

## **Progress reports**

### **Report by the Secretariat**

1. The Executive Board at its 134th session in January 2014 noted the progress reports submitted in document EB134/53.<sup>1</sup> Several reports have been updated in the light of comments made during the Board's discussions and new information. Paragraphs with substantial changes are indicated in the reports that follow.

#### **ACTION BY THE HEALTH ASSEMBLY**

2. The Health Assembly is invited to note the progress reports.

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<sup>1</sup> See the summary record of the Executive Board at its 134th session, fourteenth meeting, section 5 (document EB134/2014/REC/2).

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## Communicable diseases

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

1. The Executive Board at its 134th session noted this progress report.<sup>1</sup>
2. 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 progress in its implementation.
3. 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 improvement of their quality have been uneven across regions, countries and population groups.
4. In June 2013, WHO issued its consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection,<sup>2</sup> which included new recommendations on community-based HIV testing and counselling; earlier initiation of antiretroviral therapy; treatment of all children under five years of age 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 of treatment and care; and service integration and linkage. The guidelines placed emphasis on improving the quality of interventions and services across the continuum of HIV care, including expanding HIV testing and counselling; linking people diagnosed with HIV infection to care and treatment; maximizing adherence to antiretroviral treatment; retaining people in care; and preventing and managing major comorbidities. 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.
5. 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 people (especially women) and prisoners, often do not have access to HIV services. For example, data gathered in 2011 from 21 countries in Europe indicated that 59% of people eligible for antiretroviral therapy acquired HIV through injecting drug use, yet injecting drug users represented only 21% of

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<sup>1</sup> See the summary record of the Executive Board at its 134th session, fourteenth meeting, section 5 (document EB134/2014/REC/2).

<sup>2</sup> Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: Recommendations for a public health approach June 2013. Geneva: World Health Organization; 2013.

those receiving antiretroviral therapy.<sup>1</sup> Later in 2014, WHO will issue consolidated 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, for instance through the preparation of two sets of guidelines on HIV services for adolescents and on preventing gender-based violence. WHO has prequalified a male circumcision device in order to increase voluntary male medical circumcision for prevention of HIV by reaching vulnerable men in high-prevalence settings.

6. The global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive<sup>2</sup> advocates stronger links between programmes on HIV, maternal and child health and family planning. Under the global 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 tuberculosis/HIV activities: guidelines for national programmes and other stakeholders.<sup>3</sup>

7. WHO is focusing its HIV programmes on emerging priorities, such as the prevention and management of comorbidities. It has provided new guidance on prevention and management of hepatitis B virus and hepatitis C virus infection,<sup>4</sup> with emphasis 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, WHO is assessing the relative burden of noncommunicable diseases among people living with HIV in order to decide on the clinical and programmatic guidance that is required for comprehensive care.

8. 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)**

9. In response to resolution WHA64.16, this report provides the requested update on progress towards the eradication of dracunculiasis. The Executive Board at its 134th session noted an earlier version of this report,<sup>5</sup> which has been updated with data on new cases.

10. Five additional countries were certified free of dracunculiasis transmission by WHO on the recommendation of the International Commission for the Certification of Dracunculiasis Eradication

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<sup>1</sup> World Health Organization. Global update on HIV treatment 2013: results, impact and opportunities. Geneva: World Health Organization; 2013.

<sup>2</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>3</sup> WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders. Geneva: World Health Organization; 2012.

<sup>4</sup> World Health Organization. Guidance on prevention of viral hepatitis B and C among people who inject drugs. Geneva: World Health Organization; 2012; and WHO Guidelines for the Screening, Care and Treatment of Persons with Hepatitis C Infection, in press.

<sup>5</sup> See the summary record of the Executive Board at its 134th session, fourteenth meeting, section 5 (document EB134/2014/REC/2).

during its ninth meeting (Geneva, 3–5 December 2013); in three of the five countries the disease had been previously endemic (Côte d’Ivoire, Niger and Nigeria), and the two others (Somalia and South Africa) have had no recent history of dracunculiasis. Currently, 197 countries, territories and areas (altogether 185 Member States) have been certified free of dracunculiasis transmission. As at 31 December 2013, nine Member States remain to be certified: four countries in which the disease is endemic (Chad, Ethiopia, Mali and South Sudan), three countries in the pre-certification stage (Ghana, Kenya and Sudan) and two countries that have not reported any recent history of the disease (Angola and Democratic Republic of the Congo). At the 17th Review Meeting of National Dracunculiasis Eradication Programmes (Ougadougou, 9–12 April 2013), progress made in 2012 was reviewed and plans for 2013 were drawn up. The 18th Review Meeting is scheduled to be held from 19 to 22 March 2014 in Addis Ababa. During the Sixty-sixth World Health Assembly an informal meeting of health ministers of countries in which dracunculiasis is or was endemic was held in order to strengthen commitment to eradication.

11. During 2013, the global number of reported new cases of dracunculiasis fell by 73% to 148, compared with 542 cases reported during 2012. The cases occurred in 103 villages, whereas in 2012 the reported cases involved 272 villages. This was mainly due to a 78% reduction in the number of new cases reported in South Sudan, from 521 in 2012 to 113 in 2013. Indigenous transmission is now localized in a few zones in the countries concerned. However, Chad, Ethiopia and Mali recorded small increases in the number of reported cases in 2013 compared to 2012. Sudan, a country in the pre-certification stage, reported three cases near to its border with South Sudan.

12. The dracunculiasis outbreak in **Chad** continued into its fourth year, with 14 new cases being reported during 2013 in 10 villages; eight of the cases were contained. None of the five cases reported in Maimou village in Sarh district were contained. Five of the 10 villages that reported cases in 2013 do not have a single improved source of drinking-water. During 2012, 10 cases were reported, four of which were contained. More than 700 villages were kept under active surveillance during 2013 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 2012–2013; epidemiological investigations and further studies are under way. The Secretariat has been providing technical support to Chad in strengthening dracunculiasis surveillance and raising awareness beyond the villages under active surveillance of the cash reward for information leading to confirmation of a case. However, further support is needed for those activities and for case containment.

13. In **Ethiopia**, low intensity transmission continued in the Gambella region. During 2013, seven new cases were reported, with five in Abobo, one in Gog and one in Itang districts, respectively, compared with four reported cases in 2012. Four of the seven new cases in 2013 were contained, compared with two of the four cases in 2012. The cases were reported in five villages: in one village each in Itang and Gog districts and three villages in Abobo District. Five of the seven cases involve residents of Terkudi Batpulo village in Abobo District (Terkudi Batpulo village reported an uncontained case in April 2012 that was traced to the village of Utuyu, in which the disease is endemic, in the adjacent Gog District). Of the two remaining cases, one involves a resident of Pugnido refugee camp in Gog District; the other represented a patient who was detected and reported in December 2012 but in whom another worm emerged in January 2013, in Umaha village in Abobo District. Of the five villages that reported cases in 2013, one (Terkudi Batpulo) does not have any improved drinking-water sources. Support is needed for strengthening surveillance and raising awareness of the cash reward scheme offered by the Ethiopian Dracunculiasis Eradication Programme for voluntary reporting of dracunculiasis cases and for complying with the case containment measures, 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 strong and concerted response from local authorities is also needed in order to ensure that all rumours are investigated and new cases contained.

14. **Mali** is the only West African country where dracunculiasis transmission continues. During 2013, 11 new cases were reported in eight villages in four districts: Ansongo (six cases), Kidal (three cases), Djenné (one case) and Gourma-Rharous (one case). Seven of the cases were contained. In 2012, by comparison, four cases were reported in three villages of the districts of Kidal in Kidal region (2 cases), Djenné in Mopti region (1 case) and Macina in Segou region (1 case). Of the eight villages that reported cases in 2013, four do not have any improved drinking-water sources. Since March 2012, security concerns in the north of the country have interrupted the national eradication programme, although United Nations bodies involved in humanitarian support have facilitated intermittent surveillance. With improved security in 2013, surveillance is being strengthened in the Gao, Timbuktu, and Mopti regions, but not in Kidal region where security concerns are still high. 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 the surveillance effort, the Secretariat has provided technical and financial support for capacity-building among health staff, and has been conducting a countrywide programme to raise community awareness of the cash reward scheme for voluntary reporting of dracunculiasis cases in order to increase the sensitivity of the surveillance system. However, additional support is needed for reinstating or increasing surveillance as the security situation improves, and for wider advertising of the reward scheme.

15. **South Sudan** accounted for 76% of all dracunculiasis cases reported in 2013. Seventy-nine villages reported a total of 113 new cases, of which 67% were contained. There were 78% fewer cases than in 2012, when 521 cases were reported. Of the total number of new cases reported in 2013, 77 (68%) were from Kapoeta East County in Eastern Equatoria State. Of the 79 villages that reported cases during 2013, 17 (22%) have one or more improved sources of drinking-water. Of the 54 villages in Kapoeta East County that reported cases during 2013, 7 (13%) have access to improved sources of drinking-water. 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 improving case containment, particularly in areas bordering Sudan, and for strengthening surveillance through voluntary reporting of cases with the introduction of a reward scheme. The ongoing civil unrest in South Sudan, which began in mid-December 2013, has the potential to hinder programme implementation due to restricted access for health care workers and population displacement between areas where dracunculiasis is endemic and where it is not present. The current mobilization of the army across the country could create the risk of future outbreak in areas that are not endemic.

16. In 2013, three cases of dracunculiasis were reported in the southern Darfur region of **Sudan**, bordering Western Bahr el Ghazal State in South Sudan. Two cases were detected in June 2013 during a poliomyelitis vaccination campaign, and the third case was subsequently reported in September 2013 in another member of the same family as those two cases. Specimens taken from two cases were later laboratory confirmed as being due to *Dracunculus medinensis*. The last indigenous case in Sudan was reported in 2002 and the last imported case in 2007. Residents of the village involved alleged that in 2012 insecurity in the area led to the displacement of inhabitants and contamination of the surface water source also used by the patients. 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 approach during the vaccination campaign against poliomyelitis and raising community awareness of the cash reward scheme for the voluntary reporting of dracunculiasis cases. However, additional support is needed for strengthening surveillance and

raising awareness of the reward scheme, particularly in hard-to-access areas, such as those bordering South Sudan and Chad.

17. WHO-supported surveillance continued in dracunculiasis-free areas in the four remaining countries endemic for the disease, and in the six countries in the pre-certification stage (three of which – Côte d'Ivoire, Niger and Nigeria – were certified free of dracunculiasis in December 2013), and was supplemented by a reward scheme for voluntary reporting of information leading to confirmation of cases. In addition, the house-to-house surveys carried out during national immunization days and/or large scale medicine distribution campaigns were applied 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. Countries are encouraged to report on the degree to which individuals are aware of the cash reward offered for voluntary reporting. The level of awareness varied by country: Chad (58.5%), Côte d'Ivoire (35%), Ethiopia (44%), Ghana (47%), Mali (42%), Niger (77%), Nigeria (63%) and Sudan (21%).

18. 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 were either endemic for the disease or in the pre-certification stage, 90% of districts reported monthly during 2013. During 2013, a total of 4281 rumours were reported, of which 3817 (89%) were investigated within 24 hours.

19. Of the countries in the post-certification stage, Benin, Burkina Faso, Cameroon, Central African Republic, Mauritania, Senegal and Togo submitted quarterly reports in 2013. Countries in the post-certification stage should continue surveillance through communities and health systems and respond immediately to any suspected case or rumour. Fifty-nine rumours were reported from post-certified countries (42 in Burkina Faso, 2 in Cameroon, 1 in Mauritania, 12 in Togo, and 2 in Uganda).

## **Noncommunicable diseases**

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

20. At its 134th session, the Executive Board noted this progress report.<sup>1</sup>

21. 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.

22. 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.

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<sup>1</sup> See the summary records of the fourteenth meeting of the Executive Board at its 134th session, section 5 (document EB134/2014/REC/2).

23. 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 more than 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 short courses on violence and injury prevention; one addressing trauma care systems planning and management, and the other addressing trauma care systems quality improvement.

24. 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, the Philippines and the United Republic of Tanzania.

25. 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.

26. 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> draws attention to this issue and provides guidance and support to Member States to adopt and enforce laws on child restraints.

27. 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>

28. 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.

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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.

## 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)**

29. The Board noted this progress report at its 134th session.<sup>1</sup> Paragraph 38 has been updated.

30. 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,<sup>2</sup> and by participating in regional conferences at which the survey results were considered.

31. 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.

32. 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.

33. 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.

34. 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>3</sup> to 70% between 2005

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<sup>1</sup> See the summary record of the fourteenth meeting, section 5, of the Executive Board at its 134th session (document EB134/2014/REC/2).

<sup>2</sup> <http://icpdbeyond2014.org/about/view/29-global-review-report> (consulté le 5 Mars 2014).

<sup>3</sup> World health statistics 2010. Geneva: World Health Organization; 2010.

and 2012.<sup>1</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>

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

36. 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); 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>5</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>6</sup>

37. Improving adolescents' knowledge and understanding of sexual and reproductive health, including 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>7</sup> The Secretariat has developed case studies of successful examples in scaling up sexuality education for enabling South–South exchange of these best practices.

38. In addition to specific activities mentioned above, the Secretariat expressed its commitment at the London Summit on Family Planning, held in July 2012, to the objectives of the Summit, namely: to strengthen the evidence base and norms for effective policy and programme actions in order to

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<sup>1</sup> World health statistics 2013. Geneva: World Health Organization; 2013.

<sup>2</sup> <http://icpdbeyond2014.org/about/view/29-global-review-report> (accessed 5 March 2014).

<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.

<sup>5</sup> The Millennium Development Goals Report 2013. Statistical Annex. New York: United Nations; 2013.

<sup>6</sup> WHO guidelines on preventing early pregnancy and poor reproductive health outcomes among adolescents in developing countries. Geneva: World Health Organization; 2011.

<sup>7</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.

expand access to quality services. As part of this commitment, guidelines have been published for ensuring a human rights-based approach to family planning programmes, as contraceptive services are scaled up.<sup>1</sup> The Secretariat also remains committed to making sexual and reproductive health a priority in the post-2015 development agenda.

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

39. The Board noted an earlier version of this report at its 134th session.<sup>2</sup> Information in paragraphs 43 and 47 is updated.

40. 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.

41. Recent analyses suggest that the prevalence of female genital mutilation has declined,<sup>3</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 Eastern Mediterranean regions is estimated to be more than 125 million.<sup>3</sup> In the European Union, rates vary between countries.<sup>4</sup>

42. By September 2013, a total of 24 countries in the African and Eastern Mediterranean regions had made the practice a criminal offence.<sup>5</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>6</sup> Gambia and Mauritania have submitted draft legislation criminalizing the practice to their respective legislatures.

43. 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 information on female genital mutilation in the national school curriculum in Senegal. The International Day of

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<sup>1</sup> World Health Organization. Ensuring human rights in the provision of contraceptive information and services: guidance and recommendations. Geneva: World Health Organization; 2014.

<sup>2</sup> See the summary record of the fourteenth meeting, section 5, of the Executive Board at its 134th session (document EB134/2014/REC/2).

<sup>3</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>4</sup> Female genital mutilation in the European Union and Croatia. Report. Vilnius: European Institute for Gender Equality; 2013.

<sup>5</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, Niger, Nigeria, 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>6</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.

Zero Tolerance for Female Genital Mutilation, held annually on 6 February, provides an opportunity for countries to become actively involved in raising awareness about the practice.<sup>1</sup>

44. Since 2010, thousands of communities throughout Africa have publicly declared their decision to abandon female genital mutilation.<sup>2</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>2</sup> In 2012, some 4178 religious and traditional leaders in 15 African countries<sup>3</sup> publicly opposed female genital mutilation,<sup>2</sup> and 730 religious leaders in eight African countries<sup>4</sup> denounced any link between female genital mutilation and religion.<sup>2</sup>

45. 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>2</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.

46. 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>5</sup> and (ii) ensuring measurement of that objective,<sup>6</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.

47. Support for these efforts will continue and be enhanced in above areas, including research and guidance on effective interventions for prevention of the practice as well as improving clinical care of women living with female genital mutilation, in collaboration with Member States, national and regional centres and partner agencies, especially the joint UNFPA–UNICEF programme on female genital mutilation.

48. 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

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<sup>1</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>2</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>3</sup> Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Senegal, Somalia, Sudan and Uganda.

<sup>4</sup> Djibouti, Eritrea, Ethiopia, Gambia, Guinea-Bissau, Kenya, Mauritania and Senegal.

<sup>5</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>6</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.

adoption by the United Nations General Assembly of a resolution to intensify global efforts to eliminate female genital mutilation.<sup>1</sup>

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

49. An earlier version of this report was noted by the Executive Board at its 134th session.<sup>2</sup> The data have been revised according to estimates of mortality among adolescents for 2012 and revised prevalence of health-related behaviours to be included in a WHO report on health for the world's adolescents, due to be published in 2014.

50. The leading causes of death among people aged between 10 and 19 years are road injury, HIV/AIDS, suicide, lower respiratory infection and interpersonal violence.<sup>3</sup> Survey results for 13–15 year olds<sup>4</sup> show that the prevalence of underage alcohol drinking and heavy episodic drinking is decreasing in some high-income countries, but prevalence of alcohol use in the last 30 days can be as high as 60% in some low-income 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 40% in a few settings. In no country do adolescents meet the daily recommended level of physical activity. Prevalence of current cigarette smoking in 13–15 year olds is also decreasing, but can be as high as 33%,<sup>5</sup> and 41% of people in this age group are regularly exposed to second-hand smoke.<sup>6</sup> There is also reportedly a high exposure to bullying, with up to 67% in some settings, which 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.

51. These issues are reflected in many Member States' health policies, most focusing principally on reproductive health and HIV/AIDS.<sup>7</sup> Globally, 169 countries have implemented at least one measure to reduce the demand for tobacco. 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>8</sup> Most countries in the European Region have partially or fully implemented policies restricting the marketing of food and beverages to children and

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<sup>1</sup> United Nations General Assembly resolution 67/146.

<sup>2</sup> See the summary record of the Executive Board at its 134th session, fourteenth meeting, section 5 (document EB134/2014/REC/2).

<sup>3</sup> World Health Organization. Global Health Estimates 2013 Summary Tables: Deaths by Cause, Age and Sex by WHO regional group and World Bank income classification, 2000–2012 (provisional estimates, February 2014). Geneva: World Health Organization; 2014.

<sup>4</sup> Global school-based student health survey (GSHS). Geneva: World Health Organization; 2013 (<http://www.who.int/chp/gshs/en/>, accessed 21 October 2013).

<sup>5</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>6</sup> Global estimate of the burden of disease from second-hand smoke. Geneva: World Health Organization; 2011.

<sup>7</sup> Some 84% of national health policy documents 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).

<sup>8</sup> WHO report on the global tobacco epidemic, 2013: enforcing bans on tobacco advertising, promotion and sponsorship. Geneva: World Health Organization; 2013.

adolescents.<sup>1</sup> Setting lower limits for blood alcohol concentration (of  $\leq 0.02$  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>2</sup> National policies on the vaccination of adolescents vary between countries. The widespread interest in introducing human papillomavirus vaccine provides an opportunity to raise awareness of the need to vaccinate adolescents with booster doses against tetanus, diphtheria and meningococcal infections, and to provide catch-up vaccination against rubella, measles and hepatitis B if adolescents were not fully vaccinated during infancy.

52. 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 in resolution WHA66.8, as was the global monitoring framework for the prevention and control of noncommunicable diseases (resolution WHA66.10). 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 due to be published by WHO in 2014.

53. Current mechanisms for the coordination of activities related to the health of young people are inadequate across the Organization. A shortage of both financial and human resources has had a particularly negative impact on the systematic provision of support to countries in the implementation of existing strategies. The Regional Office for Africa has tackled this issue recently by 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 by 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)**

54. At its 134th session the Executive Board noted an earlier version of this report.<sup>3</sup> Information in paragraphs 56–59 has been updated.

55. In response to resolution WHA66.7, this 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.

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<sup>1</sup> Marketing of foods high in fat, salt and sugar to children: update 2012–2013. Copenhagen: WHO Regional Office for Europe; 2013.

<sup>2</sup> Global status report on road safety 2013: supporting a decade of action. Geneva: World Health Organization; 2013.

<sup>3</sup> See the summary record of the Executive Board at its 134th session, fourteenth meeting, section 5 (document EB134/2014/REC/2).

56. 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 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 the Federal Ministry of Health in 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 national task shifting policy; updates Federal and State Essential Medicines Lists; and develops harmonized training programmes.

57. Activities to improve access to life-saving commodities involve the provision of policy, regulatory and technical support. The WHO Model List of Essential Medicines has been updated; the 18th list was issued in April 2013 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<sup>2</sup> and a guideline compendium has been 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.

58. In June 2013, 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 were convened to ensure quality and facilitate rapid procurement for key reproductive health commodities. Surveys are in progress to establish the regulatory and quality status of targeted commodities. Products on local markets are sampled in order to provide information about where to focus technical assistance, market-shaping efforts and risk-based approaches. Technical support has been provided to manufacturers producing zinc, oral rehydration salts and amoxicillin in order to help them to secure the approval of stringent regulators.

59. 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>3</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, for instance through leveraging complementary funding streams for a “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.

60. 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

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

<sup>2</sup> WHO recommendations on postnatal care of the mother and newborn. Geneva: World Health Organization; 2013.

<sup>3</sup> The steering committee members are representatives of the donor and recipient countries Canada, Ethiopia, France, Nigeria, Norway, Senegal, Sweden and the 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.

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 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 (resolution EB124.R5)**

61. The Executive Board at its 134th session noted an earlier version of this report.<sup>1</sup> The following version has been updated in the light of comments made (see paragraph 68).

62. The report complies with the request by the 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.

63. The Secretariat has focused its awareness-raising efforts on: making health systems more resilient; safeguarding the environmental determinants of health, such as water and sanitation services; and reducing the disease burden resulting from air pollution, while 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, and ministerial-level events such as the meeting on health, air pollution and climate change, held during the Sixty-sixth World Health Assembly, and that 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 participation of health representatives. The Secretariat also collaborated in the organization of a summit bringing together nongovernmental organizations working on health and climate change and representatives of governments and bodies in the United Nations system.<sup>2</sup>

64. 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.

65. 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 Framework Convention's Nairobi Work Programme on Impacts, Vulnerability and Adaptation to Climate Change. The Secretariat has also published guidance on assessing economic damage and

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<sup>1</sup> See document EB134/53.H. Climate change and health (resolutions EB124R.5 and WHA61.19) and the summary records of the Executive Board at its 134th session, fourteenth meeting, section 5.

<sup>2</sup> <http://www.climateandhealthalliance.org/summit/climate-and-health-summit>, accessed on 13 November 2013.

adaptation costs,<sup>1</sup> and on mainstreaming gender in health adaptation programmes,<sup>2</sup> as well as a review of the effect of floods on health and prevention measures in the European Region.<sup>3</sup> A new WHO initiative aims to identify research priorities in line with paragraph 2 of resolution WHA61.19, for completion by the end of 2014. 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.

66. 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, for instance for specific focal areas including climate change, water resources and health, are also being made available.

67. 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 former Yugoslav Republic of Macedonia, the United Republic of Tanzania and Uzbekistan.

68. WHO will host the first Global Conference on Public Health and Climate Change in Geneva from 27 to 29 August 2014. The Conference will inform the revision of the current WHO work plan on climate change and health. The Secretariat will subsequently present its proposal for an updated work plan to the Executive Board for consideration at its 136th session.

## Health systems

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

69. The Executive Board at its 134th session noted an earlier version of this report,<sup>4</sup> which has been updated (see in particular paragraphs 78, 79, 81, 83, 84 and 85).

70. The global strategy and plan of action on public health, innovation and intellectual property were 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

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<sup>1</sup> Climate change and health: a tool to estimate health and adaptation costs. Copenhagen: WHO Regional Office for Europe; 2013.

<sup>2</sup> Mainstreaming gender in health adaptation to climate change programmes: user's guide: discussion draft. Geneva: World Health Organization; 2012.

<sup>3</sup> Floods in the WHO European Region: health effects and their prevention. Copenhagen: WHO Regional Office for Europe; 2013.

<sup>4</sup> See the summary record of the Executive Board at its 134th session, fourteenth meeting, section 5 (document EB134/2014/REC/2).

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.

71. 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>1</sup>

72. 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 its activities to promote research and development for the most-needed 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>2</sup>

73. 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 relevant research in order to improve transparency and strengthen the validity and value of the scientific evidence base.

74. 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.

75. 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 which will initially make an affordable monoclonal antibody against respiratory syncytial virus, infection with which is one of the leading causes of admission of infants to hospital worldwide and for which the only currently available intervention is unaffordable in most countries. In addition, the Secretariat has continued technology transfer for the local production of anti-rabies monoclonal antibodies and one of the three developing-country institutes that received the technology has completed early clinical evaluations of their locally produced monoclonal antibody. The Secretariat has also continued to support technology transfer and local production of influenza vaccines and, of the 14 developing country 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.

76. 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*:

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<sup>1</sup> The world health report 2013: research for universal health coverage. Geneva: World Health Organization; 2013.

<sup>2</sup> Global report for research on infectious diseases of poverty 2012. Geneva: World Health Organization; 2012.

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*intersections between public health, intellectual property and trade*,<sup>1</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>2</sup> in order to identify where research is being conducted into those vaccines and to what extent intellectual property may create barriers to the production of new vaccines.<sup>3</sup>

77. WHO, in collaboration with the Government of Brazil, WIPO, WTO, UNAIDS, UNITAID, 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).

78. 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 31 December 2013, WHO had prequalified 371 medicinal products (of which 62 in 2013: 27 products for treating HIV/AIDS; 17 anti-tuberculosis medicines; 10 reproductive health medicines; 7 antimalarials; and 1 treatment for a neglected tropical disease), 51 active pharmaceutical ingredients (23 in 2013), 134 vaccines, 27 diagnostic and medical devices (26 diagnostic products, for instance for use in early diagnosis of HIV infection in infants, and 1 adult male circumcision device) and 29 medicine quality-control laboratories covering all WHO regions (three in 2013).

79. The Secretariat's work on strengthening regulatory authority capacity is, where possible, based on WHO's assessment of national regulatory systems. Practical guidance on conducting assessment and self-assessment using a standardized WHO data collection tool has been developed. The main focus of work on regulatory system strengthening has been:

- developing the WHO Data Collection Tool for the review of drug regulatory systems, covering all products (including medicines, vaccines, diagnostics and devices)
- conducting assessments of regulatory capacity in priority countries (including China, India, Viet Nam and selected African countries), preparing institutional development plans and providing the required technical support
- facilitating regulatory networking, convergence and harmonization through WHO-supported networks (including the network of national pharmacovigilance centres in the WHO Programme for International Drug Monitoring, the Developing Countries Vaccine Regulators' Network and the African Vaccine Regulatory Forum) and providing secretarial support and/or technical assistance for selected regional and subregional harmonization initiatives (such as the Pan American Network for Drug Regulatory Harmonization and the African Medicines Regulatory Harmonization Initiative, with a focus on the countries in the East African Community)

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<sup>1</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>2</sup> Human pneumococcal conjugate vaccines, human conjugate typhoid vaccines and human influenza vaccines.

<sup>3</sup> Patent landscape report on vaccines for selected infectious diseases. Geneva: World Intellectual Property Organization; 2012.

- strengthening national control laboratories for medicines and vaccines, through for example prequalification of national quality control laboratories
- providing support to countries in strengthening their capacity to monitor the safety and efficacy of marketed products
- providing training opportunities for regulatory officials (more than 1700 to date), local manufacturer representatives and various partners in different technical areas such as good manufacturing practice, assessment of product quality, safety and efficacy, regulatory oversight of clinical trials, pharmacovigilance, and laboratory quality control.

80. The Alliance for Health Policy and Systems Research is producing in collaboration with WHO a report (due to be published in 2014) on access to medicines and their affordability and appropriate use. The report will include information on innovative interventions, including provision of medicines as part of universal health coverage and interventions in private markets or within patient communities.

81. In the context of element 7 (Promoting sustainable financing mechanisms), the Sixty-fifth World Health Assembly in 2012 considered the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination<sup>1</sup> and adopted resolution WHA65.22. 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 in paragraph 4 of that resolution, including establishing a global health research and development observatory, identifying and facilitating the implementation of a few health research and development demonstration projects to address identified gaps that disproportionately affect developing countries, reviewing existing mechanisms in order to assess their suitability to perform the coordination function of health research and development; and exploring and evaluating existing mechanisms for contributions to health research and development.

82. In response to element 8 (Establishing monitoring and reporting systems), the Secretariat, in collaboration with 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. The launch of the information hub is scheduled for April 2014.

83. In July 2013, in response to the conclusions of the Consultative Expert Working Group, as well as the adoption of resolution SEA/RC65/R3 by the Regional Committee for South-East Asia at its sixty-fifth session in 2012 and resolution WHA66.22 by 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.

84. The Regional Platform on Access and Innovation for Health Technologies is a cornerstone of PAHO's technical collaboration strategy for implementing the global strategy. The Platform has been operational since May 2012, but is increasingly being recognized as the channel for information

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<sup>1</sup> See the summary records of the eleventh meeting of Committee A of the Sixty-fifth World Health Assembly, section 2 (document WHA65/2012/REC/3).

exchange, collaborative work and validated information for decision-making related to health technologies in the Region of the Americas. Additionally, PAHO has conducted a formal consultation and selection process for demonstration projects in line with resolution WHA66.22 and the recommendations contained in the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination.<sup>1</sup>

85. 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 were transmitted to WHO headquarters for the global technical consultative meeting held in December 2013.

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

86. At its 134th session in January 2014, the Executive Board noted an earlier version of this progress report.<sup>2</sup> Text in paragraphs 87 and 91 has been updated.

87. In response to resolution WHA63.12 adopted in 2010, Member States and the Secretariat have undertaken numerous initiatives.

88. **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>3</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>4</sup> In October 2013, in collaboration with the Governments of Italy and Japan, WHO convened a high-level policy-makers' forum at which the Rome Declaration on Achieving Self-Sufficiency in Safe Blood and Blood Products, based on Voluntary Non-Remunerated Donation was adopted.<sup>5</sup> 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

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

<sup>2</sup> See the summary record of the Executive Board at its 134th session, fourteenth meeting, section 5 (document EB134/2014/REC/2).

<sup>3</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 February 2014).

<sup>4</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 February 2014).

<sup>5</sup> The Rome Declaration on Achieving Self-Sufficiency in Safe Blood and Blood Products based on Voluntary Non-Remunerated Donation ([http://www.who.int/bloodsafety/transfusion\\_services/romedeclarationself-sufficiencyinbloodbloodproductsVNRD.pdf](http://www.who.int/bloodsafety/transfusion_services/romedeclarationself-sufficiencyinbloodbloodproductsVNRD.pdf), accessed 25 February 2014).

Red Cross and Red Crescent Societies, provided global guidance in its publication in different languages.<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.

89. **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-mémoire 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.

90. **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.

91. **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 in 2008. WHO has issued policy guidance in an aide-mémoire 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 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).

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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 ([http://www.who.int/bloodsafety/publications/bts\\_guideline\\_donor\\_suitability/en/](http://www.who.int/bloodsafety/publications/bts_guideline_donor_suitability/en/), accessed 19 February 2014).

<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 February 2014).

<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 February 2014).

<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 February 2014).

<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 February 2014).

92. **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 good-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.

93. **WHO international biological reference preparations.** Since the adoption of resolution WHA63.12, 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 have involved countries from all regions and have proved useful in promoting WHO standards and in eliciting feedback from countries on their value.

94. 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.

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

95. The Executive Board at its 134th session noted an earlier version of this progress report.<sup>4</sup> Paragraphs 97 and 98 have been updated.

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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.

<sup>3</sup> Available at <http://www.who.int/bloodproducts/catalogue/en/> (accessed 25 February 2014).

<sup>4</sup> See the summary record of the Executive Board at its 134th session, fourteenth meeting, section 5 (document EB134/2014/REC/2).

96. 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.

97. 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, for instance, 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.

98. 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) combating 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 standard for the terminology, identification (including globally unique donation identifier), coding and labelling of medical products of human origin, ISBT 128 (responsibility for the development and management of which lies with the International Council for Commonality in Blood Banking Automation).

99. 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.

100. 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

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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).

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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.

101. 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. Haematopoietic 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.

102. 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.

103. 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**

104. The Executive Board at its 134th session noted an earlier version of this progress report.<sup>2</sup> Paragraphs 109 and 110 have been updated.

105. 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).

106. 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.

107. 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

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

<sup>2</sup> See the summary record of the fourteenth meeting, section 5, of the Executive Board at its 134th session, (document EB134/2014/REC/2).

of the WHO informal workshop on monitoring research and development resource flows that was held in February 2013.<sup>1</sup>

108. Many challenges have been identified for establishing a global observatory for health research and development, among which are the paucity of data available for indicators for health research and development, and lack of information for most Member States on both inputs (investments) and outputs (research and development pipelines and related publications).<sup>2</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 demonstrated that the distribution of global efforts in research is skewed:<sup>3</sup> 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.

109. Discussions are under way with the independent research group, Policy Cures, on specific activities for establishing links between Policy Cures' database on funding of 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. PAHO launched its Regional Platform on Access and Innovation for Health Technologies in May 2012.<sup>4</sup>

110. 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 UNICEF/UNDP/World Bank/WHO 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>5</sup>

111. Many of the concepts outlined in the strategy on research for health were further developed in *The world health report 2013*,<sup>6</sup> which includes numerous case studies highlighting the importance of research to the achievement of universal health coverage.

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<sup>1</sup> WHO informal workshop on monitoring R&D resource flows. Geneva: World Health Organization; 2013 (<http://www.who.int/phi/workshop14022013/en/index.html>, accessed 21 October 2013).

<sup>2</sup> Røttingen 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>3</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>4</sup> Regional Platform on Access and Innovation for Health Technologies. Washington, DC: Pan American Health Organization/WHO Regional Office for the Americas; 2013 (<http://prais.paho.org/rscpaho/>, accessed 21 October 2013).

<sup>5</sup> Publications & resources. Geneva: UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases; 2013 (<http://www.who.int/tdr/publications/en/> accessed 21 October 2013).

<sup>6</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).

112. 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.

113. 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)**

114. The Executive Board noted an earlier version of this report at its 134th session.<sup>2</sup> The following text has been updated and amended in light of comments made during the Board's discussion.

115. Resolution WHA65.20 calls on 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.

116. 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 across the Organization of WHO's emergency work covering all hazards, in accordance with its obligations as Global Health Cluster Lead Agency, responsibilities under the International Health Regulations (2005) and commitments to the Inter-Agency Standing Committee's Transformative Agenda. The Emergency Response Framework and an associated performance tracking system were finalized in 2013. To date, more than 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.

117. On-call WHO surge teams are being established and an initial training course for candidates was conducted in September 2013. A stand-by policy has been finalized and as of March 2014 agreements have been signed with Information Management and Mine Action Programs, the Norwegian Refugee Council, RedR Australia and CANADEM. This additional surge capacity is complemented by an

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

<sup>2</sup> See the summary records of the fourteenth meeting, section 5, of the Executive Board at its 134th session (document EB134/2014/REC/2).

arrangement supported by the European Commission's Humanitarian Aid and Civil Protection Directorate-General (ECHO), the International Medical Corps, Merlin and the Save the Children Fund. Stand-by or nongovernmental organization partners have been deployed to WHO operations in the Democratic Republic of the Congo, Jordan, Mali, Philippines, and the Syrian Arab Republic.

118. The functioning of the Global Health Cluster partnership at the international and national levels is under review in the context of the Transformative Agenda. In 2013, WHO conducted a global survey of partner capacities and field operations and undertook a strategic review of the Global Health Cluster in order 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 receive briefings on topics such as Transformative Agenda. In 2013, eight country health clusters were formally evaluated with the Inter-Agency Standing Committee's new standardized tool and areas for improvement were identified. Annual evaluations are planned for all country health clusters, beginning in 2014. 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 Global Health Cluster partners have committed themselves to enhancing substantially support to, and the performance of, the health cluster/health sector in 10 priority countries: Afghanistan, the Central African Republic, the Democratic Republic of the Congo, Haiti, Mali, Myanmar, Somalia, South Sudan, the Syrian Arab Republic and Yemen.

119. These ongoing reforms of WHO's work in humanitarian emergencies have contributed to performance at country level. Of the acute emergencies graded under the Emergency Response Framework in 2012–2013, the most challenging have been those that were also declared Level 3 crises under the Inter-Agency Standing Committee's new Protocols for Level 3 emergency responses, namely those in: the Central African Republic, the Philippines, South Sudan and the Syrian Arab Republic.

120. The crisis in the Syrian Arab Republic triggered Organization-wide support through WHO country offices in Egypt, Iraq, Jordan, Lebanon, the Syrian Arab Republic and Turkey. Application of the Emergency Response Framework in the Syrian Arab Republic resulted in more predictable and effective WHO action in such areas as rapid assessments, coordination, health service delivery, reporting, disease surveillance and response, and regularly updated health action plans.

121. Typhoon Haiyan resulted in a huge, Organization-wide effort to support relief work in the Philippines, with more than 130 emergency experts mobilized from WHO headquarters, all six regional offices and partner agencies, 84 of whom were in place within 12 days of the typhoon making landfall. With this additional capacity, the WHO Country Office was able rapidly to establish emergency operations in Manila and in eight subnational hubs, to assist the Department of Health in coordinating the work of 152 foreign medical teams and 148 national medical teams, to coordinate more than 100 Health Cluster partners, and to implement WHO's own multi-pronged response.

122. In the Central African Republic, WHO brought in 20 international staff to support operations in and outside Bangui. A rapid needs assessment, conducted with Health Cluster partners, produced information for the health sector response, advocacy for the provision of free health care to increase access, establishment of a disease early warning and response system, vaccination campaigns against measles and poliomyelitis and contingency planning for outbreaks.

123. In South Sudan, WHO immediately repurposed 47 public health and polio eradication staff, ensuring continuity of operations in 9 out of 10 states, and sent in 10 additional emergency experts for national and subnational health cluster and public health functions. Timely emergency preparedness, including prepositioning of supplies, allowed WHO to deliver life-saving medicines and supplies

rapidly to high-priority health facilities and partners, especially for dealing with trauma and providing emergency obstetric care. Mass vaccination decreased the number of measles cases and a mass cholera vaccination campaign targeting 130 000 internally displaced people in camps was started on 22 February.

124. Constraints to the emergency response of WHO and health sector partners at country level in 2012–2013 included insecurity, insufficient financing, limited national capacities, looting and attacks on health facilities and personnel, escalating costs, logistics difficulties, and, in some circumstances, complicated clearance processes.

125. WHO has developed draft 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 is advising on this process, and, in 2013, a series of technical consultations with a wide range of organizations on the development of the relevant methodology and tools was initiated. Coordination with the global protection cluster and country-based stakeholders will be enhanced in order to build capacity for collecting such data as WHO strengthens 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>

126. Accelerating the reform of WHO's capacity to meet the growing demands in humanitarian emergencies requires that chronic gaps in human and financial resources for core activities, acute emergencies and protracted crises are filled. Application of the Emergency Response Framework in 2013 has underscored the need to recruit and retain core WHO staff and ensure sustainable base funding for this purpose, especially in highly vulnerable regions and countries. For example, only three of the 29 health cluster countries currently have a full-time Health Cluster Coordinator and few have 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%) was 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 and successes. The relative underfunding of the health sector in emergencies at country level continued in 2013; only 54% of the US\$ 1331 million requested through the Consolidated Appeals Process was received, compared to an overall percentage of 62% for all sectors.<sup>2</sup> The health sector also continues to be underfunded in many major emergencies: 49.1% of the health cluster funding was received for the Central African Republic in 2013 and 71.4% for the Syrian Humanitarian Assistance Response Plan. As of 10 March 2014, WHO was funded at only 11% and 23% of requirements for the Level 3 appeals for the Central African Republic and South Sudan, respectively.

127. To further improve its performance as Global Health Cluster Lead Agency in 2014–2015, the Secretariat 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 act as a backstop for, Health Cluster coordinators, particularly in the designated priority countries; seek to staff fully core cluster functions in the designated priority countries; continue to strengthen its internal surge capacity and expand the use of its stand-by and nongovernmental organization partners; and enhance evaluation and monitoring of the capacity and performance of each health cluster at country level.

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

<sup>2</sup> Source: Office for the Coordination of Humanitarian Affairs, Financial Tracking Service, February 16 2014.

## Corporate services/enabling functions

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

128. The Board at its 134th session noted an earlier version of this progress report.<sup>1</sup> The statistics have been updated in the following report.

129. Efforts to increase multilingual content on WHO's website have continued. The multilingual team of web editors, working with the Secretariat's translation service, has reduced the gap in availability of technical content between English and the other five official languages of the Organization. The team has also made all corporate web content available in the six official languages. During the biennium 2012–2013, 1541 webpages were added in Arabic, 1852 in Chinese, 8234 in English, 2237 in French, 1955 in Russian and 1472 in Spanish.

130. As at February 2014, WHO's Institutional Repository for Information Sharing (IRIS)<sup>2</sup> included more than 71 000 records in the official languages, comprising WHO information products and governing bodies documentation (including Health Assembly and Executive Board documentation from 1998 onwards and the documentation of the WHO Framework Convention on Tobacco Control). IRIS is recording an average of two 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.

131. In 2012, the Russian Federation provided funds to support a two-year project for increasing the quality and quantity of WHO's technical and scientific information products available in Russian, and for improving their dissemination to Russian-speaking audiences. As at February 2014, 26 major publications have been translated and published in Russian at headquarters and in the Regional Office for Europe, and distribution networks for Russian-language publications have been expanded. A total of 568 existing print publications in Russian have been digitized and stored in IRIS. Three special issues of the Bulletin of the World Health Organization in Russian have been published. More than 20 new technical websites in Russian have been created or updated on the main WHO website, and 12 country profiles in Russian have been created on the website of the Regional Office for Europe.

132. Work to ensure that WHO's information products are available in official and non-official languages has continued to progress. During the biennium 2012–2013, WHO Press authorized external partners and regional offices to undertake 391 translations of 247 headquarters' products into 54 languages (5 official and 49 non-official).

133. 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

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<sup>1</sup> See document EB134/53, section N, and document EB134/2014/REC/2, the summary record of the fourteenth meeting, section 5.

<sup>2</sup> Available at <http://www.who.int/iris> (accessed 25 February 2014).

have been accorded priority in this programme; during the biennium 2012–2013 1788 staff from all WHO regions enrolled.

134. 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.

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

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

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