

## **Progress reports**

### **Report by the Secretariat**

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## Noncommunicable diseases

### A. COMPREHENSIVE MENTAL HEALTH ACTION PLAN 2013–2020 (resolution WHA66.8)

1. The comprehensive mental health action plan 2013–2020 was adopted by the Sixty-sixth World Health Assembly in May 2013.<sup>1</sup> The present report summarizes progress made in implementing the action plan, as requested in resolution WHA66.8.

2. The action plan includes six global targets and associated indicators to measure progress in its implementation. As requested in the resolution, and as one of the early implementation activities, the Secretariat prepared a more complete set of indicators for Member States to use as the basis for regular data collection and reporting to WHO. Accordingly, the Secretariat undertook a mapping of indicators to each objective and action area, and on the basis of expert consultation and national-level piloting, identified a further eight core indicators to complement those already present in the action plan, including levels of stakeholder involvement, human and financial resource inputs, service availability and social support. All core indicators have been incorporated into an updated WHO mental health atlas.<sup>2</sup>

3. By February 2015, a total of 173 Atlas questionnaires had been submitted, representing a response rate of 89%. Response rates were lower for certain indicators, including social support, continuity of care and mental health spending, which reflects the limitations in many countries in terms of availability of data and information systems. A specific report focusing on mental health activities is prepared regularly by 38% of Member States. Of the 173 Member States providing data for the Atlas, 76% report having stand-alone mental health policies; 57% report having mental health laws or relevant legislation; and 15% report having full (and a further 39%, partial) participation of persons with mental and psychosocial disabilities in policy, planning, legislation and service development. The availability of resources and services for mental health varies widely across countries and regions, and remains extremely limited in many lower-income countries. More than half of Member States report having at least two functioning promotion and prevention programmes for mental health, but only 22% have in place a national suicide prevention strategy.

4. A number of initiatives have been undertaken to improve on this baseline situation. Regional mental health strategies and frameworks for action have now been endorsed by the respective regional committees as follows: in October 2014, the 66th session of the Regional Committee of WHO for the Americas resolved to approve the Plan of Action on Mental Health;<sup>3</sup> in September 2013, the Regional Committee for Europe endorsed the European Mental Health Action Plan;<sup>4</sup> and in October 2014, the Regional Committee for the Western Pacific endorsed the Regional Agenda for Implementing the Mental Health Action Plan 2013–2020 in the Western Pacific.<sup>5</sup> Negotiations are under way to revise

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<sup>1</sup> Document WHA66/2013/REC/1, Annex 3.

<sup>2</sup> The WHO Mental Health Atlas is an instrument developed by WHO to collate information from countries on the core mental health indicators. Those indicators were proposed for assessing progress towards implementation of the Comprehensive action plan. For more information, see [http://www.who.int/mental\\_health/evidence/atlas/mnh/en/](http://www.who.int/mental_health/evidence/atlas/mnh/en/) (accessed 26 March 2015).

<sup>3</sup> See resolution CD53.R7.

<sup>4</sup> See resolution EUR/RC63/R10.

<sup>5</sup> See resolution WPR/RC65.R3 on mental health.

the regional strategy for mental health at the Regional Office for Africa.<sup>1</sup> Negotiations are also under way at the Regional Office for the Eastern Mediterranean.

5. Another initiative is MiNDbank, an online platform launched by WHO in December 2013 that gives policy-makers, advocates and researchers prompt access to international resources and national-level policies, strategies, laws and service standards related to mental health, substance abuse, disability and human rights from over 170 countries.<sup>2</sup>

6. Further WHO initiatives include the publication of several reports: its first world suicide report, *Preventing suicide: a global imperative*,<sup>3</sup> was launched in September 2014. According to WHO estimates, in 2012, there were 803 900 cases of suicide worldwide (an age-standardized rate of 11.4 per 100 000 population). In the area of emergency mental health, WHO published in 2013 the report, *Building back better: sustainable mental health care after emergencies*,<sup>4</sup> and in 2014, *Psychological first aid during Ebola virus disease outbreak*.<sup>5</sup>

7. The Secretariat is directly involved in providing technical support to 89 projects in 63 Member States, including mental health and substance abuse, service development, suicide prevention, mental health system and service strengthening (including after emergencies), and the assessment and promotion of human rights of people with mental health conditions. The intervention guide of WHO's mental health gap action programme (mhGAP) is currently being used in 84 countries, in 19 languages. WHO and its international partners (including collaborating centres) are now undertaking a revision of mhGAP guidelines and are working together on the establishment of a Mental Health Innovation Network to facilitate the sharing of best practices and resources for mental health. The Secretariat also led advocacy efforts for mental health, including the organization of the annual mhGAP forum in Geneva and participation in other global, regional and national events.

## **B. COMPREHENSIVE AND COORDINATED EFFORTS FOR THE MANAGEMENT OF AUTISM SPECTRUM DISORDERS (resolution WHA67.8)**

8. In May 2014, the Sixty-seventh World Health Assembly adopted resolution WHA67.8 on comprehensive and coordinated efforts for the management of autism spectrum disorders. The present report provides the requested update on progress made with regard to autism spectrum disorders. In particular, the resolution requested the Director-General, *inter alia*, to implement resolution WHA66.8 on the comprehensive mental health action plan 2013–2020, as well as resolution WHA66.9 on disability, in order to scale up care for individuals with autism spectrum disorders and other developmental disorders, as applicable, and as an integrated component of the scale-up of care for all mental health needs.

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<sup>1</sup> In September 1999, the Regional Committee for Africa at its forty-ninth session approved the Regional Strategy for Mental Health 2000–2010, document AFR/RC49/9, available at: <http://www.afro.who.int/en/clusters-a-programmes/dpc/mental-health-violence-and-injuries/mvi-publications.html> (accessed 1 April 2015).

<sup>2</sup> For more information on MiNDbank, see [http://www.who.int/mental\\_health/mindbank/en/](http://www.who.int/mental_health/mindbank/en/) (accessed 1 April 2015).

<sup>3</sup> *Preventing suicide: a global imperative*, see : [http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779\\_eng.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf?ua=1&ua=1) (accessed 11 March 2015).

<sup>4</sup> *Building back better: sustainable mental health care after emergencies*, see: [http://apps.who.int/iris/bitstream/10665/85377/1/9789241564571\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/85377/1/9789241564571_eng.pdf?ua=1) (accessed 11 March 2015).

<sup>5</sup> *Psychological first aid during Ebola virus disease outbreak*, see : [http://apps.who.int/iris/bitstream/10665/131682/1/9789241548847\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/131682/1/9789241548847_eng.pdf?ua=1) (accessed 23 March 2015).

9. In line with the requirements of the resolution, the Secretariat is implementing activities and is working in an integrated manner with the implementation of resolution WHA66.8 and resolution WHA66.9.

10. After convening the Consultation on Autism Spectrum Disorders and Other Developmental Disorders: from Raising Awareness to Building Capacities (Geneva, 16–18 September 2013),<sup>1</sup> the Secretariat facilitated the establishment of a network of international stakeholders, experts and advocates, to coordinate efforts towards improved care for persons with autism spectrum disorders and other developmental disorders. In addition, the Secretariat promoted, on the basis of expert consultation, the definition of priority actions by research and academic institutes, for civil society, for governments and for WHO in collaboration with partners. At regional level, it supported autism-related networks, such as the Southeast Europe Autism Network, and facilitated resource mobilization and coordination mechanisms for the implementation of priority actions towards improved care for persons with autism spectrum disorders and other developmental disorders.

11. The Secretariat contributed to international advocacy and awareness raising efforts by participating in and organizing events on the occasion of the United Nations World Autism Awareness Day and other events, in collaboration with advocate and self-advocate organizations.

12. In order to strengthen countries' capacities to develop and scale up services for persons with autism spectrum disorders and other developmental disorders, a package of capacity building materials and guidelines on the assessment and management of such conditions have been made available to policy-makers and care providers in the context of WHO's mental health gap action programme (mhGAP), which is being implemented in 84 countries.

13. Available tools include updated guidelines on management of autism spectrum disorder in children and adults, training materials for a range of non-specialist providers, including teachers and community-workers, a parent skills training programme on autism spectrum disorders and other developmental disorders, and a draft guidebook on the use of instruments for detection, assessment and follow-up of people with autism spectrum disorders and other developmental disorders. These materials were developed following a rigorous evidence-based and consultative process, with the engagement of WHO Collaborating Centres, research experts and users. A capacity building workshop on parent skills training is scheduled for April 2015.

14. The Secretariat is working with Member States and civil society organizations to mobilize human and financial resources dedicated to autism spectrum disorders.

### **C. DISABLING HEARING LOSS (resolution WHA48.9)**

15. WHO estimates that globally 360 million people live with disabling hearing loss. Thirty-two million of these are children. Among those aged 65 years or older, nearly one third suffer hearing loss. The majority of those affected live in middle- and low-income countries where human resources, treatment options and access to hearing devices are limited. Recent analysis reveals that nearly one billion people in the age group of 12–35 years, living in high- and middle-income countries, are at risk of developing hearing loss due to recreational exposure to loud sounds.

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<sup>1</sup> The meeting report of the consultation is available at: [http://apps.who.int/iris/bitstream/10665/103312/1/9789241506618\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/103312/1/9789241506618_eng.pdf) (accessed 24 March 2015).

16. Hearing loss has an impact on an individual's ability to communicate as well as on education and employment opportunities. In addition, hearing loss affects social and economic development in communities and countries. Many of the causes of hearing loss, including ear infections, noise, ototoxic medications, rubella and meningitis, can be prevented through public health measures. Once hearing loss develops, a range of interventions can help to maximize functioning, including hearing devices. In developing countries, however, only 3% of those who need a hearing aid have access to one.

17. Over the last two decades, many high-income countries and some middle-income countries have developed and implemented comprehensive screening programmes for early identification and management of infants with hearing loss. Significant technological advances have been made with the availability of new diagnostic tests and sophisticated hearing devices, such as cochlear implants.

18. While many countries were already implementing programmes for control of occupational noise, a few countries have included control of environmental and recreational noise in their purview.

19. In order to provide technical guidance to support the implementation of hearing care strategies by Member States, WHO has developed the following:

- Guidelines for the provision of hearing aids in low- and middle-income countries, which were developed in 2001 and revised in 2004.<sup>1</sup> Based on this guidance, in 2013, WHO developed a preferred product profile for hearing aids and services.
- In 1999, guidelines for community noise were formulated.<sup>2</sup>
- In 2011, guiding principles for newborn and infant hearing screening were developed through a consultative process.<sup>3</sup>
- In 2012, guidelines for promoting ear and hearing care through community-based rehabilitation programmes were developed.<sup>4</sup>

20. A survey protocol for epidemiology of hearing loss was developed in 1999, in order to have uniformity in epidemiological surveillance worldwide.<sup>5</sup> This has been used in a number of countries to conduct population-based prevalence studies on hearing loss.

21. In line with the focus on primary ear and hearing care, training manuals for training of health workers, primary level functionaries and doctors in primary ear and hearing care have been developed. They are available to suit three different levels: basic, intermediate and advanced. They were released

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<sup>1</sup> See *Guidelines for hearing aids and services for developing countries*, second edition, September 2004, at: [http://www.who.int/pbd/deafness/en/hearing\\_aid\\_guide\\_en.pdf](http://www.who.int/pbd/deafness/en/hearing_aid_guide_en.pdf) (accessed on 25 March 2015).

<sup>2</sup> See Guidelines for community noise, at: <http://whqlibdoc.who.int/hq/1999/a68672.pdf> (accessed on 25 March 2015).

<sup>3</sup> See *Newborn and infant hearing screening: current issues and guiding principles for action*, at: [http://www.who.int/blindness/publications/Newborn\\_and\\_Infant\\_Hearing\\_Screening\\_Report.pdf](http://www.who.int/blindness/publications/Newborn_and_Infant_Hearing_Screening_Report.pdf) (accessed on 25 March 2015).

<sup>4</sup> See *Community-based rehabilitation: promoting ear and hearing care through CBR*, at: <http://www.who.int/pbd/deafness/news/CBREarHearingCare.pdf> (accessed on 27 March 2015).

<sup>5</sup> For more information on the survey protocol, see the WHO website on epidemiology and economic analysis, at: [http://www.who.int/pbd/deafness/activities/epidemiology\\_economic\\_analysis/en/](http://www.who.int/pbd/deafness/activities/epidemiology_economic_analysis/en/) (accessed on 30 March 2015).

in 2006, translated into many languages and are being used by many countries to promote hearing care at primary level.

22. With technical support from WHO, national programmes for hearing care continue to be developed and implemented in the following Member States: Bangladesh, Guinea, Kenya, Malawi, Mongolia, Morocco, Nicaragua, Sri Lanka, Zambia and Zimbabwe. Technical assistance is made available to countries to enable them to: conduct situation analyses; implement programmes; and develop strategic plans, monitoring tools and outcome indicators.

23. A network of WHO collaborating centres has been established, strengthening the partnership with and between those centres that work on prevention of hearing loss.<sup>1</sup>

24. WHO partnerships with key organizations have been strengthened, including those with the International Federation of Otolaryngological Societies, International Society of Audiology, Society for Sound Hearing International, and Christian Blind Mission.

25. Revised global estimates on the prevalence of hearing loss were released in 2013.

26. In March 2014, WHO published the report, *Multi-country assessment of national capacity to provide hearing care*.<sup>2</sup> This focuses on availability of human resources for hearing care in different regions and provides a baseline of the number of countries that have national plans for hearing care.

27. WHO has developed global advocacy campaigns to raise awareness about different aspects of hearing loss. The following campaigns were in place on International Ear Care Day (March 3):

- In 2013, the theme was “Healthy hearing, happy life – hearing health care for ageing people”, which focused attention on the hearing needs of the population over 65 years of age.
- In 2014, the theme was “Ear care can avoid hearing loss”, which drew attention to the prevention of otitis media through primary ear care.
- In 2015, “Make listening safe” was the theme, intended to address the rising problem of noise-induced hearing loss due to recreational exposure to loud sounds.

28. In the coming years, WHO intends to scale up its efforts in countries to implement hearing care plans for prevention and management of hearing loss. Tools of technical support for capacity building, raising awareness and developing comprehensive hearing care services will be developed.

## Communicable diseases

### D. ERADICATION OF DRACUNCULIASIS (resolution WHA64.16)

29. In May 2011, the Health Assembly in resolution WHA64.16 called for intensified eradication efforts and requested the Director-General to closely monitor the implementation of the resolution and

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<sup>1</sup> For more information on the newly-formed network of WHO collaborating centres, see: <http://www.who.int/pbd/deafness/news/network/en/> (accessed 30 March 2015).

<sup>2</sup> The report is available at: [http://www.who.int/pbd/publications/WHOReportHearingCare\\_Englishweb.pdf](http://www.who.int/pbd/publications/WHOReportHearingCare_Englishweb.pdf) (accessed on 25 March 2015).

report every year until eradication of dracunculiasis is certified. The present report provides the requested update for 2014.

30. Since the 1980s, national eradication programmes have eliminated dracunculiasis in 17 countries. Indigenous transmission is now localized to limited areas of the four countries where the disease remains endemic: Chad, Ethiopia, Mali and South Sudan.<sup>1</sup>

31. During 2014, altogether 126 cases from 54 villages were reported to WHO: compared with 2013, these figures represented a 15% decrease in cases and a 48% reduction in affected villages. Cases were reported in South Sudan (70), Mali (40), Chad (13) and Ethiopia (2). Sudan, which is in the pre-certification stage, reported no case in 2014 (compared with three in 2013).<sup>2</sup> Active surveillance was done in 8946 villages in 2014. Control of copepods through the use of the larvicide temephos has increased and now covers all localities reporting cases.

32. Subsequent to South Sudan's introduction in April 2014 of a cash reward (equivalent to US\$ 100) for voluntary reporting of a case of dracunculiasis, all six countries<sup>3</sup> that are endemic for the disease or in the pre-certification stage are offering cash rewards for voluntary reporting of a case. Overall, about 90% of districts reported monthly during 2014. More than 14 000 rumours were reported in endemic countries and countries in pre-certification stage, with about 90% of rumours investigated within 24 hours. Post-certified countries continued to submit quarterly reports to WHO in 2014, and investigation of 518 rumours in eight post-certified countries<sup>4</sup> confirmed no case of dracunculiasis.

33. The polio surveillance network has continued to include searches for dracunculiasis cases in its national immunization day campaigns in both endemic and pre-certification countries.

34. Insecurity and inaccessibility owing to conflicts pose major challenges to eradication. Since March 2012, security concerns in the north of Mali have interrupted the activities of the national dracunculiasis eradication programme, although United Nations bodies involved in humanitarian support have facilitated intermittent surveillance. The detection of more cases in Mali in 2014 than in 2013 results from the relative improvement in security. Surveillance has also been intensified in the Malian refugee camps in Burkina Faso, Mauritania and Niger in order to detect any imported cases and to prevent further spread of the disease. Civil unrest in South Sudan has hampered programme implementation owing to massive population displacement in some areas where dracunculiasis is endemic and restricted access to endemic areas.

35. Another challenge is seen in Chad, where a sporadic and dispersed pattern of human cases has been observed since 2010, with documentation of infected dogs in the Chari River basin. Given this unusual mode of transmission, an operational research programme has been initiated by The Carter

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<sup>1</sup> Until South Sudan gained its independence on 9 July 2011, it was part of Sudan; thus, between the 1980s and 2011, 20 countries were endemic for the disease.

<sup>2</sup> A country is considered to have re-established endemicity if (1) no confirmed indigenous case of dracunculiasis was reported for >3 years and (2) indigenous transmission of laboratory-confirmed cases subsequently occurred during  $\geq 3$  consecutive calendar years (<http://www.who.int/wer/2012/wer8719.pdf?ua=1>, accessed 13 March 2015).

<sup>3</sup> Countries endemic for dracunculiasis: Chad, Ethiopia, Mali and South Sudan; countries in the pre-certification stage: Kenya and Sudan.

<sup>4</sup> Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Niger, Nigeria, Togo and Uganda.



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Center and the Centers for Disease Control and Prevention in order to find appropriate ways to accelerate interruption of transmission.

36. The Secretariat convened a scientific meeting (Geneva, 12 and 13 January 2015) to identify priority areas for operational research and to examine the canine epizootiology in Chad and continued low-level transmission in Ethiopia.

### **Certification**

37. On the recommendation of the International Commission for the Certification of Dracunculiasis Eradication at its tenth meeting (Geneva, 14 and 15 January 2015), the Director-General certified Ghana as free of dracunculiasis transmission, bringing the total number of countries, territories and areas certified free of dracunculiasis transmission to 198 (including 186 WHO Member States). With Ghana now certified, a total of eight countries remain to be certified: the four endemic countries – Chad, Ethiopia, Mali and South Sudan; the two remaining countries in the pre-certification stage – Kenya and Sudan; and Angola and the Democratic Republic of the Congo, which have had no recent history of the disease.

38. The Commission has advised the Secretariat to prepare a plan of action for implementing a global reward as soon as transmission is interrupted, as was done during the last phase of the smallpox eradication campaign.

39. The Director-General monitors the eradication programme on a monthly basis. An annual review meeting of national dracunculiasis eradication programmes is held.

40. On the margins of the Sixty-seventh World Health Assembly an informal meeting of health ministers of countries in which dracunculiasis was or is endemic was attended by more than 100 participants and addressed by the former President of the United States of America (Jimmy Carter, by video message), the Director-General and the Regional Director for Africa. The health ministers of the four remaining endemic countries, or their representatives, who were requested to provide leadership by personally advocating for the eradication programme, pledged their continued commitment to interrupting transmission of the disease at the earliest. Visits by the ministers of health of Ethiopia (2013) and South Sudan (2014) to endemic villages in their respective countries added a sense of urgency to accelerating eradication activities.

41. The Carter Center continues to provide operational support to eradication activities in endemic countries. UNICEF is supporting the provision of improved drinking-water sources to endemic and at-risk villages. WHO is providing support to strengthen surveillance in pre- and post-certified countries and in dracunculiasis-free areas of endemic countries and in preparing countries for certification. Additional funding is needed for eradication activities for the period 2015–2020, which was considered at an expert review meeting (Atlanta, United States of America, 29 and 30 July 2014).

### **E. ELIMINATION OF SCHISTOSOMIASIS (resolution WHA65.21)**

42. Schistosomiasis remains a significant public health problem, with an estimated 261 million people requiring preventive chemotherapy in 2013.

43. Sustained high-level advocacy for neglected tropical diseases and improved resource capacity in some countries has resulted in increased implementation of control programmes, especially spurred by the WHO's road map to accelerate work and the London Declaration on neglected tropical diseases (2012). For schistosomiasis, control has progressed, with 42.1 million people reported to have been

treated in 31 countries in 2012 and 40.5 million people in 23 countries in 2013. The reports for 2013 are incomplete, and the numbers are likely to increase after more countries have reported. The global availability of praziquantel increased to 282 million tablets in 2014, sufficient to meet 51.2% of the need; by that year, the donation by the pharmaceutical company Merck had increased to 72.3 million tablets.

### **African Region**

44. Of the 41 Member States that have populations requiring preventive chemotherapy for schistosomiasis, 36 (88%) were implementing that treatment in 2014 but only 14 countries had extended coverage to all endemic areas. Mapping of schistosomiasis has improved: in 2014, 25 countries were entirely mapped (61%) and 15 countries partially mapped (37%). The reported number of people receiving preventive chemotherapy for schistosomiasis increased by nearly 25% from 2011 to 27.5 million in 2013, but the coverage is far lower than WHO's target of 75% of school-age children. Elimination projects have been started in three countries (Burundi, Rwanda and United Republic of Tanzania (Zanzibar)), with integrated approaches combining all the necessary strategies, including health education, improved sanitation, water supply, and snail control.

### **Region of the Americas**

45. In the Region, populations in two countries (Brazil and Bolivarian Republic of Venezuela) require preventive chemotherapy. Two other countries (Suriname and Saint Lucia) have residual transmission while in six other countries or territories (the island of Antigua, Dominican Republic, Guadeloupe, Martinique, Montserrat and Puerto Rico) transmission may have been interrupted, although surveys are needed to verify that status. According to the latest figures (for 2012), more than 27 000 people were reported to have received preventive chemotherapy.

### **South-East Asia Region**

46. Only Indonesia has populations that require preventive chemotherapy, and, in 2013, 10 392 people were so treated (compared with 14 102 people in 2011).

### **European Region**

47. The report in 2014 of 17 autochthonous cases of schistosomiasis due to *Schistosoma haematobium* in Corsica (France) between 2011 and 2013 highlights the need for vigilance and sensitive tools to detect and prevent the establishment of transmission in new areas where snail intermediate hosts are present.

### **Eastern Mediterranean Region**

48. Four countries (Egypt, Somalia, Sudan and Yemen) have populations requiring chemotherapy. The number of people reported to have received preventive chemotherapy was 2.7 million in 2012. In 2013, Egypt, Sudan and Yemen reported treating nearly 12 million people (45.1% being school-age children), representing a considerable increase against 2012. Yemen accounted for 80.1% of those reported treated in 2013. In Yemen, treatment was administered to males and females in all age-groups, with school-age children representing 56.6% of those treated; five times more people were treated in 2013 than in 2012.

## Western Pacific Region

49. Four countries (Cambodia, China, Lao People's Democratic Republic and Philippines) have populations requiring preventive chemotherapy, with 3.8 million people being treated in 2011 and the same number in 2012. In 2013, reports on schistosomiasis treatment were received from Cambodia, Lao People's Democratic Republic and the Philippines; altogether 1 014 529 people were treated, mostly adults (77.8%). China has not submitted a report yet.

50. The public health impact of preventive chemotherapy is limited by the lack of significant investment in complementary public health measures necessary to interrupt transmission of schistosomiasis, such as snail control, provision of potable water, basic sanitation and hygiene education.

51. WHO has classified countries by status of endemicity.<sup>1</sup> Several countries that have reported no autochthonous case in several years may have interrupted transmission. There is therefore a need for elimination assessment in such countries.

52. At the request of the Islamic Republic of Iran, an expert mission was undertaken in March 2013 to assess documentation on the status of schistosomiasis. The mission recommended that the national authorities compile a dossier on the success of the control programme. On the basis of such a dossier, formerly endemic areas could be selected for assessment with tools validated elsewhere. In 2013, a similar mission to Saint Lucia found that few cases of schistosomiasis occurred each year. Appropriate surveys were recommended to determine residual transmission and to underpin the design of an elimination programme. In Suriname in 2010, the results of a coprological and serological survey showed very low levels of schistosomiasis transmission and that elimination strategies should be implemented. The Regional Office for the Americas/Pan American Health Organization and partners supported a similar survey in the Dominican Republic in 2014 to assess schistosomiasis transmission; the results have not yet been disseminated.

53. The Secretariat has drafted procedures for the evaluation of the elimination of transmission, which will be revised as necessary to meet the requirements of the Guidelines Review Committee after internal and expert review. Guidelines for assessing the efficacy of molluscicides for snail control have been updated and are being reviewed by the WHO Pesticide Evaluation Scheme. Opportunities to integrate snail control with other vector control or integrated vector management practices in areas endemic for both schistosomiasis and other vector-borne diseases are being considered. Reviews on the use of novel diagnostic tools for schistosomiasis, more appropriate for low-transmission areas, are ongoing.

## F. NEGLECTED TROPICAL DISEASES (resolution WHA66.12)

54. The Secretariat, under the guidance of the Strategic and Technical Advisory Group for Neglected Tropical Diseases, is working with Member States to implement resolution WHA66.12 through five interventions: (i) preventive chemotherapy; (ii) innovative and intensified disease management; (iii) vector control; (iv) control of neglected zoonotic diseases through adequate

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<sup>1</sup> Schistosomiasis: progress report 2001–2011 and strategic plan 2012–2020. Geneva: World Health Organization; 2012 (document WHO/HTM/NTD/2012.7, [http://www.google.ch/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CB8QFjAA&url=http%3A%2F%2Fwww.who.int%2Firis%2Fbitstream%2F10665%2F78074%2F1%2F9789241503174\\_eng.pdf&ei=YskCVZuMHdLfaqqXgMgP&usg=AFQjCNGLP01m6RZRZicNM9G6ENtRZw9CzA&sig2=P9GLfv3esEOe4KHOO7LVfA&bvm=bv.88198703,d.d2s](http://www.google.ch/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CB8QFjAA&url=http%3A%2F%2Fwww.who.int%2Firis%2Fbitstream%2F10665%2F78074%2F1%2F9789241503174_eng.pdf&ei=YskCVZuMHdLfaqqXgMgP&usg=AFQjCNGLP01m6RZRZicNM9G6ENtRZw9CzA&sig2=P9GLfv3esEOe4KHOO7LVfA&bvm=bv.88198703,d.d2s), accessed 13 March 2015).

veterinary public health services; and (v) provision of safer water, sanitation and hygiene. National plans have been prepared in 74 countries. In 2013, the Regional Committee for Africa adopted a regional strategic plan for 2014–2020 (resolution AFR/RC63/R6).

55. Standard practices and processes for data collection are being updated by the Secretariat for appropriate reporting, validation and analysis. Headquarters and regional offices are working with partners to support the monitoring and evaluation of needs for national control programmes against neglected tropical diseases and the monitoring of the efficacy of medicines. A data-quality assessment tool is being field tested, with good preliminary results. In order to improve coordination and integration among different programmes, online forms are available to facilitate application, review and reporting; national programmes are encouraged to complete and submit them every year.

56. To strengthen capacity for neglected tropical disease control programmes the Secretariat provided training courses in 2014 for national teams implementing preventive chemotherapy programmes in populous countries such as Ethiopia and Nigeria, where about 200 programme managers participated. Similar training workshops for national programme managers were also held in the Eastern Mediterranean and Western Pacific regions. The Secretariat also coordinated the preparation of a training course for district-level managers; a pilot course is planned to be held in the next few months. New courses on Chagas disease have been implemented with support from WHO Collaborating Centres.

57. Even though existing tools can bring benefit to the millions of people suffering from or at risk of neglected tropical diseases, WHO is encouraging more research and development of new and improved medicines, and studies on work to maximize expansion of interventions and intensify management of complex diseases. For some diseases, innovative strategies have been identified to integrate treatment, control and elimination activities, thereby optimizing the use of existing resources. Through WIPO's research consortium, pharmaceutical companies have opened their libraries of compounds to outside researchers, improving prospects for the development of new medicines.

58. **Dracunculiasis** is on the verge of eradication (see section D above).

59. **Yaws.** Pilot studies in Ghana, Papua New Guinea, the Solomon Islands and Vanuatu show the efficacy of single-dose oral treatment with azithromycin. In December 2014, India submitted a dossier to WHO documenting the absence of yaws in the country and requesting WHO to make a formal declaration on its elimination.

60. The Secretariat is strengthening the capacity of countries to expand **preventive chemotherapy** interventions. In 2014, it coordinated the procurement and supply of some 1300 million treatments to 78 countries. It is implementing joint forecasting and sharing of information with partners and supporting distribution of available donated medicines and expanding coverage. Through preventive chemotherapy, more than 711 million people received treatment for at least one disease in 2013, a global coverage of 31.4% of the people in need.

61. **Onchocerciasis** was eliminated in Colombia in 2013 and Ecuador in 2014. In October 2014, Mexico submitted an elimination report to the Secretariat. Guatemala ended post-treatment surveillance and is preparing to submit an elimination report later this year. Brazil and the Bolivarian Republic of Venezuela are the last two countries in the Region of the Americas where mass administration of medicines is continuing, in the cross-border Yanomami area.

62. Substantial progress has also been made with innovative and intensified disease management. The decline in the number of reported cases of **human African trypanosomiasis** is in line with the

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elimination target of WHO's road map on neglected tropical diseases. The population living in high or very high risk areas has been reduced largely as a result of continued provision of support to endemic countries by a public–private partnership. In 2014, WHO created a network for the elimination of human African trypanosomiasis in order to coordinate interventions.

63. Unprecedented progress has been made in the elimination of **visceral leishmaniasis** in the Indian subcontinent. In Bangladesh, technical expertise, political commitment and community mobilization have contributed to the more than 70% reduction achieved in the number of new reported cases between 2009 and 2013. In 2014 a Memorandum of Understanding was signed by Bangladesh, Bhutan, India, Nepal and Thailand for the elimination of visceral leishmaniasis, with all five countries adopting the use of single-dose liposomal amphotericin B.

64. A network of countries endemic for **cutaneous leishmaniasis** has been extended to include countries in the African, European and Eastern Mediterranean regions.

65. The number of **Buruli ulcer** cases reported continues to decline in many countries. Recruitment continues for a clinical trial comparing a combination of rifampicin and streptomycin with a combination of rifampicin and clarithromycin in Benin and Ghana; the aim is to validate a fully oral antibiotic. Progress has also been made in the development of a rapid diagnostic test for the disease. In 2014, WHO supported the training in the United States of America of seven health workers from three endemic countries in the use of a simple method for the detection of mycolactone in tissues. In collaboration with the Foundation for Innovative New Diagnostics, selected health centres are being equipped to use this method, which can provide results within one hour.

66. For **Chagas disease**, advances have been made in interrupting both intradomestic vectorial transmission (especially in remaining hotspots such as the north-west of Argentina and the south of Peru) and transfusional transmission (in endemic and non-endemic countries), and in case detection and care (from congenital to adult cases).

67. **Dengue** and **chikungunya** continue to spread at an alarming pace. Heavy reliance on a single class of insecticides, the pyrethroids, causes concern to the Secretariat; the detection of resistance to these compounds demands comprehensive insecticide resistance management. The Director-General has established a Vector Control Advisory Group to assess the public health value of new vector control innovations and prepare appropriate technical recommendations. The capacity and resources of the WHO Pesticide Evaluation Scheme are being strengthened to support: (i) the Scheme's role in the testing and evaluation of new public health pesticides; and (ii) Member States in developing policies, strategies and guidelines for the sound management of pesticides. WHO is also working with its partners, including those in the private sector, on a broader initiative to enhance innovation and large-scale implementation of novel vector control tools and methodologies. The global strategy for dengue prevention and control 2012–2020 further highlights the need for sustained integrated vector control measures, better diagnostics and case management, integrated surveillance, and focused research on medicines and vaccines, in order to reduce the rate of morbidity due to dengue by at least 25% and the rate of mortality by at least 50% by 2020.

68. Control of zoonotic neglected diseases requires interventions that break the human–animal–environmental cycle of transmission. WHO is collaborating with FAO, OIE, the private sector, nongovernmental organizations and other partners to increase advocacy and investment for the control of diseases such as **echinococcosis**, **foodborne trematodiasis**, **rabies**, and **taeniasis and neurocysticercosis**.

69. **Canine rabies** and **human rabies** transmitted by dogs have been eliminated in many countries in Latin America. Between 2010 and 2014, human rabies transmitted by dogs was restricted to the Plurinational State of Bolivia, the Dominican Republic, Guatemala, Haiti, and Honduras, and some limited areas within Brazil and Peru; elimination of dog-transmitted human rabies is expected in Latin America (by end-2015), and in the South-East Asia and Western Pacific regions (by 2020). Proof of concept projects in the Philippines, South Africa (the KwaZulu-Natal province) and the United Republic of Tanzania are making noteworthy progress in demonstrating that rabies can be controlled through effective vaccination and management of canine populations.

70. WHO is promoting the provision of safe water, sanitation and hygiene as part of global efforts to reduce disease transmission. School-based programmes, with the support of the education sector, have made important progress in promoting healthy behaviour and delivering interventions in remote communities. Food safety practices involving proper hand-washing have raised awareness among food handlers, and the proper management of food products has contributed to preventing oral transmission of some diseases.

71. Political will and commitment are increasing and must be sustained to overcome the global impact of neglected tropical diseases. Security concerns and conflicts are likely to have profoundly impacted surveillance systems and interrupted elimination programmes. Unpredictable epidemics such as the current outbreak of Ebola virus disease in West Africa and their potential to expand can divert focus away from neglected tropical diseases and adversely affect national control programmes. Adverse economic performance may weaken the drive to secure the financial resources needed to overcome these diseases.

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

72. Estimates for 2012<sup>1</sup> indicate a high number of new cases of four curable sexually transmitted infections among people aged 15 to 49 years: *Chlamydia trachomatis* (127 million); *Neisseria gonorrhoea* (85 million); syphilis (5 million); and *Trichomonas vaginalis* (177 million). The prevalence of herpes simplex virus type 2 infection is similarly high with 417 million people infected.

73. The Global Strategy for the Prevention and Control of Sexually Transmitted Infections, 2006–2015 has been used in all WHO regions for the development of regional strategies or frameworks, with at least 88% of countries having updated relevant policies and guidelines in respect of sexually transmitted infections. In particular most countries recommend the use of the syndromic approach for management of sexually transmitted infections. All regions have also adapted WHO's strategy for the global elimination of congenital syphilis.<sup>2</sup> The strategy is often implemented hand in hand with elimination of mother-to-child transmission of HIV. Nevertheless, challenges remain, such as the provision of human and financial resources for programmes to include sexually transmitted infection services within universal health coverage.

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<sup>1</sup> For more information on WHO estimates for 2012 relating to sexually transmitted infections, see: <http://www.who.int/reproductivehealth/topics/rtis/en/> (accessed 27 March 2015).

<sup>2</sup> *The global elimination of congenital syphilis: rationale and strategy for action* is available at: <http://www.who.int/reproductivehealth/publications/rtis/9789241595858/en/>, accessed 11 March 2015).

74. Progress has been made, and can be gauged from the information obtained through the Global AIDS Response Progress Reporting system,<sup>1</sup> the Gonococcal Antimicrobial Surveillance Programme,<sup>2</sup> and a rapid assessment of sexually transmitted infections programmes in Member States, conducted by questionnaire. WHO and its partners have published guidance on targeting screening to most-at-risk and vulnerable populations,<sup>3</sup> and most national action plans include interventions targeting sex workers, men who have sex with men, and adolescents.

75. Screening for sexually transmitted infections is rare in resource-constrained settings; it usually involves testing blood from antenatal care attendees and blood donors for syphilis and markers of HIV and hepatitis B virus infections.

76. Regional and global surveillance and monitoring systems are in great need of strengthening. More regular etiological studies are urgently needed to identify prevailing causative organisms. In response, WHO has issued guidance for strengthening surveillance systems,<sup>4</sup> revised the Global AIDS Response Progress Reporting system to include 10 indicators, and published data through the Global Health Observatory. The annual global surveillance reports<sup>5</sup> summarize data on: the number of reported cases of sexually transmitted infections; gonococcal antimicrobial resistance; burdens of disease; and progress towards elimination of mother-to-child transmission of syphilis.<sup>6</sup> Advances towards the latter goal are being made, and the proportion of antenatal care attendees tested for syphilis increased from 78% in 2008 to 84% in 2013, the reported syphilis seropositivity rate of this group decreased from 1.4% to 0.6%, and the estimated number of adverse pregnancy outcomes attributable to syphilis decreased from 520 000 in 2008 to 370 000 in 2012. Although progress is encouraging, increased efforts are needed to attain the targets of at least 95% of pregnant women being screened and 95% of those found positive being treated in every country.

77. Resistance of *Neisseria gonorrhoeae* to penicillin-based and quinolone-based antibiotics is widespread, and resistance to cephalosporins, the last-line treatment, is emerging, although globally only 67 countries, mainly in the European and Western Pacific regions, have reported on antimicrobial resistance. In response, WHO has issued information and a global action plan to control the spread and impact of gonococcal resistance in the context of the global action plan for antimicrobial resistance.<sup>7,8</sup>

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<sup>1</sup> For more information on Global AIDS Response Progress Reporting, see: <http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting> (accessed 11 March 2015).

<sup>2</sup> For more information on the Gonococcal Antimicrobial Surveillance Programme, see: [http://www.who.int/reproductivehealth/topics/rtis/gonococcal\\_resistance/en/](http://www.who.int/reproductivehealth/topics/rtis/gonococcal_resistance/en/) (accessed 13 March 2015).

<sup>3</sup> *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* is available at: <http://www.who.int/hiv/pub/guidelines/keypopulations/en/> (accessed 13 March 2015).

<sup>4</sup> *Strategies and laboratory methods for strengthening surveillance of sexually transmitted infections 2012* is available at: <http://www.who.int/reproductivehealth/publications/rtis/9789241504478/en/> (accessed 11 March 2015).

<sup>5</sup> *Report on global sexually transmitted infection surveillance 2013* is available at: <http://www.who.int/reproductivehealth/publications/rtis/stis-surveillance-2013/en/> (accessed 17 March 2015).

<sup>6</sup> For more information on progress towards elimination of mother-to-child transmission of syphilis, see: [http://www.who.int/reproductivehealth/topics/rtis/cs\\_global\\_updates/en/](http://www.who.int/reproductivehealth/topics/rtis/cs_global_updates/en/) (accessed 13 March 2015).

<sup>7</sup> More information on gonococcal antimicrobial resistance and the publication, *Sexually transmitted infections*, are available at: <http://www.who.int/reproductivehealth/publications/rtis/articles/en/> (accessed 11 March 2015); The publication, *Global action plan to control the spread and impact of antimicrobial resistance in Neisseria gonorrhoeae*, is available at: <http://www.who.int/reproductivehealth/publications/rtis/9789241503501/en/> (accessed 11 March 2015).

<sup>8</sup> See document A68/20.

78. The Global Strategy needs a successor for the post-2015 period. Based on the successes observed and lessons learnt, it should include the following measures in the context of both universal health coverage framework and the sustainable development goals:

- strengthened financing mechanisms for services for sexually transmitted infections, and human resource capacity
- increased access to services through the integration of the prevention and management of sexually transmitted infections into the broader agendas on HIV infection and reproductive health, in particular
- provision of guidance to Member States on mechanisms for expanding interventions, in particular for vulnerable and key populations, strengthened surveillance, improved knowledge and an increase in the number of countries reporting on prevalence, etiology and antimicrobial resistance
- accelerated access to innovations through the development and introduction of point-of-care diagnostic tests and new preventive interventions, such as vaccines, microbicides and health promotion methods.

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

### **H. NEWBORN HEALTH (resolution WHA67.10)**

79. Progress in reducing neonatal mortality and stillbirths and in increasing coverage of related essential interventions in countries is described in the accompanying reports on monitoring of achievement of health-related Millennium Development Goals and on working towards universal coverage of maternal, newborn and child health interventions.<sup>1</sup> A more detailed progress report on efforts by Member States, organizations within the United Nations system and non-State actors is available as a separate multistakeholder document.<sup>2</sup>

80. Recognizing the urgent need to improve newborn health, Member States made specific commitments during the consultations on the action plan, with several countries aligning their national priorities with those of the action plan. Since the adoption of resolution WHA67.10, many more countries have finalized national newborn action plans or strengthened the relevant components within existing plans for reproductive, maternal, newborn and child health, and other countries are drafting national newborn action plans or revising existing strategies and plans (see Table 1.). In addition, at least 10 countries have hosted national events to support dissemination of the action plan<sup>3</sup> or participated in regional events.<sup>4</sup> The Table summarizes the status of updated national strategies and plans as of March 2015.

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<sup>1</sup> Respectively, documents A68/13, Monitoring the achievement of the health-related Millennium Development Goals, and this report, section I.

<sup>2</sup> UNICEF, Every newborn action plan progress report 2015 ([www.everynewborn.org](http://www.everynewborn.org)).

<sup>3</sup> Examples include China, Ethiopia, Ghana, India, Nigeria, Pakistan, Rwanda, South Africa, Uganda and United Republic of Tanzania,.

<sup>4</sup> In sub-Saharan Africa, Latin America and the Caribbean, South-East Asia, the Eastern Mediterranean and the Western Pacific. See also [www.everynewborn.org](http://www.everynewborn.org) for links to information on progress (accessed 1 April 2015).



**Table 1. Countries with national newborn action plans and countries with strengthened newborn components within existing plans**

<b>Countries with specific commitments to improving newborn health up to March 2015</b>	Afghanistan, Bangladesh, Benin, Bolivia (Plurinational State of), Cambodia, Cameroon, China, Democratic Republic of the Congo, Egypt, Ethiopia, Ghana, Haiti, Kenya, India, Indonesia, Lao People's Democratic Republic, Malawi, Mali, Mongolia, Morocco, Mozambique, Namibia, Nepal, Nigeria, Oman, Papua New Guinea, Philippines, Rwanda, Senegal, Solomon Islands, South Africa, Swaziland, Timor-Leste, Uganda, United Republic of Tanzania, Viet Nam, Yemen, Zambia and Zimbabwe
<b>Countries developing specific commitments to improving newborn health</b>	Botswana, Chad, Guinea-Bissau, Djibouti, Lesotho, Madagascar, Myanmar, Pakistan, Sierra Leone, Tajikistan

81. Various regional initiatives led by WHO support the implementation of the newborn action plan. These include initiatives for improving quality of maternal and newborn care in the African and European regions; the Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care (2008–2015) in the Region of the Americas; a technical advisory group and regional network for strengthening newborn health and preventing stillbirths in the South-East Asia region; maternal and child health acceleration plans in the Eastern Mediterranean Region; and the Action Plan for Healthy Newborns (2014–2020) and accompanying First Embrace campaign in the Western Pacific Region.

82. Consensus on essential interventions for reproductive, maternal, newborn and child health<sup>1</sup> has enabled governments and partners to make strategic investments for their scale-up. Under strategic objective 2 of the action plan (improve the quality of maternal and newborn care), the Secretariat is developing a strategy for improving the quality of care for mothers and newborns, with a particular focus on quality of care around the time of childbirth and care for small and sick newborns. This includes the development of evidence-based standards for service delivery. WHO is also coordinating an extensive research agenda on newborn health.<sup>2</sup>

83. After the launch of the every newborn action plan, three working groups were established to facilitate coordinated actions, namely on country implementation, advocacy, and monitoring and evaluation.<sup>3</sup> Through this mechanism, WHO is elaborating an approach for monitoring the implementation of national plans to end preventable maternal and newborn mortality and stillbirths.<sup>4</sup> Work will include mapping, defining and validating core indicators to track quality, coverage and

<sup>1</sup> The Partnership for Maternal, Newborn and Child Health. Essential interventions, commodities and guidelines for reproductive, maternal, newborn and child health: a global review of the key interventions related to reproductive, maternal, newborn and child health. Geneva: World Health Organization; 2011 (available in English at [http://www.who.int/pmnch/topics/part\\_publications/essential\\_interventions\\_18\\_01\\_2012.pdf](http://www.who.int/pmnch/topics/part_publications/essential_interventions_18_01_2012.pdf), accessed 9 April 2015).

<sup>2</sup> See document A68/13.

<sup>3</sup> <http://www.everynewborn.org/contact/> (accessed 1 April 2015).

<sup>4</sup> See <http://www.everynewborn.org/every-newborn-event-summary-enap-metrics-meeting/> (accessed 1 April 2015).

impact of essential interventions, and aim at institutionalizing these indicators into national data collection platforms.<sup>1</sup>

84. In response to the request of the Human Rights Council,<sup>2</sup> the Secretariat provided technical assistance to the development of a report on under-5 mortality and human rights, and elaboration of technical guidance on the application of a human rights-based approach to the reduction and elimination of under-5 mortality, in particular the integration of human rights norms and standards in efforts to improve newborn health.

85. Development partners, health care professional organizations, civil society and other stakeholders continue to collaborate to support government leaders, policy-makers and programme managers in implementing the actions laid out in the plan. More than 40 new commitments to the action plan were announced at Partners Forum hosted by the Partnership for Maternal, Newborn and Child Health,<sup>3</sup> including many from the private sector.

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

86. The present report provides the requested biennial update on progress towards reducing exclusion and achieving universal access to, and coverage of, reproductive, maternal, newborn and child health care. It cites data for 75 countries that account for 95% of maternal, newborn and child deaths (see the Table 2).

87. The progress made since 2010 in reducing maternal, newborn and child mortality has been encouraging.<sup>4</sup> Average annual rates of reduction of maternal, newborn and child mortality have been greater than at any other time in the past two decades. Overall progress, however, has been insufficient.

88. Essential interventions for reproductive, maternal, newborn and child health have been the basis of strategic investments in countries.<sup>5</sup> While overall coverage has increased, inequities are pervasive and, in most countries, the population coverage score among the richest far exceeds that of the poor.

89. WHO is involved with Member States and partners in a number of initiatives that aim to improve the outcomes for reproductive, maternal, newborn and child health, including the Global Vaccine Action Plan.<sup>6</sup> Donors committed US\$ 7539 billion over the next five years to deliver vaccines and immunization to countries supported by the GAVI Alliance.<sup>7</sup>

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<sup>1</sup> See EB137/4 on newborn health: draft accountability framework.

<sup>2</sup> Human Rights Council resolutions 22/32 and 24/11.

<sup>3</sup> For more information on the 2014 Partners' Forum, see: <http://www.who.int/pmnch/about/governance/partnersforum/pf2014/en/> (accessed 30 March 2015).

<sup>4</sup> Document EB136/14.

<sup>5</sup> The joint publication (WHO, Aga Khan University, and the Partnership for Maternal, Newborn & Child Health), Essential interventions, commodities and guidelines: for reproductive, maternal, newborn and child health, is available at [http://www.who.int/pmnch/knowledge/publications/201112\\_essential\\_interventions/en](http://www.who.int/pmnch/knowledge/publications/201112_essential_interventions/en) (accessed 30 March 2015).

<sup>6</sup> See document EB136/25.

<sup>7</sup> <http://www.gavi.org/> (accessed 24 April 2015).

90. WHO has intensified its work with Member States and partners to ensure the implementation of the newborn health action plan.<sup>1</sup> Additional guidance was provided by the Secretariat, including the publication, *Strategies toward ending preventable maternal mortality (EPMM)*.<sup>2</sup> As a result, coverage of essential interventions, such as family planning, skilled care around the time of childbirth, and integrated postnatal care for mother and baby, is expected to improve in the coming years.<sup>3</sup>

91. The global action plan on ending preventable child deaths from pneumonia and diarrhoea<sup>4</sup> recognizes the critical importance of protective, preventive and curative actions. Progress in implementation of the action plan is, however, modest and requires increased commitment, investment and coordination by all relevant stakeholders.<sup>5</sup>

92. The upcoming United Nations Secretary-General's Global Strategy for Women's and Children's and Adolescents' Health,<sup>6</sup> scheduled to be published in September 2015, will take into consideration the goals and targets for ending preventable maternal, newborn and child agenda and promote a multisectoral approach to improve the health of women, children and adolescents along the life course, with particular attention to populations in need of humanitarian assistance. A Global Financing Facility is being established to accelerate implementation of the Global Strategy in countries through context-specific and evidence-based investment plans and sustainable financing strategies.

**Table 2. Coverage of essential reproductive, maternal, newborn and child health interventions<sup>7,8</sup> for 75 "countdown countries"**

Indicator	Number of countries with data	Median coverage (%)	Range (%)
<b>Pre-pregnancy</b>			
Demand for family planning satisfied	54	64	13–95

<sup>1</sup> See document A68/36 progress report H and document WHA67/2014/REC/1, Annex 4.

<sup>2</sup> The publication, *Strategies toward ending preventable maternal mortality (EPMM)*, is available at: [http://who.int/reproductivehealth/topics/maternal\\_perinatal/epmm/en/](http://who.int/reproductivehealth/topics/maternal_perinatal/epmm/en/) (accessed 30 March 2015).

<sup>3</sup> See document EB136/18.

<sup>4</sup> The joint publication (UNICEF and WHO), *Ending preventable child deaths from pneumonia and diarrhoea by 2025: the integrated Global Action Plan for Prevention and Control of Pneumonia and Diarrhoea (GAPPD)*, [http://www.who.int/maternal\\_child\\_adolescent/documents/global\\_action\\_plan\\_pneumonia\\_diarrhoea/en/](http://www.who.int/maternal_child_adolescent/documents/global_action_plan_pneumonia_diarrhoea/en/) (accessed 30 March 2015).

<sup>5</sup> See document EB136/14.

<sup>6</sup> See: <http://www.everywomaneverychild.org/news-events/news/1014-shaping-the-future-for-healthy-women-children-adolescents-learn-more-about-the-process-to-update-the-global-strategy> (accessed 30 March 2015).

<sup>7</sup> Levels of coverage for selected indicators for reproductive, maternal, newborn and child health interventions in 75 "countdown countries", based on the most recent survey, 2008 or later.

<sup>8</sup> The publication, *Countdown to 2015: Fulfilling the health agenda for women and children: the 2014 report*, is available at: <http://www.countdown2015mnch.org/reports-and-articles/2014-report> (accessed on 30 March 2015).

<b>Indicator</b>	<b>Number of countries with data</b>	<b>Median coverage (%)</b>	<b>Range (%)</b>
<b>Pregnancy</b>			
Antenatal care (at least one visit)	58	90	40–100
Antenatal care (at least four visits)	48	53	15–94
Intermittent preventive treatment of malaria for pregnant women	34	22	2–69
Neonatal tetanus protection	67	84	43–94
<b>Birth</b>			
Skilled attendant at birth	60	63	10–100
<b>Postnatal</b>			
Early initiation of breastfeeding	47	50	18–95
Postnatal visit for mother	32	45	7–93
Postnatal visit for baby	17	30	5–83
<b>Infancy</b>			
Exclusive breastfeeding	51	41	3–85
Introduction of solid, semisolid or soft foods	47	66	20–92
Diphtheria-tetanus-pertussis (three doses)	75	85	33–99
Measles immunization (first dose)	75	84	42–99
<i>Haemophilus influenzae</i> type b immunization (three doses)	66	52	10–99
Vitamin A supplementation (two doses)	55	78	0–99
<b>Childhood</b>			
Children sleeping under insecticide-treated nets	36	38	10–77
Care seeking for symptoms of pneumonia	53	52	26–80
Antibiotic treatment for symptoms of pneumonia	40	46	7–88
Malaria treatment (first-line antimalarial)	35	32	3–97
Oral rehydration therapy with continued feeding	45	47	12–76
Oral rehydration salts	55	37	11–78
Improved drinking water sources (total)	72	75	30–99
Improved sanitation facilities (total)	72	38	9–100

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

93. Resolution WHA66.7 urges Member States to put into practice, as appropriate, the implementation plan on life-saving commodities for women and children; and requests the Director-General, inter alia, to provide support to the independent Expert Review Group on Information and Accountability for Women's and Children's Health in its work on assessing the progress made in the implementation of the United Nations Secretary-General's Global Strategy for Women's and Children's Health, as well as the implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children. The present report provides the requested annual update on progress achieved in the follow-up of the recommendations since 2014.

94. Ministries of health, the H4+ partnership<sup>1</sup> and almost 100 partner organizations have undertaken activities related to the recommendations. Examples include nine "pathfinding" countries that have implemented specific plans to address bottlenecks: Democratic Republic of the Congo, Ethiopia, Malawi, Niger, Nigeria, Senegal, Sierra Leone, Uganda and the United Republic of Tanzania. The Reproductive, Maternal, Newborn and Child Health Trust Fund<sup>2</sup> that was tasked to support the implementation of the recommendations committed close to US\$ 112 million in 2014 to the countries listed, through UNFPA, UNICEF and WHO. All foreseen activities in these countries are expected to be completed by 2015. A further set of countries are developing plans to be supported by the H4+ and the same fund in 2015.

95. Countries have committed to the training of health care workers, and the development of demand-driven activities, in line with the resolution's request of Member States to put into practice, as appropriate, the implementation plan on life-saving commodities for women and children, including, inter alia, implementing proven mechanisms and interventions to ensure that health care providers are knowledgeable about the latest national guidelines for maternal and child health. Over 3600 health care workers from the nine countries mentioned, for example, have trained in the administration of life-saving commodities, including insertion of etonogestrel implant for family planning, and misoprostol for preventing and treating haemorrhage during childbirth. In Niger, high adolescent fertility rates were addressed by procuring and distributing 60 000 etonogestrel implants to service delivery points and mobile clinics. In Senegal, more than 12 000 community agents were trained to strengthen the provision of care at the community level. Increased access to emergency contraception and female condoms has been supported by literature reviews on best practices, the development by WHO, together with the United States Agency for International Development and UNFPA, of a new module on emergency contraception for the family planning training resource package, and through operations research in Malawi.

96. In Uganda, key recommendations were developed to support the development, delivery and evaluation of the local use of WHO maternal and perinatal health guidelines. Similar efforts are ongoing in the United Republic of Tanzania to increase the access and effective utilization of WHO

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<sup>1</sup> The H4+ partnership comprises United Nations agencies (UNAIDS, UNFPA, UNICEF, UN Women and WHO) and the World Bank. For more information, see: <http://www.who.int/reproductivehealth/publications/reports/9789241506007/en/> (accessed 17 March 2015).

<sup>2</sup> For more information on the Reproductive, Maternal, Newborn and Child Health Trust Fund, see: <http://www.lifesavingcommodities.org/uk-contributes-to-rmnch-trust-fund-to-save-newborn-and-mothers-lives/> (accessed 27 March 2015).

maternal health guidelines. In Sierra Leone, funds were rapidly reprogrammed in July 2014 to respond to the outbreak of Ebola virus disease. The funds were used for training contact tracers and their supervisors, and procurement and distribution of equipment and consumables for Ebola treatment and holding centres.

97. Globally, a network of technical resource teams has enhanced partnerships and addressed overarching barriers. The 13 life-saving commodities, for example, are now on the WHO Model List of Essential Medicines List, guiding procurement and financing. Corresponding treatment guidelines have been updated or are under way. Regulatory pathways for child health products were agreed by regulatory agencies in 22 countries from the African Region. Six “pathfinder” countries signed on and used a new fast-track process to approve reproductive health and other products. In Nigeria, technical assistance led to four manufacturers achieving certification in current good manufacturing practices from WHO – a first in the region. In addition, alignment of procurement specifications for life-saving commodities products is under way. Nongovernmental organizations are playing a critical role in advocacy efforts.

98. Delays were experienced by most countries in the implementation of their plans, frequently related to changes of implementing partners or assignment of contracts. There is a strong political will to collaborate as a means of increasing impact but the operational complexities and costs often remain beyond the means of most countries. A lesson learnt is that there would be value in harmonizing at the country level the administrative requirements of United Nations partner organizations. Countries have noted the continued challenge of managing dependency on imported medicines. For certain medicines, for example, unstable financing and supply contribute to their high cost.

## **Health systems**

### **K. SOCIAL DETERMINANTS OF HEALTH (resolution WHA65.8)**

99. In May 2012, the Sixty-fifth World Health Assembly adopted resolution WHA65.8 on advancing the social determinants of health and health equity agenda. This report provides the requested update of the report noted by the Sixty-sixth World Health Assembly in May 2013.<sup>1</sup>

100. Political commitment to and action on social determinants of health and health equity have steadily increased. In March 2013, 103 country cooperation strategies included requests for technical support for social determinants or a “health in all policies” approach. The widely recognized need to integrate social determinants and health equity in global health and development agendas is an area of particular focus in the post-2015 sustainable development goals and universal health coverage processes.

101. The 8th Global Conference on Health Promotion (Helsinki, 10–14 June 2013) focused on health in all policies. The Health Assembly in resolution WHA67.12 called for a draft framework for country action. Health in all policies skills and approaches are supported by WHO’s Health in All Policies Training Manual.<sup>2</sup> In March 2015, a training course on use of the manual was attended by representatives of institutions from each region.

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<sup>1</sup> Document A66/15.

<sup>2</sup> The training manual is available at: [http://apps.who.int/iris/bitstream/10665/151788/1/9789241507981\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/151788/1/9789241507981_eng.pdf?ua=1) (accessed 13 March 2015).

102. **Social determinants are prioritized in the strategic plans of the WHO regional offices.** In 2013, the Regional Office for Africa published the strategy, Health promotion: strategy for the African Region,<sup>1</sup> which includes a strong emphasis on health in all policies.

103. For the Regional Office for the Americas, social determinants are an integral part of its strategic plan for 2014 to 2019.<sup>2</sup> In 2014, a regional plan on health in all policies was adopted by the Directing Council of the Pan-American Health Organization at its 53rd session (66th session of the WHO Regional Committee for the Americas),<sup>3</sup> and a high-level meeting on implementing the plan was held in March 2015. In addition, in the plan of action for 2010–2015 of the Union of South American Nations, social determinants are among the five priorities.

104. In 2014, the South-East Asia Region published a regional framework on health in all policies.<sup>4</sup>

105. In 2012, the Regional Committee for Europe approved the policy framework, Health 2020: a European policy framework and strategy for the 21st century, which focuses on government and society action to reduce health inequalities and is reinforced by a review of social determinants and the health divide in the European Region.<sup>5</sup> All countries in the region have adopted national health policies aligning with Health 2020, and its integration into the forthcoming United Nations Development Assistance Framework and regional coordination on social determinants were discussed when the Regional Committee for Europe met in 2014.

106. A 2014 meeting, which took place prior to that of the Eastern Mediterranean Regional Committee, presented a review on key social determinants in the Eastern Mediterranean Region. A regional social determinants strategy and thematic taskforce was requested.

107. In the Western Pacific Region, health ministers renewed commitment to action on social determinants within the “healthy islands” vision.<sup>6</sup>

108. WHO advanced a methodology to **support national health programmes to improve equity results** (drawing from the fields of social determinants, gender and human rights). A series of related pilot studies is under way. In 2013, the Regional Office for Europe finalized a project using this methodology in four countries to revise national maternal health and child health strategies and programmes, with a focus on excluded populations.

109. In 2014, the Regional Office for Africa established a technical group to support work on social determinants and conducted health equity analyses in four Small Island States. The Regional Office

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<sup>1</sup> The strategy is available at the following website: <http://www.afro.who.int/en/clusters-a-programmes/hpr/cluster.html> (accessed 20 March 2015).

<sup>2</sup> The Strategic Plan of the Pan American Health Organization 2014-2019 is available at: [http://www.paho.org/hq/index.php?option=com\\_docman&task=doc\\_download&gid=22850&Itemid=270&lang=en](http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=22850&Itemid=270&lang=en) (accessed 13 March 2015).

<sup>3</sup> See PAHO resolution CD53.R2 on the plan of action on health in all policies.

<sup>4</sup> See [http://www.searo.who.int/nepal/mediacentre/searo\\_regional\\_framework\\_on\\_hiap.pdf](http://www.searo.who.int/nepal/mediacentre/searo_regional_framework_on_hiap.pdf) (accessed 13 March 2015).

<sup>5</sup> The Review of social determinants and the health divide in the WHO European Region: final report is available at: [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/251878/Review-of-social-determinants-and-the-health-divide-in-the-WHO-European-Region-FINAL-REPORT.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/251878/Review-of-social-determinants-and-the-health-divide-in-the-WHO-European-Region-FINAL-REPORT.pdf) (accessed 13 March 2015).

<sup>6</sup> For more information on the “healthy islands” vision, see [http://www.wpro.who.int/southpacific/programmes/pacific\\_initiatives/healthy\\_islands/en/](http://www.wpro.who.int/southpacific/programmes/pacific_initiatives/healthy_islands/en/) (accessed 16 March 2015).

for South-East Asia published Health Literacy Toolkits to strengthen stakeholder participation in health systems.

110. Progress was made by the Organization in addressing equity, social determinants, gender and human rights through its work involving normative guideline development processes, including the Guidelines Review Committee.

111. New activities and projects have been designed to **strategically align social and environmental determinants of health** in WHO. In 2013, at headquarters, the Social Determinants of Health unit joined the reformed Department of Public Health, Environmental and Social Determinants of Health and the areas identified as first priority include housing and health, water and sanitation and air quality.

112. There are numerous examples of WHO's multisectoral involvement and approach: the Regional Office for Europe with the Environmental Health Directorate of Malta, for example, published a national report on environmental health inequalities.<sup>1</sup> Another example of that Regional Office's contribution to a project was the joint funding, together with the European Commission, of the project: networking for physical activity. The project centres on the promotion of networking and action on healthy and equitable environments for physical activity, with a particular focus on children and disadvantaged groups.<sup>2</sup>

113. In the Eastern Mediterranean Region, WHO supported the publication of a report with Jordan on environmental health activities and social determinants; assessments of poor urban areas were conducted.

114. The Urban Health Equity Assessment and Response Tool (Urban HEART)<sup>3</sup> was adapted to regional needs, namely, for island settings, by the Regional Office for the Western Pacific and by the Regional Office for South-East Asia for the needs of Indonesia, in particular its islands.

115. Capacities have increased for **monitoring trends in and impacts of social determinants of health**. In 2013, the *Handbook on health inequality monitoring: with a special focus on low- and middle-income countries*, was published, followed by training sessions in 2013, 2014 and 2015 on the use of the handbook at regional and national levels. WHO's Global Health Observatory houses the Health Equity Monitor, with databases, country profiles and visualizations on disaggregated indicators from 93 countries.

116. The EQUity-oriented Analysis of Linkages between health and other sectors (EQUAL) framework, being developed by WHO, will monitor intersectoral factors and pathways influencing universal health coverage and health with an emphasis on equity.

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<sup>1</sup> The report can be found at: [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0016/243160/Environmental-Health-Inequalities-in-Malta.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0016/243160/Environmental-Health-Inequalities-in-Malta.pdf?ua=1) (accessed on 17 March 2015).

<sup>2</sup> The brochure provides an overview of the Networking for Physical Activity project, available at: <http://www.euro.who.int/en/health-topics/environment-and-health/Transport-and-health/publications/2013/networking-for-physical-activity-brochure-for-download> (accessed on 16 March 2015). The main reports and deliverables from the project are available at: <http://www.euro.who.int/en/health-topics/disease-prevention/physical-activity/activities/promoting-networking-and-action-on-healthy-and-equitable-environments-for-physical-activity-phan> (accessed 27 March 2015).

<sup>3</sup> For more information on the Urban Health Equity Assessment and Response Tool, see: [http://www.who.int/kobe\\_centre/measuring/urbanheart/en/](http://www.who.int/kobe_centre/measuring/urbanheart/en/) (accessed on 16 March 2015).



117. Efforts at headquarters in association with the Regional Office for the Americas continue to support progress in the development of relevant process indicators in equity-oriented health in all policies and programme reorientation, and instruments for data collection.

118. In 2014, the Regional Office for Europe identified indicators for monitoring the Health 2020 framework, and the Regional Office for the Western Pacific published a fact sheet describing indicators of determinants impacting gender health equity. In 2013, the Regional Office for the Eastern Mediterranean published the report, Demographic, Social and Health Indicators for Countries of the Eastern Mediterranean.<sup>1</sup>

119. Several initiatives at national level related to monitoring social determinants trends and progress were undertaken, including a health observatory in the Islamic Republic of Iran and a quality of care assessment in Bhutan for unreached populations.

120. The Organization participates in many cross-cutting activities, including **collaboration within the United Nations system and with other intergovernmental organizations** on advocacy, research, capacity building and direct technical support on the social determinants of health. In 2013, the Roll Back Malaria Partnership and UNDP launched a multisectoral action framework for malaria. In the same year, UNDP published a discussion paper on addressing the social determinants of noncommunicable diseases and organized a webinar series. In 2014, a mission to Rwanda to prepare for joint work by the United Nations on social determinants of health in that country identified priority health issues requiring multisectoral actions.

121. Led by WHO and UNICEF, *Every newborn: an action plan to end preventable deaths*, was published in 2014,<sup>2</sup> and has a strong focus on equity and determinants. Action on social determinants is also a theme in the updated draft of the global strategy for women's, children's and adolescents' health. Explicit reference is made to the need to address the social determinants of tuberculosis, in the End TB Strategy and targets developed in 2014.<sup>3</sup>

## **L. SUSTAINABLE HEALTH FINANCING STRUCTURES AND UNIVERSAL COVERAGE (resolution WHA64.9)**

122. In resolution WHA64.9, Member States are urged, inter alia, to ensure that health financing systems evolve so as to avoid significant direct payments at the point of delivery and include a method for prepayment of financial contributions for health services as well as a mechanism to pool risks among the population in order to avoid catastrophic expenditures that may impoverish individuals as a result of seeking the services needed.

123. A growing number of countries in all regions have made more explicit political commitment to universal health coverage in their national policies. In the past three years, this trend has endured at global, regional, subregional and national levels, in the form of resolutions, declarations and high-level conferences. In many countries, intensive efforts have been made to raise more money for health and

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<sup>1</sup> The report is available at: [http://applications.emro.who.int/dsaf/EMROPUB\\_2013\\_EN\\_1537.pdf](http://applications.emro.who.int/dsaf/EMROPUB_2013_EN_1537.pdf) (accessed 18 March 2015).

<sup>2</sup> *Every newborn: an action plan to end preventable deaths* is available at: [http://apps.who.int/iris/bitstream/10665/127938/1/9789241507448\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/127938/1/9789241507448_eng.pdf) (accessed 27 March 2015).

<sup>3</sup> For more information on the strategy and targets, see: [http://www.who.int/tb/post2015\\_strategy/en/](http://www.who.int/tb/post2015_strategy/en/) (accessed 27 March 2015).

reduce direct out-of-pocket payments. Gabon and the Philippines are examples of countries that have created or raised specific taxes, from which funds have been channelled into health insurance premiums for the poor. Countries have also acted to improve efficiency and equity in the use of resources. In response to the economic crisis, for example, 18 countries in the European Region consolidated capacity in health ministries, public health agencies and insurance funds for the purpose of reducing administrative costs. Many countries also improved procurement processes to reduce expenditures related to medicines. As a result, there has been a steady reduction in the extent to which countries throughout much of the world have relied on out-of-pocket payments to fund their health systems.

124. Over 80 countries from all regions and levels of income were supported by WHO in this process, often in collaboration with partners in the United Nations system, other multilateral organizations, bilateral development agencies, foundations, civil society organizations, and researchers. The range of support included high-level political engagement and detailed technical analysis of existing financing systems, which provided a basis for the development of health financing strategies and implementation plans, and for monitoring the progress of those plans once implemented. These efforts benefited greatly from the generation of new knowledge and sharing of reform experiences across countries, increased attention to resource tracking and accountability, and the efforts made to strengthen country capacities for evidence-informed decision-making. There were strong links between the normative work and the work undertaken at country level, a prime example of which is the development of the joint WHO–World Bank framework for monitoring progress towards universal health coverage.

125. Important lessons have emerged that reinforce and extend those highlighted in *The world health report 2010*. There is no one-size-fits-all solution, but it is possible to distil practical guidance from recent experience with health financing reforms on promising directions for countries seeking to move towards universal health coverage.

126. Country experience demonstrates that the scope is limited for generating substantial, stable resources through voluntary health insurance. Public spending, derived from various forms of taxation, including social health insurance contributions where relevant, must lead the way. This is a challenge for countries with a significant proportion of the workforce outside regular, salaried employment – a factor that constrains revenue collection. Numerous countries have nevertheless met this challenge. In the Western Pacific Region, for example, 14 countries increased the priority given to the health sector in their allocation of budget resources in the past few years. Others have introduced new forms of taxation or improved collection mechanisms to allow for increased government spending in the health sector.

127. One important direction taken by many countries to improve efficiency is to reduce fragmentation. More than 50 countries combine general budget revenues and social health insurance contributions in a common pool, enabling greater redistributive capacity from the total available funds than would exist if countries maintained separate schemes for different population groups according to the source of funds. Such consolidation also reduces administrative costs and strengthens purchasing power, enabling conditions for greater efficiency in the system.

128. Countries have recognized that they cannot simply spend their way to universal health coverage, and are making use of explicit financial incentives to promote efficiency and ensure delivery of priority health services. While the specific mechanisms vary, they all involve a link between resource allocation and information on population health needs, provider performance, or a combination.

129. Experience also demonstrates that, while health financing plays a critical role, more than health financing is required to ensure progress towards universal health coverage. In particular, greater attention is being paid to the link between financing and provision, recognizing the importance of aligning rules in order for providers to have the autonomy to respond to new payment incentives while ensuring that they are accountable for good quality health services.

130. Looking to the future, many challenges remain, although the inclusion of universal health coverage in the post-2015 development agenda would give added impetus to countries moving in that direction. Resource mobilization is a challenge for low-income countries; sufficient external funding will still be important, channelled through mechanisms that are non-distortionary and consistent with the principles of aid effectiveness. Evidence from recent years also reinforces the importance of strengthening productive engagement between health and finance authorities at national and international levels in order to increase the sustainability of funding mechanisms while ensuring transparency and accountability in the use of public resources.

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

131. As requested in resolution WHA60.25, the present report focuses on progress in implementing the strategy for integrating gender analysis and actions into the work of WHO.<sup>1</sup> It proposes recommendations and presents information on: building WHO capacity for gender analysis and planning; bringing gender into the mainstream of WHO's management; promoting the use of sex-disaggregated data and gender analysis; and establishing accountability.

132. WHO's capacity for gender analysis and planning in the workplace has advanced in the past two years. Training workshops for gender analysis and mainstreaming gender, equity and human rights in planning have been conducted for national programme officers in five regional offices, and for regional and country professional staff from diverse programme areas. Mandatory induction training for new staff at headquarters now includes capacity building on gender, equity and human rights.

133. Progress has been steady since the adoption of resolution WHA60.25, however, certain challenges persist with staff using gender analysis in their work without the dedicated support of gender experts across the Organization. It would help to address these challenges by identifying both innovative means of translating skills into practice within the Organization, as well as efficient mechanisms for supporting and monitoring the use of gender analysis in the face of limited capacity in gender human resource expertise.

134. Substantial progress has been made with respect to capacity for gender analysis at the country level, resulting in concrete, gender-responsive national health policy and health programme actions. Public health capacities in gender mainstreaming have increased in 69 countries across five regions (including the African Region, Region of the Americas, South-East Asia Region, Eastern Mediterranean Region and Western Pacific Region).

135. WHO has increased its institutional mechanisms for gender mainstreaming, and integrating equity and human rights. The *WHO handbook for guideline development* (second edition), for example, includes a chapter on how to incorporate equity, human rights, gender and social

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<sup>1</sup> See document WHASS1/2006—WHA60/2007/REC/1, Annex 2.

determinants into WHO guidelines.<sup>1</sup> In addition, the WHO management development programme, as well as the *WHO evaluation practice handbook*, includes content on gender, equity and human rights.<sup>2</sup> At the regional level, the new manual for developing the biennial programme of work of the Regional Office for the Americas includes clear guidelines for mainstreaming gender, equity, human rights and ethnicity.<sup>3</sup>

136. It would be useful to identify barriers to scaling up and sustaining mainstreaming in planning, reporting and management functions across the Organization. Strategies to scale up mainstreaming could be developed based on monitoring findings.

137. At all levels of the Organization, there is an increasing demand for technical guidance on gender mainstreaming and integrating equity and human rights within the work of WHO. Examples include Health 2020 documents, as well as regional action plans on noncommunicable diseases and ageing in the Regional Office for Europe, health system strategies and the Regional framework for action on ageing and health in the Western Pacific (2014–2019),<sup>4</sup> and, in the Regional Office for the Americas, the handbook on health situation analysis.

138. There is increasing demand at country level for technical support on integrating gender, equity and human rights in health programmes and policies. In the Region of the Americas, 31 countries are implementing plans to advance gender mainstreaming in the health sector. WHO supported 18 countries across the regions (which include the African Region, South-East Asia Region, European Region, Eastern Mediterranean Region and Western Pacific Region) in mainstreaming gender, equity and human rights in national health policies, strategies and plans.

139. WHO has provided strong support to countries in collecting more disaggregated data and using them to analyse health equity. Seven countries in the European Region and three in the Region of the Americas were supported in producing or revising health profiles and health plans, including 46 countries in the African Region that developed country profiles on gender and women's health. Five countries in the South-East Asia Region, three countries in the Eastern Mediterranean Region, six countries in the Region of the Americas and six countries in the Western Pacific Region received technical support to strengthen their health information systems towards disaggregation and equity analysis of health data. WHO and country health reports are increasingly using data disaggregated by sex. WHO's health equity monitor disaggregates data by sex, place of residence, wealth quintile and educational level for 91 countries.

140. The Secretariat's accountability in gender mainstreaming and gender analysis has advanced. WHO's enhanced electronic tool to evaluate performance (ePMDS+), for example, includes staff and supervisor evaluation on respecting and promoting individual and cultural differences; the supervisory objective requires supervisors to set targets that contribute to gender and geographical balance in hiring practices. The senior management compact includes an indicator on closing the gender gap in staffing. Finally, WHO has progressed to meeting requirements on 50% of the 15 performance

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<sup>1</sup> WHO handbook for guideline development, 2nd ed. Geneva: World Health Organization; 2014.

<sup>2</sup> WHO evaluation practice handbook. Geneva: World Health Organization; 2013.

<sup>3</sup> AMRO–PAHO Operational planning manual for biennial work plans (BWPs) and performance monitoring and assessment (PMA) 2014–2015.

<sup>4</sup> The Regional framework for action on ageing and health in the Western Pacific (2014–2019) is available at: [http://www.wpro.who.int/topics/ageing/regional\\_framework\\_final.pdf](http://www.wpro.who.int/topics/ageing/regional_framework_final.pdf) (accessed 19 March 2015).

indicators of the United Nations system-wide action plan on gender equality and women's empowerment in 2014, up from 20% in 2012.

## **N. PROGRESS IN THE RATIONAL USE OF MEDICINES (resolution WHA60.16)**

141. In response to resolution WHA60.16, Member States in collaboration with the Secretariat and international, regional and national partners promote the rational use of medicines, aiming to minimize overuse, underuse and misuse of medicines, all of which actions result in poor health outcomes and waste scarce resources. In growing numbers, countries in all regions have made explicit political commitments to improve access and rational use of medicines as a contribution to universal health coverage and to the attainment of the health-related Millennium Development Goals.

142. An analysis of WHO global data from low- and middle-income countries on medicines use and pharmaceutical policy has been completed and clearly shows that those countries implementing more policies aimed at promoting rational use of medicines<sup>1</sup> have significantly better use of medicines in primary care.<sup>2</sup>

143. In the European Region, work on developing, implementing, monitoring and evaluating national policies on access and use of medicines has been initiated in 13 countries.<sup>3</sup>

144. In the East Mediterranean Region, Lebanon has promoted rational use through best pharmacy practice. Jordan updated its national essential medicines list and organized regional meetings on strengthening social health insurance schemes for universal health coverage and held a short course on pharmacoeconomics and rational selection of medicines (Amman, 20–25 September 2014) for sensitizing and building health professionals' capabilities.

145. In the West Pacific Region, some Pacific island countries have issued standard treatment guidelines to strengthen the rational use of medicines. Viet Nam has established a national selection committee to better implement, monitor and evaluate policies on medicines use. The Lao People's Democratic Republic has undertaken capacity-building activities for policy-makers and health professionals.

146. In the African Region, 17 countries<sup>4</sup> have carried out work to improve the selection, prescribing, dispensing and the use of medicines. Activities included revision of national essential medicines lists and/or standard treatment guidelines, and surveys to assess the prescription and use of medicines. In the Region, health workers and dispensers have been trained to ensure the rational use of essential medicines according to national standard treatment guidelines. Regional workshops have been held in Burkina Faso and Ghana, respectively, to update countries on evidence-based methodology used for the selection of medicines for the WHO Model List of Essential Medicines and to guide countries on how to develop, revise and apply a national essential medicines list.

<sup>1</sup> WHO. Promoting rational use of medicines: core components. Geneva: World Health Organization, 2002.

<sup>2</sup> Holloway KA, Henry D. WHO essential medicines policies and use in developing and transitional countries: an analysis of reported policy implementation and medicines use surveys. *PLOS Medicine*, Sept 2014; 11(9): e1001724.

<sup>3</sup> Albania, Armenia, Bosnia and Herzegovina, Croatia, Cyprus, Estonia, Greece, Hungary, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan and Ukraine.

<sup>4</sup> Benin, Burkina Faso, Burundi, Cameroon, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Mali, Niger, Senegal, Togo, United Republic of Tanzania, Zambia and Zimbabwe.

147. In the South-East Asia Region, a coordinated approach to promoting rational use of medicines is being taken by conducting a situational analysis of medicines management in health care delivery every four years and publishing the reports on the website<sup>1</sup> as mandated by Member States.<sup>2</sup> Such analyses involve data collection on medicines use (including antibiotics), medicines availability and implementation of policies aimed to promote better medicines use, by a multi-disciplinary government team over a two-week period, using a pre-designed tool, and ending with a national workshop to plan future action.

148. With regard to commitments to the responsible use of antimicrobials in humans, an international meeting (Oslo, 13 and 14 November 2014)<sup>3</sup> contributed to the consultative process for the drafting of a global action plan on antimicrobial resistance.<sup>4</sup> Participants from more than 20 countries agreed a series of strategies and interventions for promoting better use of antibiotics, for inclusion in that draft plan. A study on antibiotic consumption was carried out in 17 countries in the European Region and two national workshops on qualitative research on medicines use were held in Slovenia and Uzbekistan in the second half of 2014 in order to foster development of new approaches to the prudent use of antimicrobial medicines. In the West Pacific Region, the endorsement by the Regional Committee of the regional action agenda on antimicrobial resistance in resolution WPR/RC65.R4 in 2014 renewed countries' mandate to act urgently to correct irrational use of antimicrobial medicines and respond to the threat of antimicrobial resistance.

149. A meeting on "Universal health coverage: considerations in designing medicines benefits policies and programs" (Cape Town, South Africa, 28–30 September 2014) brought together representatives from eight countries in the African Region<sup>5</sup> and international aid agencies to discuss practical approaches and best practices in designing and managing the medicines benefits in the context of universal health coverage initiatives.

150. At the Third Global Symposium on Health Systems Research (Cape Town, South Africa, 30 September–3 October 2014), the Alliance for Health Policy and Systems Research and WHO jointly launched the report on advancing access, affordability and appropriate use of medicines in health systems,<sup>6</sup> which focuses on: the role of medicines in achieving universal health coverage; innovation in improving access to medicines; and using a systems approach to improving access to medicines.

151. The WHO Model List of Essential Medicines was revised in 2013 as part of the two-yearly cycle, with the publication of the 18th Model List and the 4th WHO Model List of Essential Medicines for Children. Key agenda points for the next revision, by the Expert Committee on the Selection and Use of Essential Medicines at its 20th meeting, scheduled to be held on 20–24 April 2015, are a review of essential medicines for cancer, and applications for new medicines for hepatitis C.

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<sup>1</sup> Country situational analysis, available at: [http://www.searo.who.int/entity/medicines/country\\_situational\\_analysis/en/](http://www.searo.who.int/entity/medicines/country_situational_analysis/en/) (accessed 10 April 2015).

<sup>2</sup> Regional Committee resolutions SEA/RC64/R5 on National essential drug policy including the rational use of medicines in 2011 and SEA/RC66 on Effective management of medicines in 2013.

<sup>3</sup> More information on the meeting is available at: <http://www.who.int/drugresistance/events/Oslomeeting/en/> (accessed on 3 March 2015).

<sup>4</sup> See accompanying documents A68/19 and A68/20.

<sup>5</sup> Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.

<sup>6</sup> Bigdeli M, Peters DH, Wagner AK, Eds. Medicines in health systems: advancing access, affordability and appropriate use. Geneva, World Health Organization; 2014 ([http://www.who.int/alliance-hpsr/resources/FR\\_webfinal\\_v1.pdf](http://www.who.int/alliance-hpsr/resources/FR_webfinal_v1.pdf), accessed 30 March 2015).

## Preparedness, surveillance and response

### O. PANDEMIC INFLUENZA PREPAREDNESS: SHARING OF INFLUENZA VIRUSES AND ACCESS TO VACCINES AND OTHER BENEFITS (resolution WHA64.5)

152. In resolution WHA64.5, the World Health Assembly adopted the Pandemic Influenza Preparedness Framework (the “PIP Framework”),<sup>1</sup> which seeks to improve and strengthen the sharing of influenza viruses with human pandemic potential through a WHO-coordinated network of laboratories, known as the Global Influenza Surveillance and Response System, and to promote fair and equitable access to the benefits arising from such sharing, by developing countries.

153. Section 7.4.1 of the Framework states that the Director-General shall on a biennial basis, inform the World Health Assembly on the status of and progress on the Framework’s implementation.<sup>2</sup> The present document describes progress since the biennial report to the Sixty-sixth World Health Assembly in May 2013.<sup>3</sup>

154. **Laboratory and surveillance capacity:** An assessment by the Global Influenza Surveillance and Response System laboratories was completed in September 2014. It found that the system is a robust network with strong technical foundations and expertise that can potentially be extended to some other infectious pathogens. Significant geographical gaps remain, however, in Africa, the Middle East and eastern Europe. For many National Influenza Centres (NICs), two significant challenges are funding and government commitment. Strengthening influenza laboratory and surveillance capacities is a major component of the pandemic influenza preparedness capacity building activities supported by the Partnership Contribution (PC).<sup>4</sup>

155. **Global influenza vaccine production capacity:** Since 2006, the Global Action Plan for Influenza Vaccines has helped to increase global vaccine production capacity from 500 million doses in 2006 to 1500 million doses in 2013; manufacturing capacity is projected to reach 5000 million doses by 2016.<sup>5</sup>

156. **Agreements with industry:**<sup>6</sup> The Standard Material Transfer Agreement 2 concluded with GlaxoSmithKline and the Serum Institute of India will provide WHO with real-time access to 10% of their pandemic influenza vaccine production; the Standard Material Transfer Agreement 2 with Sanofi Pasteur will provide WHO with real-time access to 15% of its pandemic vaccine production. GlaxoSmithKline has also committed to providing access to 10 million treatment courses of antiviral

<sup>1</sup> Document WHA64/2011/REC/1, Annex 2.

<sup>2</sup> Section 7.4.1 specifies five areas for review: laboratory and surveillance capacity; global influenza vaccine production capacity; status of agreements entered into with industry, including information on access to vaccines, antivirals and other pandemic material; financial report on the use of the partnership contribution; and the experience arising from the use of the definition of PIP biological materials.

<sup>3</sup> Document WHA66/17. For additional information on progress, see the meeting reports of the Pandemic Influenza Preparedness Framework Advisory Group and the Advisory Group Annual Reports to the Director-General from 2013 and 2014 at: [http://www.who.int/influenza/pip/pip\\_meetings\\_consultations/en/](http://www.who.int/influenza/pip/pip_meetings_consultations/en/) (accessed 4 March 2015).

<sup>4</sup> See section 1 of the Partnership Contribution Implementation Plan 2013–2016: [http://www.who.int/influenza/pip/pip\\_pcimpplan\\_17jan2014.pdf?ua=1](http://www.who.int/influenza/pip/pip_pcimpplan_17jan2014.pdf?ua=1) (accessed 4 March 2015).

<sup>5</sup> See [http://apps.who.int/iris/bitstream/10665/112307/1/9789241507011\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/112307/1/9789241507011_eng.pdf?ua=1) (accessed 4 March 2015).

<sup>6</sup> See [http://www.who.int/influenza/pip/benefit\\_sharing/smta2/en/](http://www.who.int/influenza/pip/benefit_sharing/smta2/en/) (accessed 4 March 2015).

medicine. Several agreements have been signed with academic and scientific institutions and negotiations are under way to conclude additional agreements.

157. **Use of the Partnership Contribution:**<sup>1</sup> For 2013, WHO received contributions from manufacturers of over US\$ 27.2 million; by 31 December 2014, nearly US\$ 15 million had been received against 2014 contributions. In January 2014, detailed implementation plans based on the high-level Partnership Contribution Implementation Plan 2013–2016<sup>2</sup> and the supporting Gap Analyses<sup>3</sup> were finalized for the following five areas of preparedness work: laboratory and surveillance capacity building; burden of disease; regulatory capacity building; risk communications; and planning for deployment. Disbursement of funds and implementation of activities began in the second quarter of 2014. The Organization-wide response to the Ebola virus disease outbreak has had an impact on implementation, particularly in the African Region.

158. In November 2014, the Director-General approved the Guiding Principles for use of PIP Partnership Contribution Response Funds,<sup>4</sup> submitted by the PIP Advisory Group following consultation with industry and other stakeholders. The Principles provide guidance on the use of Partnership Contribution funds reserved for pandemic response.

159. A Partnership Contribution Implementation Portal<sup>5</sup> was developed to increase transparency and accountability with respect to the use of partnership contribution funds.

160. **Genetic sequence data:** To assist in its examination of issues related to the handling of genetic sequence data under the PIP Framework,<sup>6</sup> the Advisory Group established a Technical Expert Working Group.<sup>7</sup> In October 2014, the Advisory Group held a technical consultation with representatives of genetic sequence databases. The work of the Advisory Group will continue in 2015, and focus on examining and identifying the optimal characteristics of a system under the PIP Framework for the handling of influenza viruses with human pandemic potential genetic sequence data.

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

161. This report provides an overview of the work undertaken by the Secretariat since the Sixty-seventh World Health Assembly. It summarizes the conclusions of the sixteenth meeting of the WHO Advisory Committee on Variola Virus Research (Geneva, 20–21 October 2014) and the work

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<sup>1</sup> See: PIP Framework section 6.14.3. The partnership contribution is an annual payment to WHO from influenza vaccine, diagnostic and pharmaceutical manufacturers using the Global Influenza Surveillance and Response System. For the period 2012–2016, 70% of partnership contribution funds will be directed to preparedness measures and 30% to pandemic response.

<sup>2</sup> See [http://www.who.int/influenza/pip/pip\\_pcimpplan\\_17jan2014.pdf?ua=1](http://www.who.int/influenza/pip/pip_pcimpplan_17jan2014.pdf?ua=1) (accessed 4 March 2015).

<sup>3</sup> See [http://www.who.int/influenza/pip/pip\\_pc\\_ga.pdf?ua=1](http://www.who.int/influenza/pip/pip_pc_ga.pdf?ua=1) (accessed 4 March 2015).

<sup>4</sup> See Annex 5, [http://www.who.int/influenza/pip/pip\\_ag\\_oct2014\\_meetingreport\\_final\\_7nov2014.pdf?ua=1](http://www.who.int/influenza/pip/pip_ag_oct2014_meetingreport_final_7nov2014.pdf?ua=1) (accessed 4 March 2015).

<sup>5</sup> See <https://extranet.who.int/pip-pc-implementation/> (accessed 4 March 2015).

<sup>6</sup> See PIP Framework, section 5.2.4.

<sup>7</sup> See [http://www.who.int/influenza/pip/advisory\\_group/PIP\\_AG\\_Rev\\_Final\\_TEWG\\_Report\\_10\\_Oct\\_2014.pdf?ua=1](http://www.who.int/influenza/pip/advisory_group/PIP_AG_Rev_Final_TEWG_Report_10_Oct_2014.pdf?ua=1) (accessed 4 March 2015).



undertaken for the consultation on the implications of the use and potential of technologies for synthetic biology on smallpox preparedness and control.

162. The WHO Advisory Committee on Variola Virus Research confirmed at its sixteenth meeting that it had overseen the work of the authorized programme of research with variola virus. In 2014, eight projects, which were extensions of existing approved proposals, were evaluated by the Advisory Committee's scientific subcommittee and approved by the Secretariat. No new proposals for research involving live variola virus were approved.

163. The Advisory Committee received reports on the virus collections held at the two WHO Collaborating Centres that are the authorized repositories of variola virus.<sup>1</sup> The Advisory Committee also considered updates on the use of live variola virus for the development of diagnostic tests, two animal models, smallpox vaccines and antiviral and therapeutic agents. Representatives from two pharmaceutical companies described progress towards the registration of two candidate antiviral agents. Progress has been made towards testing and registration of new non-replicating smallpox vaccines that could be suitable for use in people who are immunological compromised.

164. In 2014, a WHO biosafety inspection team visited the variola virus repository and inspected the bio-containment facilities in the Russian Federation. An inspection visit to the United States of America is scheduled to take place in May 2015. The protocol used follows the European Committee for Standardization's Laboratory Biorisk Management Standard CWA 15793, which covers 16 elements of laboratory biorisk management.

165. Glass ampoules of variola virus samples stored in the mid-1950s were found at one of the campuses of the National Institutes of Health in the United States of America. They were transported to the WHO Collaborating Centre at the Centers for Disease Control and Prevention. The samples were destroyed in February 2015 under the supervision of WHO.

166. At the Sixty-seventh World Health Assembly in May 2014, WHO was requested to undertake a consultation of the use and potential of technologies for synthetic biology on smallpox preparedness and control, to further inform the Health Assembly in its discussions on the timing of the destruction of existing variola virus stocks. This consultative process is under way and a group of experts is being convened at the end of June in order to provide an assessment to the Director-General.

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<sup>1</sup> One of the repositories referred to is the State Research Centre for Virology and Biotechnology, in Koltsovo, Novosibirsk Region, Russian Federation. The other is the Centers for Disease Control and Prevention, in Atlanta, United States of America.