<sup>1</sup> Following a series of national, regional and global consultations on the conclusions of the report, the Sixty-sixth World Health Assembly adopted resolution WHA66.22, endorsing the strategic work plan contained therein. The Secretariat is continuing to perform the actions requested under paragraph 4 of the resolution.

72. In response to element 8 (Establishing monitoring and reporting systems), the Secretariat, through Organization-wide collaboration that includes the Regional Office for the Americas, is developing the Global Platform on Innovation and Access, an online portal for monitoring the progress made by Member States and other stakeholders in implementing the global strategy. The platform comprises an information hub, a knowledge repository and a virtual forum on innovation. WHO plans to launch the information hub before the end of April 2014.

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<sup>1</sup> Documents A65/24 and A65/24 Corr.1.

73. In July 2013, in response to the conclusions of the Consultative Expert Working Group, as well as the adoption of resolution SEA/RC65/R3 at the Sixty-fifth session of the Regional Committee for South-East Asia in 2012 and resolution WHA66.22 at the Sixty-sixth World Health Assembly in 2013, the Regional Office for South-East Asia organized a regional consultation in order to draw up a regional strategic work plan. The consultation examined norms and standards for classification of health research and development; suggested a classification grid that could serve as a model for the proposed health research and development observatory; and identified specific demonstration projects.

74. The Regional Platform on Access and Innovation for Health Technologies (PRAIS) is a cornerstone of PAHO's technical collaboration strategy for implementing the global strategy. Although the Platform has only been operational since May 2012, it is increasingly recognized as the channel for information exchange, collaborative work and validated information for decision-making related to health technologies in the Region of the Americas. Additionally, PAHO is conducting a formal consultation and selection process for demonstration projects in line with the recommendations contained in the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination.<sup>1</sup>

75. The European Advisory Committee on Health Research continued to meet and to follow a dedicated work plan for advising the Regional Director on health research matters. The Regional Office for Europe held a web-based consultation on health research and development demonstration projects in line with the requests made in resolution WHA66.22 and decision WHA66(12) in the follow-up of the report of the Consultative Expert Working Group, the results of which have been transmitted to WHO headquarters for the global technical consultative meeting to be held in December 2013.

## **J. AVAILABILITY, SAFETY AND QUALITY OF BLOOD PRODUCTS (resolution WHA63.12)**

76. In response to resolution WHA63.12, the Member States and the Secretariat have undertaken numerous initiatives during the period 2010–2013.

77. **Self-sufficiency based on voluntary non-remunerated donation.** The number and proportion of voluntary non-remunerated blood donations reported to the WHO Global Database on Blood Safety have increased each year; in 2011, 71 countries reported that more than 90% of their blood supply was derived from voluntary non-remunerated blood donations compared with 66 in 2008. A *WHO expert consensus statement* was issued,<sup>2</sup> providing the global definition, strategies and mechanisms for achieving self-sufficiency in blood and blood products based on voluntary non-remunerated blood donation. In 2013, the WHO Global Forum for Blood Safety identified the priority needs for achieving self-sufficiency and strengthening blood systems and WHO published a report, *Towards self-sufficiency in safe blood and blood products based on voluntary non-remunerated donation: global status 2013*.<sup>3</sup> In October 2013, in collaboration with the Government of Italy and the Government of Japan, WHO convened a high-level policy-makers' forum at which the Rome

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<sup>1</sup> Document A65/24, Annex.

<sup>2</sup> Expert consensus statement on achieving self-sufficiency in safe blood and blood products based on voluntary non-remunerated donation ([http://www.who.int/entity/bloodsafety/Expert\\_Consensus\\_Statement\\_Self-Sufficiency.pdf](http://www.who.int/entity/bloodsafety/Expert_Consensus_Statement_Self-Sufficiency.pdf), accessed 25 November 2013).

<sup>3</sup> Towards self-sufficiency in safe blood and blood products based on voluntary non-remunerated donation: global status 2013. Geneva: World Health Organization; 2013 ([http://www.who.int/entity/bloodsafety/transfusion\\_services/WHO\\_GlobalStatusReportSelf-SufficiencyinBloodBloodProducts.pdf](http://www.who.int/entity/bloodsafety/transfusion_services/WHO_GlobalStatusReportSelf-SufficiencyinBloodBloodProducts.pdf), accessed 25 November 2013).

Declaration on Achieving Self-sufficiency in Safe Blood and Blood Products based on Voluntary Non-Remunerated Donation was adopted. World Blood Donor Day continues to be celebrated in a growing number of countries, providing a focus for campaigns on donating blood. WHO, jointly with the International Federation of Red Cross and Red Crescent Societies provided global guidance in its publication in different languages, *Towards 100% voluntary blood donation: a global framework for action*.<sup>1</sup> It also published guidelines on blood donor selection (2012)<sup>2</sup> and donor counselling (2013)<sup>3</sup> and prepared training materials for blood donor management.

78. **Blood supply systems.** Resolution WHA63.12 paved the way for major blood system reforms by strengthening leadership and management in many countries. In addition to publishing recommendations on screening donated blood for transfusion-transmissible infections,<sup>4</sup> policy guidance in an aide-memoire on developing a national blood system,<sup>5</sup> the Secretariat has provided technical support for strengthening systems and human resource capacity in several countries, including Bangladesh, Bhutan, Burkina Faso, Cambodia, Ethiopia, Haiti, Lao People's Democratic Republic, Mali, Nepal, Pakistan, Papua New Guinea, South Sudan and Uganda through regional and national workshops on leadership and management, voluntary non-remunerated blood donation, donor selection, quality-assured blood screening, management of blood safety data and the blood cold chain.

79. **Quality systems and haemovigilance.** WHO tools and training materials for enhancing the quality of blood transfusion services management have been used in the development of national standards and quality systems in many countries including Bangladesh, Bhutan, Cambodia, China, Kazakhstan, Kyrgyzstan, Nepal, Pakistan, Papua New Guinea, South Sudan, Tajikistan and Viet Nam. According to the data, 71 countries reported having national haemovigilance systems in 2011, compared with 57 in 2008. In November 2012, WHO organized a global consultation on haemovigilance in collaboration with the Government of United Arab Emirates and key international partners, including the International Haemovigilance Network and the International Society of Blood Transfusion, with the aim of providing guidance on establishing national haemovigilance systems.

80. **Safe and rational use of blood and blood products and patient blood management.** In 2011, 109 countries reported having national transfusion guidelines, compared with 90 in 2008; 52 countries reported that more than 50% of their hospitals had transfusion committees, compared with 28. WHO has issued policy guidance in an aide-memoire on clinical transfusion process and patient safety,<sup>6</sup> has convened a global forum on patient blood management; has provided technical support to countries including Bangladesh, Nepal and Uganda through capacity building, training materials and tools for

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<sup>1</sup> *Towards 100% voluntary blood donation: a global framework for action*. Geneva: World Health Organization; 2010.

<sup>2</sup> *Blood donor selection: guidelines on assessing donor suitability for blood donation*. Geneva: World Health Organization; 2012.

<sup>3</sup> *Blood donor counselling: implementation guidelines*. Geneva: World Health Organization; 2013. ([http://www.who.int/entity/bloodsafety/voluntary\\_donation/Blooddonorcounselling.pdf](http://www.who.int/entity/bloodsafety/voluntary_donation/Blooddonorcounselling.pdf), accessed 25 November 2013).

<sup>4</sup> *Screening donated blood for transfusion transmissible infections: recommendations*. Geneva: World Health Organization; 2010. ([http://www.who.int/bloodsafety/publications/bts\\_screendondbloodtransf/en/index.html](http://www.who.int/bloodsafety/publications/bts_screendondbloodtransf/en/index.html), accessed 25 November 2013).

<sup>5</sup> WHO aide-mémoire for ministries of health: developing a national blood system. Geneva: World Health Organization; 2011 (document WHO/EHT/11.01, available online at [http://www.who.int/entity/bloodsafety/publications/am\\_developing\\_a\\_national\\_blood\\_system.pdf](http://www.who.int/entity/bloodsafety/publications/am_developing_a_national_blood_system.pdf), accessed 25 November 2013).

<sup>6</sup> WHO aide-mémoire for national health authorities and hospital management: clinical transfusion process and patient safety. Geneva: World Health Organization; 2010 (document WHO/EHT/10.05, available online at [http://www.who.int/bloodsafety/clinical\\_use/en/](http://www.who.int/bloodsafety/clinical_use/en/), accessed 25 November 2013).

safe transfusion practice and patient safety; and has organized several multicountry consultations and workshops on appropriate use of blood, safe transfusion practices and patient safety (including an interregional consultation on strengthening the role of nurses and midwives in ensuring safe clinical transfusion and patient safety for 20 countries, and a subregional workshop on safe and appropriate use of blood and patient safety for Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan).

81. **National blood regulatory systems.** The Secretariat has focused its support on the development of legal regulatory frameworks, including enforcement and implementation of good manufacturing practices in blood establishments, and regulation of blood safety-related in vitro diagnostic devices. In that context, it published guidelines on good manufacturing practices for blood establishments<sup>1</sup> and organized regional workshops bringing together national regulatory authorities and national blood services. The Organization also published a document on assessment criteria for national blood regulatory systems that represents the collective view of the WHO Blood Regulators Network and the WHO Expert Committee on Biological Standardization.<sup>2</sup> WHO is working with the Africa Society for Blood Transfusion and regulatory authorities and national blood services in Africa, Asia and Latin America in order to ensure implementation of blood regulatory systems and to enhance local production of quality plasma from whole blood donations in low- and middle-income countries. In October 2013, WHO published the addition of blood and blood components (red cells, platelets and fresh frozen plasma) as essential medicines on the Essential Medicines List. This action should contribute to improving blood availability, safety and quality by encouraging Member States to make the necessary investment for building and sustaining quality assurance systems in blood establishments.

82. **WHO international biological reference preparations.** Since the adoption of resolution WHA63.12 in 2010, 34 WHO biological reference preparations have been produced in order to reinforce quality control in the areas of blood products and blood safety-related in vitro diagnostic devices. Regulators define requirements on the basis of the WHO biological reference preparations. The Organization has been working to establish reference panels to assess the level of efficiency of hepatitis and HIV diagnostic kits in terms of the different genotypes and subtypes prevalent in different regions. WHO reference standards for blood products and related in vitro diagnostic devices are promoted through the Organization's online catalogue,<sup>3</sup> as well as through workshops and international professional organizations. The workshops and technical seminars involved countries from all regions and have proved useful in promoting WHO standards and in eliciting feedback from countries on their value.

83. Major challenges remain for many low- and middle-income countries in strengthening their national blood systems to ensure the safety of blood and blood products, as well as in implementing policies to enhance self-sufficiency and timely accessibility to blood and blood products in order to meet patients' needs. In future, WHO will focus on meeting the challenge of supporting national blood systems in low- and middle-income countries to be self-sufficient in safe blood and blood products.

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<sup>1</sup> WHO guidelines on good manufacturing practices for blood establishments. Technical Report Series, No. 961, Annex 4. Geneva: World Health Organization; 2011.

<sup>2</sup> Assessment criteria for national blood regulatory systems. WHO Technical Report Series, No. 979, Annex 7. Geneva: World Health Organization, 2012. Geneva: World Health Organization, 2012.

<sup>3</sup> Available at <http://www.who.int/bloodproducts/catalogue/en/> (accessed on 30 November 2013).

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**K. HUMAN ORGAN AND TISSUE TRANSPLANTATION (resolution WHA63.22)**

84. In resolution WHA63.22 the Health Assembly endorsed the WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation. Since then, the Principles have influenced the creation or modification of the laws, legislation and regulations of some 40 countries, enabling them in particular to combat commercial transplantation more effectively and to simplify the development of donation after death.

85. During the Third WHO Global Consultation on Organ Donation and Transplantation (Madrid, 23–25 March 2010) discussions on the theme, “Striving to Achieve Self-Sufficiency”, led to the self-sufficiency paradigm, namely: meeting the needs of patients from a given population with an adequate provision of transplantation services and supply of organs from that population. With government support and oversight, the paradigm underwrites: (i) equity in donation from possible donors and equity in allocation; (ii) education about donation but also about prevention of diseases that create a need for transplantation; and (iii) transparency and professionalism. Striving towards self-sufficiency requires comprehensive management of chronic kidney disease, from prevention to renal replacement. Likewise, the national organ donation and transplantation service must provide the opportunity to donate organs after death in as many circumstances as possible.

86. The Secretariat has increased its collaboration with national health authorities and encouraged scientific and professional societies to take up roles in the global governance of donation and transplantation. Scientific and professional societies contribute to the global good by:

(i) harmonizing practices, including through accreditation schemes (e.g. the Worldwide Network for Blood and Marrow Transplantation);

(ii) combatting unethical practices, in particular commercialism, organ trafficking and transplant tourism (e.g. the Declaration of Istanbul on Organ Trafficking and Transplant Tourism, which was drafted on the initiative of The Transplantation Society and the International Society of Nephrology);

(iii) fostering access to relevant transplantation (The Transplantation Society, the Worldwide Network for Blood and Marrow Transplantation); and

(iv) developing and maintaining globally applied terminology and coding systems for transplants that are consistent with the global information standard for blood and transplants, ISBT 128 (International Council for Commonality in Blood Banking Automation).

87. Data on activities and practices are collected by the Global Observatory on Donation and Transplantation, a collaborative project with the Spanish national transplant organization, which is a WHO collaborating centre. Data on organ transplantation are available on the websites of the Global Observatory on Donation and Transplantation or of WHO’s Global Health Observatory.<sup>1</sup> The practice of organ transplantation is increasing worldwide, and now involves 100 countries; however, the total number of transplantations meets only 10% of the global need.

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<sup>1</sup> Available at, respectively, <http://www.transplant-observatory.org/Pages/home.aspx> and <http://www.who.int/gho/en/> (accessed 11 October 2013).

88. Organ donation after death is reported in 69 countries. The transplantation of kidneys from deceased donors increased by 17% between 2008 and 2011, while no significant variation was recorded in the transplantation of kidneys from living donors. It is essential that progress continues to be made so that the possibility of organ donation after death can become an integral part of end-of-life care. Only 20 countries reported organ donation after circulatory death in 2011.

89. Few Member States are able to provide activity data on the procurement, processing and use of human tissues and cells, in the way that they are for organs. Hematopoietic stem cell transplantations are monitored by the Worldwide Network for Blood and Marrow Transplantation. Ensuring the global harmonization of the regulatory oversight of xenotransplantation, cellular therapies and regenerative medicine based on allogeneic or autologous cells, tissue and organs remains a priority.

90. Developed by WHO and the Italian national transplant centre (a WHO collaborating centre), the Notify Library<sup>1</sup> of didactic cases of adverse events and reactions allows the dissemination of the lessons learnt by vigilance and surveillance schemes run by national authorities and by scientific and professional societies, as requested in resolution WHA63.22.

91. In response to the growing interest in issues relating to medical products of human origin, the Secretariat has created a special initiative in the Health Systems and Innovation cluster. From donation to the follow-up of the recipient, medical products of human origin have a shared exposure to the risk of breaches of ethical standards; they also share risks to safety, in particular that posed by transmissible diseases. Ensuring the protection of the donor, the recipient and society at large will require the establishment of global consensual principles to govern the use of medical products of human origin, including the non-commercial nature of the human body and its parts as such, and strict traceability associated with vigilance and surveillance.

## **L. WHO STRATEGY ON RESEARCH FOR HEALTH**

92. During the biennium 2012–2013, implementation of the WHO strategy on research for health was harmonized with that of the global strategy and plan of action on public health, innovation and intellectual property, and in particular with element 1 of the plan of action (Prioritizing research and development needs) and element 2 (Promoting research and development).

93. As part of the follow-up activities to the global strategy and plan of action on public health, innovation and intellectual property, regional offices have been involved in mapping research efforts and coordinating the identification of demonstration projects that explore new and innovative mechanisms to support research into priority public health topics.

94. Work has begun on the planning stage for a global observatory on health research and development and an initial stakeholder mapping exercise is under way. The work builds on the results of the WHO informal workshop on monitoring research and development resource flows that was held in February 2013.<sup>2</sup>

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<sup>1</sup> See <http://www.notifylibrary.org/> (accessed 11 October 2013).

<sup>2</sup> WHO informal workshop on monitoring R&D resource flows [website]. Geneva: World Health Organization; 2013 (<http://www.who.int/phi/workshop14022013/en/index.html>, accessed 21 October 2013).

95. The challenges of establishing a global observatory for health research and development have been outlined in a paper published by *The Lancet*.<sup>1</sup> A study of the value of the WHO International Clinical Trials Registry Platform in assessing the global distribution of clinical trials and informing health research and development policies has been published in the *Bulletin of the World Health Organization*.<sup>2</sup> The study demonstrated that the distribution of global efforts in research is skewed: for every million disability-adjusted life years in high-income, upper-middle-income, lower-middle-income and low-income countries, an estimated 292.7, 13.4, 3.0 and 0.8 registered trials, respectively, were recruiting.

96. Discussions are under way with the independent research group, Policy Cures, on specific activities for establishing links between Policy Cures' database on funding for research on neglected diseases (the G-FINDER survey) and a product pipeline database for neglected diseases. Initial discussions are also taking place with Research Africa, an Africa-based organization that maintains a database of research funders, with a view to generating a map showing where funding is awarded. The WHO Regional Office for the Americas/PAHO launched its Regional Platform on Access and Innovation for Health Technologies in May 2012.<sup>3</sup>

97. In addition, the Secretariat has compiled a database that gives a systematic overview of health research and development priorities that have been identified through the WHO technical programmes and a selection of leading donor agencies and nongovernmental organizations. The database includes, for example, the research priorities identified in the disease-specific reference group reports published by the Special Programme for Research and Training in Tropical Diseases on Chagas disease, human African trypanosomiasis, leishmaniasis, helminth infections, zoonoses and marginalized infectious diseases of poverty, and the interactions between the environment, agriculture and infectious diseases of poverty.<sup>4</sup>

98. Many of the concepts outlined in the strategy on research for health were further developed in *The world health report 2013*,<sup>5</sup> which includes numerous case studies highlighting the importance of research to the achievement of universal health coverage.

99. The Secretariat is participating in the work of a group of major international funders of public health research, the Public Health Research Data Forum. The members of the group have made a commitment to work together to increase the availability of data emerging from research funded by them, in order to accelerate advances in public health.

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<sup>1</sup> Röttingen JA, Regmi S, Eide M, Young AJ, Viergever RF, Årdal C et al. Mapping of available health research and development data: what's there, what's missing, and what role is there for a global observatory? *The Lancet*. 2013;382:1286–1307. doi: [http://dx.doi.org/10.1016/S0140-6736\(13\)61046-6](http://dx.doi.org/10.1016/S0140-6736(13)61046-6).

<sup>2</sup> Viergever RF, Terry RF, Karam G. Use of data from registered clinical trials to identify gaps in health research and development. *Bulletin of the World Health Organization*. 2013;91:416–425C. doi: <http://dx.doi.org/10.2471/BLT.12.114454>.

<sup>3</sup> Regional Platform on Access and Innovation for Health Technologies [website]. Washington, DC: Pan American Health Organization/WHO Regional Office for the Americas; 2013 (<http://prais.paho.org/rscpaho/>, accessed 21 October 2013).

<sup>4</sup> Publications & resources [website]. Geneva: Special Programme for Research and Training in Tropical Diseases; 2013 (<http://www.who.int/tdr/publications/en/> accessed 21 October 2013).

<sup>5</sup> The world health report 2013: research for universal health coverage. Geneva: World Health Organization; 2013 (<http://apps.who.int/iris/handle/10665/85761>, accessed 21 October 2013).

100. Meetings of the Advisory Committees for Health Research were held in five of the six WHO regions.<sup>1</sup> WHO is undertaking a review of its structures that support research, in line with the core functions of shaping the research agenda and articulating policy options. Planning for the re-establishment of a research unit in WHO headquarters is under way.

### **Preparedness, surveillance and response**

#### **M. WHO'S RESPONSE, AND ROLE AS THE HEALTH CLUSTER LEAD, IN MEETING THE GROWING DEMANDS OF HEALTH IN HUMANITARIAN EMERGENCIES (resolution WHA65.20)**

101. Resolution WHA65.20 calls on the WHO to provide a faster, more effective and more predictable humanitarian response. This report describes WHO's work to put in place the necessary policies and processes, strengthen surge capacity, fulfil its role as Health Cluster Lead Agency, operationalize the WHO Emergency Response Framework, and collect and disseminate data on attacks on health workers and services.

102. A Global Emergency Management Team has been established, comprising Assistant Directors-General, department directors from headquarters, and divisional directors from each of the six regions with responsibility for humanitarian emergencies, outbreaks and implementation of the International Health Regulations (2005). The Management Team oversees the alignment of WHO's emergency work covering all hazards across the Organization, in accordance with its obligations as the lead agency for the Global Health Cluster and under the International Health Regulations (2005) and the Inter-Agency Standing Committee's transformative agenda. The Emergency Response Framework and an associated performance tracking system were finalized in 2013. To date, over 30 emergencies have been graded and a process for systematically monitoring WHO's performance has been introduced. Common WHO readiness checklists are being finalized for each level of the Organization in order to enhance preparedness to respond to crises arising from any hazard with public health consequences. WHO has led or participated in five major simulation exercises to test preparedness under the Emergency Response Framework and the transformative agenda.

103. On-call WHO surge teams are being established and an initial training course for candidates was conducted in September 2013. The Organization is scaling up its administrative procedures for rapidly deploying emergency experts. A stand-by policy has been finalized, and, on 4 November 2013, an agreement was signed with Information Management and Mine Action Programs, the Norwegian Refugee Council, RedR Australia and CANADEM. This additional surge capacity has been further complemented by an arrangement supported by the European Commission's Humanitarian Aid department with three nongovernmental organization partners: the International Medical Corps, Merlin and the Save the Children Fund. Stand-by or nongovernmental organization partners have been deployed to WHO operations in Democratic Republic of the Congo, Jordan, Mali, Philippines, Syrian Arab Republic and Turkey.

104. The work and functioning of the Global Health Cluster and its partners at the international and national level is under review in the context of the Inter-Agency Standing Committee's transformative agenda and as a basis for enhancing support to health clusters and operations at country level. In 2013,

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<sup>1</sup> The following regional offices were involved: Regional Office for Africa, the Regional Office for the Americas, the Regional Office for South-East Asia, the Regional Office for Europe and the Regional Office for the Eastern Mediterranean.

WHO conducted a global survey of partner capacities and field operations and undertook a strategic review of the Global Health Cluster to inform planning for the next biennium. In June 2013, 24 of the 29 Country Health Cluster coordinators were convened to review country operations and be briefed on the transformative agenda. A standardized tool has been finalized by the Inter-Agency Standing Committee to evaluate the performance of country clusters. In 2013, five country health clusters were evaluated and areas for improvement identified. Annual evaluations are planned for all country health clusters, beginning in the biennium 2014–2015. In order to enhance WHO's role as Health Cluster lead agency, a global health cluster unit is being established within the Department of Emergency Risk Management and Humanitarian Response. For the biennium 2014–2015, WHO and its Global Health Cluster partners have committed to substantially enhancing support to, and the performance of, the health cluster and/or health sector in 10 priority countries: Afghanistan, Central African Republic, Democratic Republic of the Congo, Haiti, Mali, Myanmar, Somalia, South Sudan, Syrian Arab Republic and Yemen.

105. These ongoing reforms of WHO's work in humanitarian emergencies have contributed to improving performance at country level. Of the acute emergencies graded under the Emergency Response Framework in 2012–2013, the most challenging have been those in Mali, Central African Republic and Syrian Arab Republic. The crisis in the Syrian Arab Republic triggered Organization-wide support through WHO country offices in Egypt, Iraq, Jordan, Lebanon, Syrian Arab Republic and Turkey. In the Syrian Arab Republic, application of the Emergency Response Framework resulted in more predictable and effective WHO action in such areas as rapid assessments, coordination mechanisms, improved reporting, disease surveillance and response systems, and regularly updated health action plans. In Mali, WHO led an exercise to assess and map health resources, which has been central to the development of a government-led transition plan for the health sector. In the Central African Republic, WHO worked with the Ministry of Health on a rapid assessment of services and assisted with the delivery of those that were feasible in the prevailing context, such as mass measles vaccination. Constraints on the response of WHO and the health sector at country level during major crises in 2013 included, insecurity, shortages of health personnel and supplies, escalating costs and difficulties associated with transportation, insufficient financing and, in some circumstances, complicated clearance processes.

106. WHO is developing methods for the systematic collection and dissemination of data on attacks on health facilities, health workers, health transport and patients in humanitarian settings. A partner contact group has been convened to advise on this process, and, in 2013, a series of technical consultations were initiated with a wide range of United Nations agencies, nongovernmental and humanitarian organizations and academic institutions. Coordination with the global protection cluster and country-based stakeholders will be enhanced in order to build capacity for collecting such data. WHO will strengthen its advocacy for the neutrality of health workers, facilities and services, in keeping with the statement to this effect signed by more than 50 countries from five continents, affirming the obligation of all parties to conflicts to respect the rules of international humanitarian law.<sup>1</sup>

107. Accelerating the reform of WHO's capacity to meet the growing demands of health in humanitarian emergencies means addressing chronic gaps in human and financial resources for its core activities, acute emergencies and protracted crises. Application of the Emergency Response Framework in 2013 has underscored the need to recruit and retain WHO core staff and ensure sustainable base funding for this purpose, especially in highly vulnerable regions and countries. For

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<sup>1</sup> The Common Statement on Access to Medical Care in Syria.

example, only three of the 29 health cluster countries currently have a full-time Health Cluster Coordinator and none has a dedicated information management officer. Against WHO's base budget of US\$ 106.7 million for its humanitarian work in the biennium 2012–2013, only US\$ 44.6 million – or 42% of planned costs – were received. Full funding of WHO's base budget of US\$ 87.9 million for its humanitarian work in 2014–2015 is essential for meeting the Organization's obligations and commitments in this area and building on the recent reforms. The downward trend in humanitarian financing for health sector requirements at country level continued in 2013 in both percentage and nominal terms; 49% of the US\$ 1300 million required in 2013 was received as at 4 November 2013, down from 53% of US\$ 1400 million in 2012 and 64% of US\$ 1000 million in 2011.<sup>1</sup> The health sector also continues to be underfunded in major emergencies; only 53% of the health sector requirements in the Syrian humanitarian assistance response plan for 2013 were funded as at 4 November 2013 and in the Central African Republic, only 25% of the health sector requirements in the 2013 consolidated appeal were received.

108. To further improve its performance as Global Health Cluster Lead Agency during the 2014–2015 biennium, WHO will: establish a global health cluster unit; carry out a Global Policy Group review of WHO's role, functions and performance as Global Health Cluster Lead Agency; scale up support to, and backstopping of, Health Cluster Coordinators, particularly in the designated priority countries for the biennium; seek to fully staff core cluster functions in the designated priority countries; build the internal surge capacity of WHO and its stand-by and nongovernmental organization partners; and enhance evaluation and monitoring of the capacity and performance of each health cluster at country level.

### **Corporate services/enabling functions**

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

109. In May 2012, the Sixty-fifth World Health Assembly noted the latest progress report on the implementation of the action plan on multilingualism.<sup>2</sup> This report provides a further update on activities to implement the plan.

110. Efforts have continued in support of accessible multilingual content on WHO's website. The multilingual team of web editors, working with the WHO translation service, has reduced the gap between English and the other five official languages of the Organization with regard to the availability of technical content. The team has also made all corporate web content available in the six official languages. Between January 2012 and September 2013, 1142 webpages were added in Arabic, 1521 in Chinese, 7152 in English, 1722 in French, 1752 in Russian and 1202 in Spanish.

111. As at September 2013, WHO's Institutional Repository for Information Sharing (IRIS)<sup>3</sup> includes more than 50 000 records in the official languages, comprising WHO information products and governing bodies documentation (including Health Assembly and Executive Board documentation from 1998 onwards, together with the documentation of the WHO Framework Convention on Tobacco

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<sup>1</sup> Source: Office for the Coordination of Humanitarian Affairs, Financial Tracking Service, 4 November 2013.

<sup>2</sup> See documents A65/26, section Q, and WHA65/2012/REC3, summary record of the sixth meeting of Committee B, section 3.

<sup>3</sup> Available at <http://www.who.int/iris>.

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Control). IRIS is recording an average of 1.5 million downloads per month. The entire historical set of governing bodies documentation dating from 1948 to 1997 will be included in IRIS before the end of 2014.

112. In 2012 the Russian Federation provided funds to support a two-year project for increasing the quality and quantity of WHO technical and scientific information products available in Russian, and for improving their dissemination to Russian-speaking audiences. As at September 2013, 15 key publications have been translated and published in Russian at headquarters and in the WHO Regional Office for Europe, and distribution networks for Russian publications have been expanded. A total of 120 existing print publications in Russian have been digitized and entered in IRIS. Two special issues of the *Bulletin of the World Health Organization* in Russian have been published. Over 20 new technical websites in Russian have been created or updated on the WHO headquarters website, and 12 country profiles in Russian have been created on the website of the WHO Regional Office for Europe.

113. Work to ensure that WHO information products are available in official and non-official languages has continued to progress. In 2012 and 2013, WHO Press authorized external partners and regional offices to undertake 337 translations of 219 headquarters products into 52 languages (five official and 47 non-official).

114. Language training continues to be offered to staff members free of charge. During the biennium 2012–2013, enrolments in face-to-face language courses at headquarters totalled 1358: 75 were for Arabic, 35 for Chinese, 128 for English, 726 for French, 35 for Russian and 359 for Spanish. Since September 2012, WHO has been offering a distance-learning language programme in the official languages of the Organization, as well as in German and Portuguese. Regional and country office staff are accorded priority in this programme. As at September 2013, 1688 staff from all WHO regions have enrolled, with a further 200 expected to enrol by the end of 2013.

115. In 2012 and 2013, WHO participated in a roundtable discussion on multilingualism organized by the United Nations Office at Geneva and the Organisation internationale de la Francophonie.

116. The ePORTUGUÊSe network continued to strengthen collaboration among health institutions and professionals in the eight Portuguese-speaking Member States. In 2012 and 2013 the ePORTUGUÊSe network in partnership with the relevant WHO technical units organized several online and face-to-face training courses on patient safety, epidemiology and library management involving more than 16 000 participants.

117. WHO continues to work with other United Nations agencies and European Union institutions to enhance multilingualism. At the International Annual Meeting on Language Arrangements, Documentation and Publications, the Secretariat chairs two task forces that seek to optimize structures and methods in translation and interpretation services.

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