

Progress reports

Report by the Secretariat

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A. POLIOMYELITIS: MECHANISM FOR MANAGEMENT OF POTENTIAL RISKS TO ERADICATION (resolution WHA61.1)

1. In 2008, the World Health Assembly in resolution WHA61.1 requested the Director-General to develop a new strategy to renew the fight to eradicate poliomyelitis from the remaining affected countries. In order to lay the basis for the new strategy, a special, one-year Programme of Work 2009 of the Global Polio Eradication Initiative was undertaken. It included evaluating tactical innovations, conducting clinical trials of new vaccine formulations (e.g. bivalent oral poliovirus vaccine) and facilitating an independent examination of the major barriers to interrupting poliovirus transmission. The Sixty-third World Health Assembly noted the progress made and concurred with the framework for a new strategic plan for 2010–2012,¹ which was subsequently finalized and launched in June 2010.

2. The Executive Board, at its 128th session, considering a previous version of this report, noted the impact of the new Strategic Plan 2010–2012, in particular the strong progress achieved in India and Nigeria, and expressed concern at the ongoing transmission of some re-established polioviruses, the continued international spread of wild poliovirus, and, in particular, the Global Polio Eradication Initiative's gap in financing which threatened to undermine recent progress. In addition, the Board welcomed the establishment of the Independent Monitoring Board, which held its inaugural meeting on 21–22 December 2010 and will meet quarterly to monitor the implementation and impact of the new Strategic Plan 2010–2012 against the major milestones and process indicators established for that purpose, and advise countries and partner agencies on corrective actions as appropriate.² The Board noted that the Independent Monitoring Board created a new dynamic for poliomyelitis eradication and called on Member States to commit additional resources to ensure the full implementation of the Strategic Plan 2010–2012.

3. As at 1 March 2011, the status of the three major milestones of the Strategic Plan 2010–2012 was as follows:

(i) Countries with new outbreaks of poliomyelitis due to an imported poliovirus:³ since mid-2010, no cases of poliomyelitis had been detected due to the original importation in any of the 15 countries that had reported new outbreaks in 2009. In the 11 countries in which there had been new outbreaks in 2010, no outbreak had persisted for longer than six months.

(ii) Countries with “re-established poliovirus transmission”:⁴ the re-established wild poliovirus type 1 in south Sudan had not been detected since 27 June 2009. Countries which were considered to have ongoing transmission of their re-established poliovirus were: Chad (most recent case: 23 December 2010); the Democratic Republic of the Congo (27 December 2010); and Angola (7 January 2011).

¹ Document WHA63/2010/REC/3, summary record of the eighth meeting of Committee B, section 2A.

² Document EB128/2011/REC/2, summary record of the eleventh meeting, section 3.

³ Defined as countries with, by mid-2010, cessation of all poliomyelitis outbreaks with onset in 2009. The target for stopping any new outbreaks (i.e. with onset in 2010, 2011 or 2012) is within six months of the confirmation of the index case.

⁴ Defined as countries with, by end-2010, cessation of all “re-established” poliovirus transmission.

(iii) Countries with endemic transmission of poliovirus:¹ overall, in the four remaining countries with endemic poliovirus transmission, cases of poliomyelitis had declined by 82% in 2010 compared to the same period in 2009 (232 cases in 2010 compared with 1256 cases in 2009, as at 1 March 2011)². In India cases had declined by 95% (42 cases compared with 740 cases), in Nigeria, by 95% (21 cases compared with 388 cases), and in Afghanistan by 35% (25 cases compared with 38 cases). In Pakistan, cases had increased by 61% (144 cases in 2010 compared with 89 cases in 2009).

4. Although progress towards the first and third milestones of the Strategic Plan was broadly on track, serious obstacles remain. In particular, attainment of the second, end-2010 milestone of stopping all “re-established poliovirus transmission” was missed in Angola and at high risk of being missed in Chad and the Democratic Republic of the Congo. In Angola, more than 25% of children had been missed during supplementary immunization activities in some areas of the country, contributing to the persistence of transmission of the re-established virus, the outbreak in 2010 and the cross-border spread into Congo and the Democratic Republic of the Congo. In addition, in the Democratic Republic of the Congo, a virus strain that had not been detected since 2008 was isolated in the eastern province of Katanga in June 2010 through at least December, illustrating failures in the implementation of both surveillance and supplementary immunization activities in the area. Achievement of the third, end-2011 milestone of stopping poliovirus transmission in countries where the virus is endemic is at risk in Pakistan because of continued operational difficulties in optimizing the quality of supplementary immunization activities in the persistent reservoir areas of poliovirus in the country. These problems were further complicated by insecurity and conflict in the Federally Administered Tribal Areas and the severe floods affecting the country in mid-2010. Recognizing these risks, and in keeping with the provisions of the Strategic Plan 2010–2012, Angola, the Democratic Republic of the Congo and Pakistan established or updated their emergency plans to intensify eradication activities, under the authority of their respective heads of state. These plans were presented to the Independent Monitoring Board on 21–22 December 2010, with implementation beginning in January 2011. Chad was invited to present its emergency plan to the Independent Monitoring Board at its end-March 2011 meeting.

5. International spread of wild polioviruses continues to pose a substantial risk to achieving a polio-free world. All of the 11 new outbreaks in 2010 have been stopped within six months, or are on track to be stopped in such a time frame. However, the explosive nature of the outbreaks in the Congo and Tajikistan, both of which are associated with further international spread of wild poliovirus, clearly demonstrates this ongoing risk. As at March 2011, the highest priorities for stopping outbreaks associated with new, recent importations were: Congo; Gabon; the border area between Uganda and Kenya; the Russian Federation; and, especially, Chad which was re-infected with a new importation of wild poliovirus type 1 in September 2010.

6. With the declining incidence of wild poliovirus globally, Member States are taking additional measures to reduce the risk of new outbreaks caused by the international spread of wild polioviruses or the emergence of circulating vaccine-derived polioviruses. These measures include supplementary and routine immunization activities to close gaps in population immunity and vaccination of travellers to and from poliomyelitis-affected areas. Similarly, ensuring timely vaccination responses to circulating vaccine-derived polioviruses has become increasingly important as progress is made towards

¹ Defined as countries with, by end-2011, cessation of all poliovirus transmission in at least two of the four disease-endemic countries.

² Data available at <http://www.polioeradication.org/Dataandmonitoring/Poliothisweek.aspx>.

eradication of wild poliovirus. In 2010, outbreaks due to circulating vaccine-derived polioviruses have occurred in Afghanistan, the Democratic Republic of the Congo, Ethiopia, India and Nigeria.

7. At the launch of the Strategic Plan 2010–2012, the results of a new study on the economics of the Global Polio Eradication Initiative were released. These indicated that the incremental net benefits of completing poliomyelitis eradication, aggregated over the period 1988–2035, would be at least US\$ 42 000 million.¹ However, shortfalls in the financing of the Global Polio Eradication Initiative continue to result in a scaling back of supplementary immunization and surveillance activities in some areas, delays in implementing outbreak response activities in others, and reductions in the long-term technical assistance provided by the Secretariat to some Member States. As at March 2011, 38% of the 2011–2012 budget of US\$ 1860 million remained unfunded.

B. ONCHOCERCIASIS CONTROL THROUGH IVERMECTIN DISTRIBUTION (resolution WHA47.32)

8. Onchocerciasis (river blindness) is currently endemic mainly in 30 countries in sub-Saharan Africa,² but also in six countries in Latin America³ and in Yemen.

Africa

9. In 1974, the Onchocerciasis Control Programme was established in 11 West African countries with the objective of eliminating onchocerciasis as a disease of public health importance and an obstacle to socioeconomic development. The Programme's main strategy was vector control, combined from 1989 onwards with mass treatment with ivermectin. Although the Programme closed in 2002, having achieved its main objective in all 11 countries except Sierra Leone, it was decided to continue regular surveillance activities and mass treatment with ivermectin in all the countries in order to safeguard the achievements.

10. In 1994, the Health Assembly adopted resolution WHA47.32 on onchocerciasis control through ivermectin distribution, noting in particular that onchocerciasis could be brought under control by using ivermectin, which was provided free of charge by the manufacturer.

11. In 1995, the African Programme for Onchocerciasis Control was launched to control the disease in 19 remaining countries in Africa where it was endemic, with the objective of establishing sustainable community-directed treatment with ivermectin and, where appropriate, eradicating the vector from selected foci with environmentally safe methods.

12. In line with the request in resolution WHA47.32 to Member States to prepare **national plans**, the strategy of Community-directed Treatment with Ivermectin is being implemented through the

¹ Thompson K, Pallansch MA, Cochi SL et al. Economic analysis of the Global Polio Eradication Initiative. *Vaccine*, 29 (2011) 334–343.

² Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Sierra Leone, Senegal, Sudan, Togo, Uganda and United Republic of Tanzania.

³ Brazil, Colombia, Ecuador, Guatemala, Mexico and Venezuela (Bolivarian Republic of).

national onchocerciasis task force in 15¹ of the 19 countries participating in the Programme. Clinic-based ivermectin treatment is being applied in some of the remaining countries endemic for the disease.

13. The results of **rapid epidemiological mapping of onchocerciasis**, conducted in more than 13 000 villages in the 19 countries in the Programme, facilitated the selection of priority areas for ivermectin mass treatment to about 120 million people at risk of being infected.

14. The African Programme for Onchocerciasis Control is **strengthening primary health care** by building the capacity of communities and front-line health personnel. The decision to engage communities in control activities has empowered them to take responsibility for ivermectin delivery, to decide how, when and by whom treatment should be administered, and to oversee implementation of community-directed treatment with ivermectin. In 2009, more than 507 000 trained community-directed distributors and nearly 37 000 health workers in 15 countries administered ivermectin to 66 million people.

15. Community-directed treatment with ivermectin also offers an effective entry point for other health interventions. Several of the Programme's projects reported distribution of nearly 26 million treatments or commodities for use against other diseases in 2009. Expanded joint implementation of ivermectin distribution alongside other health interventions is currently happening, contributing to the implementation of preventive chemotherapy for the control of neglected tropical diseases.

16. The African Programme for Onchocerciasis Control ensures **coordination** between stakeholders (governments, sponsoring agencies, donors, nongovernmental organizations and the manufacturing company that donates ivermectin) as well as the monitoring of progress.

17. Based on recent epidemiological evaluations conducted by the Programme, 20 countries² in Africa have the potential to eliminate infection and interrupt transmission of onchocerciasis in most foci.

18. However, challenges remain to ensure sustainability of national programmes after the end of the Programme in 2015, particularly in providing support to enable the seven post-conflict countries to increase their geographical and therapeutic coverage.

The Americas

19. The Onchocerciasis Elimination Program for the Americas began in 1992 and is currently carried out under a 2008 PAHO/WHO resolution CD48.12 calling for the elimination of ocular morbidity and interruption of parasite transmission throughout the Region by 2012. The operational goal of the Program is to eliminate human onchocerciasis by providing ivermectin at least twice yearly, reaching a minimum of 85% coverage of the eligible population in all disease-endemic communities. Coordination between stakeholders is conducted by the Program, which includes

¹ Angola, Burundi, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Liberia, Malawi, Nigeria, Sudan, Uganda and United Republic of Tanzania.

² Benin, Burkina Faso, Burundi, Cameroon, Chad, Congo, Democratic Republic of the Congo, Ethiopia, Equatorial Guinea, Ghana, Guinea, Guinea-Bissau, Malawi, Mali, Niger, Nigeria, Senegal, Togo, Uganda and United Republic of Tanzania.

governments of disease-endemic countries, the Regional Office for the Americas and several international partners.

20. As in Africa (see above), countries in the Onchocerciasis Elimination Program for the Americas have developed national onchocerciasis programmes based in their health ministries. All 13 foci in the Americas achieved a coverage of more than 85% in 2006, and parasite transmission was interrupted in 7 of them in 2010 where, consequently, ivermectin distribution has been stopped. No instance of blindness attributable to onchocerciasis has been reported in the Region for more than 10 years. In 2011, Colombia may become the first country to request certification of elimination by completing a three-year period of post-treatment surveillance. Ecuador could follow with a similar request in 2013. The Yanomami area shared by Brazil and Venezuela (Bolivarian Republic of) is considered to be the greatest obstacle to completing regional interruption of transmission by 2012. Recent cooperation agreements initiated between the two countries offer the possibility of a breakthrough in programmatic activities in that area of difficult accessibility.

Yemen

21. Clinic-based ivermectin treatment of severe skin lesions (sowda) has been implemented successfully in Yemen during the past decade. A national action plan was developed in 2010, aiming at onchocerciasis elimination in the country by 2015 through mass distribution of ivermectin and vector control.

C. CLIMATE CHANGE AND HEALTH (resolutions WHA61.19 and EB124.R5)

22. The present report responds to the request in resolution WHA61.19 and resolution EB124.R5 to report on progress in implementing the resolution and workplan. The Executive Board at its 128th session in January 2011 noted an earlier version of this report.¹

23. **Advocacy and awareness raising.** The Secretariat has worked with Member States to organize a series of high-level conferences either specifically on climate change and health (in the South-East Asia Region, for example, meetings of parliamentarians (Thimphu, 5–7 October 2010) and of ministers (Dhaka, 19–21 October 2010)) or in which the links between climate change and health have been an important component (Fifth Ministerial Conference on Environment and Health in Europe; Parma, Italy, 10–12 March 2010, and the Second Inter-Ministerial Conference on Health and Environment in Africa: Luanda, 23–26 November 2010). The Secretariat is further supporting coordination among the growing number of interested health-professional associations and nongovernmental organizations in order to generate and disseminate information for health advocacy.

24. **Partnership with organizations of the United Nations system and other parties.** WHO contributes the health perspective to the discussions of the United Nations System Chief Executives Board and the High Level Committee on Programmes, and jointly organizes a new United Nations working group on the Social Dimensions of Climate Change. WHO has also organized two health events during the preparatory sessions for the sixteenth Conference of the Parties to the Framework Convention (Cancún, Mexico, 29 November – 10 December 2010), at which it organized three side events. It engages fully in climate change forums at the regional level, for example, with the Regional

¹ See document EB128/2011/REC/2, summary record of the twelfth meeting, section 4.

Office for the Eastern Mediterranean representing health interests in UNDP's Arab Climate Resilience Initiative Regional Forum. Such engagement has led to improved representation of health within the various mechanisms of the United Nations system and in the Framework Convention's negotiating texts.

25. Promoting and supporting the generation of scientific evidence. The Secretariat has completed a systematic review of the extent to which recent research on climate change and health responds to priorities such as those set out by the Health Assembly in resolution WHA61.19. The assessment of the global burden of disease resulting from climate change continues, with the final estimates to be published in early 2011. The Secretariat is identifying the likely health benefits of strategies to mitigate the effects of climate change proposed in the Intergovernmental Panel on Climate Change in its reports on agriculture, transport, household energy use and housing. The Secretariat is drafting policy briefings on how mitigation in those sectors can also improve health. In addition, it is contributing to the Special Report of the Intergovernmental Panel on Climate Change on extreme events, and the Regional Office for Europe has contributed technical guidance on heat-health warning systems, which has been prepared in conjunction with WMO.

26. Strengthening health systems to protect populations from the adverse impacts of climate change on health. Draft guidance on health vulnerability and adaptation to climate change has been produced. Subsequently, PAHO hosted a global meeting (San José, 20–23 July 2010) to incorporate feedback from 16 countries into the final text, published in early 2011. The Regional Office for Africa has reviewed coverage of health by the national adaptation programmes of action in the least-developed countries, finding major weaknesses. A consultation on an “Essential Public Health Package to enhance Climate-Change Resilience in Developing Countries” was subsequently held with relevant WHO programmes and selected Member States (Geneva, 6–7 September 2010). At the country level, the Secretariat has supported assessments of vulnerability and adaptation in more than 30 countries, for example, through an initiative by the Regional Office for the Western Pacific covering 15 countries, including 11 Pacific island countries, and initiatives of the Regional Office for Europe in 13 European countries. The Organization is now implementing practical projects on health protection from climate change in 16 countries, covering all regions, and supporting a new initiative on “Green and Safe Hospitals” in China. In addition, a new regional initiative is being developed to strengthen health protection from climate change across Africa.

D. IMPROVEMENT OF HEALTH THROUGH SOUND MANAGEMENT OF OBSOLETE PESTICIDES AND OTHER OBSOLETE CHEMICALS (resolution WHA63.26)

27. The Strategic Approach to International Chemicals Management provides an umbrella for actions on the sound management of chemicals.¹ The Secretariat continues to contribute to implementation of the Strategic Approach. The present report describes progress in implementing resolution WHA63.26. An earlier version of the report was noted by the Executive Board at its 128th session in January 2011.²

¹ See document A63/21.

² See document EB128/2011/REC/2, summary record of the twelfth meeting, section 4.

28. The Secretariat is providing evidence for decision-makers on the health impacts of selected obsolete pesticides and other obsolete chemicals, sharing information on actions that have been successful, and facilitating strategies and national actions for dealing with other important chemicals. For example, the use of mercury-containing devices for measuring blood pressure and thermometers in hospitals is obsolete because validated and cost-effective alternatives that do not contain mercury are available. The Secretariat is collaborating with health-sector partners to phase out such devices. It is collaborating with Indonesia and Thailand to strengthen national capacities for sound management of major industrial carcinogens, including asbestos. WHO, in partnership with UNEP, is leading a global initiative to phase out lead-based paints, which continue to be a source of raised concentrations of lead in the blood of children.

29. An updated edition of *The WHO recommended classification of pesticides by hazard and guidelines to classification 2009* produced under the auspices of the Inter-Organization Programme for the Sound Management of Chemicals, was published in 2010.¹ It lists pesticides that are obsolete or discontinued for use as pesticides and provides lists of hazardous pesticides. It facilitates judicious selection of pesticides, thereby preventing the accumulation of stockpiles.

30. Through the WHO Pesticide Evaluation Scheme (WHOPES) and in close collaboration with FAO and UNEP, the Secretariat has provided support to Member States in the life-cycle management of pesticides used for public health. The focus of this support has included development of policies, strategies, guidelines and standards, and the implementation of projects in selected countries. A set of tools for pesticide management has been developed to provide support to Member States in the sound management of public-health pesticides, including issues related to registration, distribution and sale, use and application, and disposal of pesticide waste, as well as for training and awareness raising and for enforcement of pesticide regulations.²

31. Support has been provided to 13 countries in different WHO regions, with priority to those in Africa, covering situation analysis, needs assessment and development of national action plans through a multisectoral and multistakeholder approach. The support has also included assessment of the capacity of the national laboratories for pesticide quality control and training in the development of specifications for such quality control. Assuring the quality of pesticides prevents rejection by purchasers, in turn preventing accumulation of stockpiles of unwanted materials.

32. In 2010, the WHO Pesticide Evaluation Scheme carried out a global survey in about 140 countries where vector-borne diseases are endemic in order to map and document registration and management practices for public-health pesticides. The information derived will be used to provide a better base for plans to optimize and harmonize registration procedures and post-registration regulations for public-health pesticides. It will also serve in the development of strategies and action plans for strengthening capacity in Member States for sound management of public-health pesticides and as a preventive measure to avoid accumulation of obsolete pesticides. A common theme that emerged from the findings of the survey was that the resources of Member States for sound management of public-health pesticides generally remain starkly inadequate.

¹ World Health Organization. *The WHO recommended classification of pesticides by hazard and guidelines to classification 2009*. Geneva, World Health Organization, 2010.

² For details, see http://www.who.int/whopes/recommendations/who_fao_guidelines/en/index.html (accessed 1 March 2011).

E. IMPROVEMENT OF HEALTH THROUGH SAFE AND ENVIRONMENTALLY SOUND WASTE MANAGEMENT (resolution WHA63.25)

33. **Project supported by the Global Environment Facility.** Resolution WHA63.25 requested the Director-General, inter alia, to continue supporting the prevention of health risks associated with exposure to health-care waste and promoting environmentally sound management of health-care waste. In line with this, the Secretariat has pursued this four-year project which began in mid-2008. The aim of the project is to demonstrate and promote best techniques and practices for minimizing or eliminating releases of persistent organic pollutants and mercury into the environment. Argentina, India, Latvia, Lebanon, Philippines, Senegal and Viet Nam are participating in the project with the involvement of national stakeholders. Additionally, the College of Engineering and Technology of the University of Dar es Salaam, United Republic of Tanzania, is developing and testing affordable technologies for treating health-care waste without incineration. The aim is to apply the processes concerned in treatment facilities that can be built and serviced in sub-Saharan African countries, using locally available supplies and skills.

34. **Support from the GAVI Alliance.** In addition, in the area of health-care waste, the GAVI Alliance has provided all 72 eligible countries with financial support for capacity building and for the development of national plans, policies, regulations and implementation strategies. WHO has been involved in providing technical support. Most of the countries concerned now have such plans and are implementing them.

35. **The Libreville Declaration on Health and Environment in Africa (2008).** The Libreville Declaration was the outcome of the first Inter-Ministerial Conference on Health and Environment in Africa (Libreville, 26–29 August 2008), which was hosted by the Government of Gabon and co-organized by WHO and UNEP. In the Declaration, the African countries committed themselves to establishing strategic alliances for health and the environment as a basis for plans of joint action.

36. **Use of mercury in health care.** In July 2008, a global initiative to substitute medical devices that contain mercury with safer alternatives that are both affordable and accurate was launched by Health Care Without Harm and WHO as part of the UNEP Global Mercury Partnership. WHO provides technical advice on how to evaluate mercury-free thermometers and blood pressure measuring devices. In 2010, the Ministry of Health in Argentina issued an administrative decision prohibiting the production, importation, sale or free transfer of mercury column blood pressure sphygmomanometers for use by the general population, medical doctors or veterinarians.¹ Importation of those articles was halted immediately, with all sales due to cease within six months. Countries such as Brazil, Mexico, Nepal and United Republic of Tanzania are moving towards a similar objective.

37. **Advocacy.** WHO has provided advocacy for the adoption of core principles on health-care waste, according to which all those associated with financing and supporting health-care activities should provide for the costs of managing health-care waste. Despite some encouraging results, greater emphasis is needed in this area.

38. **Management of health-care waste in emergencies.** In the framework of the United Nations Inter-Agency Standing Committee, WHO's activities have included transmitting advice and undertaking immediate action in response to needs relating to health-care waste that arose during the emergencies in Haiti and Pakistan.

¹ Administrative Decision 274/2010.

39. **Activities to generate scientific evidence.** In the European Region, health inequalities in relation to environmental exposure to waste have been assessed, and a report was given at the Fifth Ministerial Conference on Environment and Health (Parma, Italy, 10–12 March 2010) as part of a background document on inequalities in relation to environment and health.¹ In addition, health impact assessment guidelines have been reviewed for a variety of specialized waste dumps (e.g. military sites and fuel depots).

40. **Empowerment.** Several regional workshops have been organized on the management of health-care waste and training materials have been distributed widely and used extensively. The second edition of the WHO reference handbook, *Safe management of wastes from health-care activities*, will be available in 2011. Documents, guidelines and policy papers have been translated and widely disseminated in countries. Every effort is being made to ensure that the pages dedicated to health-care waste on WHO's web site are kept up to date and user friendly. The pages concerned receive a large number of visitors.

41. **Strengthening management of health-care waste.** Work in this area has principally involved Member States in the European Region. In Azerbaijan, for example, technical support has been provided to assess the current situation. The results thus generated have made it possible to elaborate a national policy and to prepare a budget estimation and road map for implementation. The documents are being considered at the national level, and endorsement is pending.

42. A three-day workshop on national strategies on health-care waste was held in Kazakhstan in 2009. Delegates from 10 countries – eight countries eligible for support from the GAVI Alliance, together with Bosnia and Herzegovina and Kazakhstan – took part and developed approaches for framing their national strategies.

43. The Executive Board noted this progress report at its 128th session in January 2011.²

F. WORKING TOWARDS UNIVERSAL COVERAGE OF MATERNAL, NEWBORN AND CHILD HEALTH INTERVENTIONS (resolution WHA58.31)

44. The global annual number of child deaths in 2009 was estimated at 8.1 million, a reduction from 9.0 million in 2005.³ Between 1990 and 2009, the greatest progress was made in the European Region, where the observed average annual rate of mortality reduction for children under five years was 5.1%; and in the Region of the Americas, where the rate was 4.3%. Progress was much more modest in the African Region, where the rate was 1.8%; and the Eastern Mediterranean Region, where the rate was 1.9%. There is considerable disparity between these rates and the 4% annual reduction required to achieve the target of Millennium Development Goal 4 (Reduce child mortality).⁴ Among the 68 countries with a high burden of mortality of children under five years, identified in the Countdown

¹ *Environment and health risks: a review of the influence and effects of social inequalities*. Copenhagen, World Health Organization, 2010.

² See document EB128/2011/REC/2, summary record of the twelfth meeting, section 4.

³ UN Inter-agency Group for Child Mortality Estimation, *Levels and trends in child mortality: report 2010*. New York, United Nations Children's Fund, 2010.

⁴ The target 4.A of Millennium Development Goal 4 is to "reduce by two thirds, between 1990 and 2015, the under-five mortality rate".

to 2015 decade report (2000–2010),¹ 19 are on track to achieve that target, of which 17 have reduced mortality by at least half. In 47 countries, there was an increase in the average annual rate of mortality reduction for children under five years, over the period 2000–2008 compared to 1990–2000.

45. The global annual number of maternal deaths in 2008 was estimated at 358 000, compared with 546 000 in 1990, that is, a reduction of 34%.² The greatest progress was made in the South-East Asia and Western Pacific regions, with an average annual reduction of 5.0% in the maternal mortality ratio between 1990 and 2008. There was less progress in the African Region, where the average annual reduction was 1.7%, and in the Eastern Mediterranean Region, where the average annual reduction was 1.5%. Again, there is a marked disparity between these rates of reduction and the 5.5% reduction required to achieve the relevant target of Millennium Development Goal 5 (Improve maternal health).³ However, countries such as Egypt, Iran (Islamic Republic of), Morocco and Nepal have shown that it is possible to reduce maternal mortality through focused strategies.

46. Coverage of effective interventions for reproductive, maternal, newborn and child health has remained uneven. The Countdown report showed that in 68 countries, median coverage was high for interventions at scheduled times, such as immunization (greater than 80%) and vitamin A supplementation (85%). However, median coverage remained low for interventions on demand, such as treatment of diarrhoea (41%) and pneumonia (27%), skilled attendance at birth (54%), family planning (31%), and caesarean section (less than 5%). The unmet need for family planning (median value, 24%) continued to be reflected in a large number of unintended pregnancies. Reducing the number of unintended pregnancies, particularly among adolescents, remains a priority. Rapid progress in intervention coverage is possible, as has been illustrated in two examples: dramatic increases in the coverage of insecticide-treated bednets; and the prevention of mother-to-child transmission of HIV in several countries. Twelve countries have increased the prevalence of exclusive breastfeeding among infants under six months by at least 20% in the past two decades.

47. Quality of services remains a concern in many settings. For example, it is clear that a gap in the quality of care exists when comparing the proportion of women who seek antenatal care services with the proportion who receive effective interventions in the course of those antenatal visits. Similarly, quality of care at birth is very uneven. For example, women seeking “skilled care” during childbirth may receive care, but the quality of that care may not meet the standard implicit in the term “skilled care”, leading to medical complications and at worst, mortality. Overall, there is a need to strengthen indicators used to assess the quality of services that are provided to women during pregnancy, childbirth and the postnatal period, as well as to newborn infants and children.

48. There are also gaps in the continuum of care, in particular in the postnatal period when the risk of mortality is high for the mother and the newborn infant. Only six countries collected data on postnatal care for the baby born at home (that is, outside the health facility), and they showed an extremely low median coverage of care within two days of birth, of 4%.

¹ *Countdown to 2015 decade report (2000–2010): taking stock of maternal, newborn and child survival*. Geneva, World Health Organization and United Nations Children’s Fund, 2010.

² *Trends in maternal mortality: 1990 to 2008*. Geneva, World Health Organization, 2010.

³ The target 5.B of Millennium Development Goal 5 is to “reduce by three quarters, between 1990 and 2015, the maternal mortality ratio”.

49. National data on coverage levels often hide important disparities among population subgroups, including issues such as gender, urban versus rural residence, income and ethnicity. Countries with similar levels of overall national coverage of interventions may differ substantially in terms of equity of coverage among population groups. Generally, intervention coverage is substantially higher among households with higher incomes. Countries that are bridging this equity gap include Bangladesh, Brazil, Egypt, Swaziland and Zambia.

50. Too few countries have adopted recent evidence-based policies to increase access to essential reproductive, maternal, newborn and child health interventions. Enhancing access to such health interventions has been challenged by limitations on the scope of health worker responsibilities in some countries. Among the 68 “countdown countries” (that is, those countries bearing the highest burden), for example, in only 26 countries were midwives performing seven life-saving tasks and in only 29 countries were community health workers identifying and treating children who showed signs of pneumonia. Twenty-two countries had adopted the International Code of Marketing of Breast-milk Substitutes¹ and 41 countries reported having a national plan with costings for maternal, newborn and child health. These data make clear the need for strengthening national policies and programmes in order to accelerate action for reproductive, maternal, newborn and child health.

51. The United Nations Secretary-General’s *Global strategy for women’s and children’s health*,² endorsed by world leaders in September 2010, provides a platform for joint action to make the continuum of care for reproductive, maternal, newborn and child health a reality. The Strategy highlights relevant aspects of all health-related Millennium Development Goals. It recognizes the special vulnerability of pregnant women, newborn infants and adolescents. It calls for unity in support of country-led health plans for increased investment along with greater efficiency. Accountability is an important aspect of the strategy in which all partners have a role to play.

52. The Executive Board at its 128th session in January 2011 noted the present progress report.³

G. FEMALE GENITAL MUTILATION (resolution WHA61.16)

53. In response to resolution WHA61.16, the Secretariat is working with Member States, in collaboration with international, regional and national partners, towards the elimination of the practice of female genital mutilation. This report highlights progress since 2008, and the Executive Board noted this progress report at its 128th session.⁵

54. The Secretariat supported studies in several countries⁴ on the practice of female genital mutilation, the aim of which was to collect information that would contribute to improving efforts to eliminate the practice. In addition, the studies provided information about the care for those girls and

¹ International Code of Marketing of Breast-milk Substitutes. Geneva, World Health Organization, 1981.

² United Nations Secretary-General Ban Ki-moon, *Global strategy for women’s and children’s health*. New York, United Nations, 2010.

³ See document EB128/2011/REC/2, summary record of the twelfth meeting, section 4.

⁴ Burkina Faso, Egypt, Gambia, Ghana, Kenya, Nigeria, Senegal, Sierra Leone and Sudan.

women who have undergone the practice. In eight countries across Africa and Asia, education and information initiatives targeted special groups at the community level and through the mass media.¹

55. As at November 2010, laws criminalizing the practice of female genital mutilation exist in 20 African countries, and in several states of two additional countries.² Three countries have enacted such laws since May 2008: Egypt (in 2008), Uganda (in 2009), and Sudan. Egypt and Djibouti have strengthened existing laws and cases have been brought to court in several countries.³ Furthermore, 13 countries that receive immigrants from communities where female genital mutilation is practised have introduced legislation against that practice.

56. Four countries in Africa launched national plans of action against the practice of female genital mutilation. Other governments issued public statements and improved the coordination of the response to the practice. Furthermore, nine European countries have developed plans of action. The European Parliament has adopted four resolutions on combating female genital mutilation, and in 2009 the European Union launched the “End Female Genital Mutilations” campaign.

57. Community interventions were carried out in 16 countries by nongovernmental organizations, governments and religious leaders, resulting in hundreds of communities publicly declaring their intention to discontinue the practice.

58. Intersectoral collaboration has increased. In 2008, the Regional Office for Africa conducted a mid-term review of the regional plan of action (for the period 1996–2015) on the elimination of the practice.⁴ Collaborative programmes and funding partnerships were formed between key stakeholders, including organizations in the United Nations system, government ministries, nongovernmental organizations, safe-motherhood projects, community and faith-based organizations, and religious leaders. New cross-cutting collaborations were established in four countries: in Burkina Faso and Sudan legal and human rights issues were the focus; and in Ethiopia and Guinea the focus was regional networks with local governments, nongovernmental organizations and civil society institutions.

59. The Secretariat has updated its health-care guidelines for girls and women who have undergone female genital mutilation, and prepared multimedia material for the training of health providers.⁵ Clinical guidelines have been adapted and used by five African countries. In-service training on the elimination of the practice and development of curricula for various health-care professionals on their role were reported from two African countries.

60. National helplines offering a support service to girls or women who have undergone female genital mutilation have been established in Egypt and are being set up in Djibouti.

¹ Côte d’Ivoire, Djibouti, Eritrea, Ghana, Indonesia, Mauritania, Nigeria and Sudan.

² Benin, Burkina Faso, Central African Republic, Chad, Côte d’Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Mauritania, Niger, Nigeria (13 states), Senegal, South Africa, Sudan (multiple states), Togo, Uganda, United Republic of Tanzania and Zambia.

³ Including Burkina Faso, Djibouti, Egypt, Kenya, Senegal and Sierra Leone. Since 2008, new cases were brought before courts in the Netherlands and Switzerland.

⁴ World Health Organization, *Regional plan of action to accelerate the elimination of female genital mutilation in Africa*. Brazzaville, WHO Regional Office Africa, 1997.

⁵ *Female genital mutilation – mapping the evidence. Guidelines for health-care providers for curative and preventive work*. Geneva, World Health Organization, in press.

61. Furthermore, there is evidence that the proportion of cases of female genital mutilation being performed by health-care providers is increasing. A global strategy¹ to reverse this trend was developed by the United Nations family and intergovernmental and international professional associations.² The strategy is being promoted at regional and country levels. In addition, networks of physicians and professional organizations against female genital mutilation have been established in five countries.

H. STRATEGY FOR INTEGRATING GENDER ANALYSIS AND ACTIONS INTO THE WORK OF WHO (resolution WHA60.25)

62. The present report responds to the request in resolution WHA60.25 to report on progress in implementing the strategy for integrating gender analysis and actions, by providing an overview of the work of WHO since 2009.³ An earlier version of this report was noted by the Executive Board at its 128th session in January 2011.⁴

63. A monitoring and evaluation framework was developed in response to the request to provide a biennial report on progress. Two stages of the framework, the baseline assessment⁵ and the mid-term review,⁶ were successfully implemented in 2008–2009 and in 2010, respectively. Results of the assessment and review are presented in this report, and reflect achievements in each strategic direction of the strategy for integrating gender analysis and actions into the work of WHO.⁷

PROGRESS BY STRATEGIC DIRECTION

Strategic direction 1: Building WHO capacity for gender analysis and planning

64. In terms of the Gender, Women and Health Network, progress includes an increase in the number of gender focal points in all WHO regions. Currently there are 112 such focal points.

65. The baseline assessment of the WHO gender strategy undertaken in 2008–2009 indicated that most (60%) WHO staff members who participated in the survey have a good knowledge of gender concepts. In contrast, almost 35% are applying gender analysis and actions to their work. WHO has

¹ *Global strategy to stop health-care providers from performing female genital mutilation*. Geneva, World Health Organization, 2010 and New York, United Nations Population Fund, 2010.

² The International Federation of Gynecology and Obstetrics, International Council of Nurses, International Organization for Migration, Medical Women's International Association, World Confederation for Physical Therapy, and the World Medical Association.

³ For progress up to 2009, see document A62/23, section H.

⁴ See document EB128/2011/REC/2, summary record of the twelfth meeting, section 4.

⁵ *Gender mainstreaming in WHO: where are we now? Report of the baseline assessment of the WHO strategy 2010*. Geneva, World Health Organization, 2011.

⁶ *The mid-term review of the strategy for integrating gender analysis and actions into the work of WHO*. Geneva, World Health Organization, in press.

⁷ *Strategy for integrating gender analysis and actions into the work of WHO*. Geneva, World Health Organization, 2009.

continued efforts to build capacity, including the publication of a manual on gender mainstreaming,¹ as well as training seminars on operational planning where the focus is on gender issues. However, much more work needs to be done to build capacity and to create an enabling institutional environment for staff members to apply gender analysis skills to their work.

Strategic direction 2: Bringing gender into the mainstream of WHO's management

66. There has been a 5% increase in the number of women in the professional category since 2007. WHO is still some way from achieving its commitment of 50% of women in professional and higher graded posts set out in 1997.

67. The findings from the baseline assessment related to this strategic direction reveal some gender integration in the operational planning process.² This progress is most evident in humanitarian emergencies, blindness, food safety, HIV, malaria, mental health, noncommunicable diseases, occupational health and tobacco control programmes.

Strategic direction 3: Promoting the use of sex-disaggregated data and gender analysis

68. The mid-term review in 2010 showed very limited progress. In the next reporting period, that is, 2010–2011, the Secretariat, through the Gender, Women and Health Network, is scaling up and plans to continue to scale up efforts in support of the use of sex-disaggregated data and gender analysis. In 2009, a workshop was held in Quito, Ecuador³ in order to provide support to Bolivia (Plurinational State of), Chile, Colombia, Ecuador and Peru in the identification of core indicators for gender and health. Tools were developed to advance this work, including a set of guidelines.⁴

69. An important achievement is the publication in November 2009 of the WHO report *Women and health: today's evidence tomorrow's agenda*.⁵ The report attracted many statements of endorsement from WHO key partners. A policy meeting to strengthen the knowledge base on gender, women and health was held in late 2010, resulting in a call for action endorsed by various participating Member State representatives on improving gender and health statistics and reducing inequities.⁶

¹ World Health Organization, *Gender mainstreaming for health managers: a practical approach*. Geneva, World Health Organization, 2010.

² Measuring gender integration took the form of interviews during the baseline assessment, involving 131 focal points who based the structure of their interviews on prepared questionnaires.

³ "Capacity building workshop on gender and health indicator for countries involved in the collection of sex-disaggregated data and gender analysis", convened by the Regional Office for the Americas, in Quito, Ecuador, 12–16 October 2009.

⁴ Haworth-Brockman M, Isfeld H, Prairie Women's Health Centre of Excellence, *Guidelines for gender-based analysis of health data for decision making*. Washington DC, Gender, Ethnicity and Health Office of the Pan-American Health Organization.

⁵ *Women and health: today's evidence tomorrow's agenda*. Geneva, World Health Organization, 2009.

⁶ "Global policy dialogue for better evidence to improve women's health through gender and health statistics". Washington DC, World Health Organization, 25–27 October 2010.

Strategic direction 4: Establishing accountability

70. The baseline assessment pointed to the need for additional actions. In 2010, WHO introduced a gender classification into the Global Management System, which asks WHO staff members involved in the preparation of workplans to indicate whether their products and services are gender responsive. In this way, staff members are accountable and WHO can track progress on the integration of gender within its products and services.

I. PROGRESS IN THE RATIONAL USE OF MEDICINES (resolution WHA60.16)

71. Work to promote the rational use of medicines has involved a variety of activities. In the African Region, training sessions for health workers on good prescribing practices and on promoting the rational use of medicines in health facilities have been held in the Central African Republic, Chad, Ethiopia, Mali, Senegal and Zambia. A national communication strategy to improve rational use in the community has been developed in the United Republic of Tanzania.

72. In the Region of the Americas, a regional strategy to promote the rational use of medicines, based on the resolution, has been developed in cooperation with Member States, and pilot initiatives have been launched in Bolivia (Plurinational State of), Brazil and Nicaragua.

73. In the South-East Asia Region, a regional strategy on prevention and containment of antimicrobial resistance has been developed. In addition, an intercountry meeting on medicines use was held in New Delhi from 13 to 15 July 2010; it recommended coordinated action in countries to improve rational use, including the creation of dedicated, fully resourced units in health ministries.

74. In the European Region, a workshop was organized so that European countries could discuss strategies for improving information to patients on medicines (Amsterdam, the Netherlands, 6–8 October 2010); this was followed by a two-day conference to discuss the regulation of medicines promotion. Lastly, a workshop was organized to enable the Newly Independent States and the countries of south-eastern Europe to discuss current national legislation on drug promotion (Chisinau, 12–13 October 2010).

75. In the Eastern Mediterranean Region, a joint workshop on the rational use of medicines, organized between the Regional Office for the Eastern Mediterranean and the Executive Board for the Health Ministers' Council for the Gulf Cooperation Council States, was held in Muscat from 7 to 9 November 2010. The successful experience of the Directorate of Rational Use of Medicines in Oman was described and recommendations on rational use of medicines were transmitted to the Executive Board for the Health Ministers' Council.

76. In the Western Pacific Region, a Pacific working group for medicines selection and use has been formed to devise a common framework for treatment guidelines and a shared medicines list. A multidisciplinary working group on containment of antimicrobial resistance has also been formed and technical support has been provided to Member States on the following: training in rational use; evidence-based selection of medicines; and the development and implementation of treatment guidelines.

77. The WHO Model List of Essential Medicines was revised and published in April 2009.¹ Countries are continuing to revise national essential medicines lists, using the Model List as a template. The WHO Model Formulary was published in 2009.² The WHO database on use of medicines in primary care in developing countries and countries in transition was revised to include surveys up to 2009. It shows that for the period 2004–2009, 50% of prescriptions issued in the public sector adhered to clinical guidelines, whereas in the private-for-profit sector during the same period prescription adherence was 30%.

78. In the area of HIV/AIDS, WHO's guidelines for antiretroviral treatment have been updated and published online in respect of pregnant women (preventing HIV infection in infants),³ infants and children,⁴ and adults and adolescents.⁵ Malaria treatment guidelines have been revised and published,⁶ together with the fourth edition of the guidelines for the treatment of tuberculosis.⁷

79. All 80 countries in which falciparum malaria is endemic have adopted artemisinin-based combination therapies and have removed the artemisinin-based monotherapies from their malaria treatment guidelines. These are important steps in the rational use of medicines to treat malaria.

80. The Third International Conference on Improving Use of Medicines, which was due to be held in Alexandria, Egypt, from 10 to 14 April 2011, has been postponed. However, preparatory work is continuing and it is intended that the Conference will take place later in 2011. The Conferences, which are cosponsored by WHO, constitute an important platform for setting the agenda for rational use in the coming decade.

81. Antimicrobial resistance and its global spread will be the theme of World Health Day 2011; rational use of antibiotics forms a significant part of the effort to manage antimicrobial resistance. Cross-cutting activities emphasizing the importance of treatment and antibiotic guidelines, and involving the programmes on patient safety, HIV/AIDS, tuberculosis and malaria, will be important components of World Health Day 2011.

82. A manual has been drafted to assist national programmes for the control of neglected tropical diseases to improve management of serious adverse events following large-scale preventive

¹ *The selection and use of essential medicines: report of the WHO Expert Committee, March 2009 (including the 16th WHO model list of essential medicines and the 2nd WHO model list of essential medicines for children)*. Geneva, World Health Organization, 2009 (WHO Technical Report Series, No. 958). An update to the Model List, issued in March 2010, is available in English and French at <http://www.who.int/medicines/publications/essentialmedicines/en/> (accessed 2 March 2011).

² *WHO model formulary 2008*. Geneva, World Health Organization, 2009.

³ *Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: recommendations for a public health approach. 2010 version*. Available at http://whqlibdoc.who.int/publications/2010/9789241599818_eng.pdf. (accessed 10 November 2010).

⁴ *Antiretroviral therapy of HIV infection in infants and children: towards universal access: recommendations for a public health approach. 2010 revision*. Available at http://whqlibdoc.who.int/publications/2010/9789241599801_eng.pdf. (accessed 10 November 2010).

⁵ *Antiretroviral therapy for HIV infection in adults and adolescents: recommendations for a public health approach. 2010 revision*. Available at http://whqlibdoc.who.int/publications/2010/9789241599764_eng.pdf. (accessed 10 November 2010).

⁶ *Guidelines for the treatment of malaria. 2nd edition*. Geneva, World Health Organization, 2010.

⁷ *Treatment of tuberculosis: guidelines. 4th edition*. Geneva, World Health Organization, 2010.

chemotherapy interventions. Following field-testing in selected African countries, the manual is now being used by national authorities, which are adapting it to suit their needs. National versions are currently being developed by Uganda and United Republic of Tanzania. In addition, India, Lao People's Democratic Republic, Malawi, Nepal and Viet Nam are preparing to develop their own versions.

83. The 18th Meeting of the WHO Expert Committee on the Selection and Use of Essential Medicines will be held in Accra, Ghana, 21–25 March 2011 and will revise the 16th WHO Model List of Essential Medicines. The material for the meeting has been posted on WHO's web site and numerous comments have been received.

84. These diverse activities reflect the wide-ranging nature of work on rational use; however, the majority of countries have yet to tackle rational¹ use of medicines in their national plans and commit resources as recommended in the resolution.

85. The Executive Board noted an earlier version of this progress report at its 128th session in January 2011.²

J. IMPLEMENTATION BY WHO OF THE RECOMMENDATIONS OF THE GLOBAL TASK TEAM ON IMPROVING AIDS COORDINATION AMONG MULTILATERAL INSTITUTIONS AND INTERNATIONAL DONORS (resolution WHA59.12)

86. Following a recommendation by the UNAIDS Programme Coordinating Board at its 20th meeting (Geneva, 25–27 June 2007), the Global Task Team Oversight Reference Group was established to oversee progress and the reporting requirements of stakeholders, with WHO representing the UNAIDS cosponsors. The Oversight Reference Group submitted a report to the 25th meeting of the UNAIDS Programme Coordinating Board in December 2009, which was considered within the context of the final report of the Second Independent Evaluation of UNAIDS (2002–2008).³ The Second Independent Evaluation took into consideration the implementation of all Global Task Team recommendations. It was agreed that the work of the Oversight Reference Group had been concluded and that further oversight should be incorporated into other governance and reporting processes of UNAIDS.

87. WHO has worked closely with UNAIDS, Member States, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and other key technical support providers and recipients to coordinate and harmonize technical support to countries. In response to the Second Independent Evaluation, the UNAIDS Programme Coordinating Board recommended that a UNAIDS technical support strategy be drawn up that clarifies the comparative advantages and roles of the UNAIDS Secretariat, its cosponsors, and other United Nations entities and technical support providers. WHO has contributed to the development of this strategy and is elaborating a plan to outline WHO's role and contributions. In September 2009, WHO held a consultation meeting on the development of regional networks of WHO collaborating centres, knowledge hubs and technical partners working in the area of HIV, with

¹ See http://www.who.int/selection_medicines/committees/expert/18/en/index.html (accessed 4 March 2011).

² See document EB128/2011/REC/2, summary record of the eleventh meeting, section 3.

³ Document UNAIDS/PCB(25)/09.18.

the aim of building regional and national capacity to broker, manage and provide high-quality technical support to strengthen health sector responses to HIV. WHO chairs the informal Joint Working Group on Global Fund-related issues, which comprises representatives of relevant WHO departments and the secretariats of UNAIDS and the Global Fund, and coordinates the provision of technical support to countries with regard to grants from the Global Fund.

88. In response to a recommendation of the UNAIDS Programme Coordinating Board, the UNAIDS division of labour has been revised,¹ taking into consideration the recommendations of the Second Independent Evaluation, the identification of 10 priority areas of work under the UNAIDS Outcome Framework, and the development of the UNAIDS Strategic Plan for 2011–2015. Within the new division of labour, WHO will continue to lead the health-sector response to HIV, specifically in the areas of HIV treatment and care, HIV/TB and prevention of HIV infection in infants. WHO will also make major contributions to the UNAIDS response in the areas of health-sector planning, health system strengthening, HIV strategic information, HIV prevention in the health sector, and health services for most-at-risk and vulnerable populations.

89. Progress has been made in establishing and improving the performance of Joint United Nations Teams on AIDS and joint programmes of support at country level. By the end of 2009, joint United Nations teams had been established in 84 countries, with WHO taking an active role in all of these teams, including in joint programming with other United Nations agencies and partners. Full engagement of WHO in these joint teams, however, is dependent on the presence in countries of WHO HIV programme staff.

90. During 2010, a series of five WHO updated recommendations were released on: antiretroviral therapy for HIV infection in adults and adolescents;² antiretroviral therapy for HIV infection in infants and children;³ antiretroviral drugs for treating pregnant women and preventing HIV infection in infants;⁴ diagnosis of HIV infection in infants and children;⁵ and infant feeding in the context of HIV.⁶ In 2010, the progress report on achievement of universal access was published,⁷ as was a review of WHO's HIV programme highlights for 2008–2009.⁸

¹ 26th meeting of the UNAIDS Programme Coordinating Board, Geneva, June 2010.

² *Antiretroviral therapy for HIV infection in adults and adolescents: recommendations for a public health approach. 2010 revision.* Geneva, World Health Organization, 2010.

³ *Antiretroviral therapy for HIV infection in infants and children: towards universal access: recommendations for a public health approach. 2010 revision.* Geneva, World Health Organization, 2010.

⁴ *Antiretroviral drugs for treating pregnant women and preventing HIV infections in infants: recommendations for a public health approach. 2010 version.* Geneva, World Health Organization, 2010.

⁵ *WHO recommendation on the diagnosis of HIV infection in infants and children.* Geneva, World Health Organization, 2010.

⁶ *Guidelines on HIV and infant feeding 2010.* Geneva, World Health Organization, 2010.

⁷ *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector: progress report 2010.* Geneva, World Health Organization, 2010.

⁸ *HIV/AIDS programme highlights.* Geneva, World Health Organization, 2010.

91. The Executive Board at its 128th session in January 2011 noted an earlier version of the present report.¹

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¹ See document EB128/2011/REC/2, summary record of the eleventh meeting, section 3.