

Progress reports

Report by the Secretariat

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Communicable diseases

A. ERADICATION OF DRACUNCULIASIS (resolution WHA64.16)

1. Since the 1980s, national eradication programmes have eliminated dracunculiasis in 17 countries where it had previously been endemic, reducing the number of individuals affected from an estimated 3.5 million in 1986 to only 22 in 2015. Indigenous transmission is now limited within four countries: Chad, Mali, Ethiopia and South Sudan, where nine, five, three and five cases were reported, respectively.¹ The 22 cases occurred in 20 villages, representing reductions of 83% in cases and 63% in affected villages compared to 2014.

2. The Carter Center continues to provide operational support to eradication activities in those four countries. UNICEF supports the provision of improved sources of drinking water in villages at risk of the disease or where it is endemic. WHO continues to provide support to strengthen surveillance in the pre- and post-certification countries, to prepare countries for certification, and to monitor and regularly report on the existing guinea-worm disease situation. The WHO Collaborating Centre at the Centers for Disease Control and Prevention of the United States of America continues to provide laboratory diagnostic support to the guinea-worm eradication programme.

3. Upon the recommendation of the International Commission for the Certification of Dracunculiasis Eradication, WHO certified a total of 198 countries, territories and areas, including 186 WHO Member States, as free from dracunculiasis transmission. Eight Member States remain to be certified: Chad, Ethiopia, Mali and South Sudan; Kenya and Sudan, which remain in the pre-certification stage; and Angola and the Democratic Republic of the Congo, which have had no recent history of the disease but need to provide evidence for the absence of any transmission.

4. As recommended by the International Commission, WHO is preparing a plan of action for implementing a global reward as soon as transmission is interrupted in all countries, as during the final phase of the smallpox eradication campaign.

5. Active surveillance was carried out in more than 4200 villages in 2015. Control of copepods through the use of the larvicide temephos covered all localities reporting cases, except in Chad, where some bodies of water were too large to treat.

6. The six countries² in pre-certification or where the disease is endemic continue to offer cash rewards for voluntary case reporting. Overall, approximately 90% of districts reported monthly during 2015; more than 20 000 rumours were reported, 87% of them investigated within 24 hours. The majority of post-certification countries³ continued to submit quarterly reports to WHO in 2015. The investigation of more than 286 rumours in four post-certification countries confirmed no cases of dracunculiasis.

7. The polio surveillance network continued to include searches for dracunculiasis cases in its national immunization day campaigns in pre-certification countries.

¹ Prior to South Sudan's independence in 2011, the disease had been endemic in 20 countries.

² Dracunculiasis is endemic in Chad, Ethiopia, Mali and South Sudan; Kenya and Sudan are in the pre-certification stage.

³ Cameroon, Côte d'Ivoire, Ghana and Niger.

8. Insecurity and inaccessibility owing to conflicts continue to pose challenges to eradication efforts. In Mali, despite some improvement, security concerns in the regions of Gao, Kidal, Mopti and Segou remain challenging. United Nations humanitarian support bodies facilitated intermittent surveillance. Surveillance was stepped up among Malian refugees in camps in Burkina Faso, Mauritania and Niger in order to detect any imported cases and to prevent further spread of the disease. Civil unrest and massive population displacement in South Sudan have hampered programme implementation and restricted access to endemic areas.

9. *Dracunculus medinensis* infection in dogs poses a challenge to the programme particularly in Chad and Ethiopia. More than 500 dogs in Chad and 13 dogs in Ethiopia were reported with guinea worm infection in 2015. Overall, 67% of the infected dogs were contained and transmission from 705 (72%) of the 979 guinea worms extracted from infected dogs was contained. Given this unusually high rate of infection in dogs, the national programme in Chad, The Carter Center and the Centers for Disease Control and Prevention are undertaking an operational research programme to find appropriate ways to accelerate interruption of transmission. In addition, Mali and South Sudan each reported one infected dog. WHO is following up in the priority areas for operational research identified by the January 2015 scientific meeting to address the situation in Chad and Ethiopia.

10. The Director-General monitors the eradication programme regularly and there is an annual review meeting of national dracunculiasis eradication programmes.

11. An informal meeting during the Sixty-eighth World Health Assembly, chaired by the WHO Regional Director for Africa and addressed by the Director-General, requested the health ministers of the four countries where dracunculiasis remained endemic to lead in advocating for the eradication programme; they and others in attendance pledged their continued commitment to interrupting transmission of the disease as quickly as possible.

12. The US\$ 214 million funding gap for the period 2016–2020 must be closed to achieve the goals of eradication and its certification.

Noncommunicable diseases

B. SUSTAINING THE ELIMINATION OF IODINE DEFICIENCY DISORDERS (resolution WHA60.21)

13. As WHO finalizes the update of the Micronutrients Database in the Vitamin and Mineral Nutrition Information System, the Iodine Global Network has been tracking the progress of public health efforts to eliminate iodine deficiency disorders. Since 1993, tremendous progress has been made in reducing iodine deficiency globally. It was estimated in 1993 that the populations of 110 countries had inadequate iodine intakes; this has been steadily reduced over the years to 54 countries in 2003, 47 in 2007, 32 in 2012 and only 25 in 2015.¹ However, these data are based primarily on school-age children and it is now known that the adequate iodine nutrition status of school-age children may not indicate adequate iodine nutrition status among other population groups,

¹ Global Iodine Nutrition Scorecard 2015. Zurich: Iodine Global Network; 2015 (http://www.ign.org/cm_data/Scorecard_2015_August_26_new.pdf, accessed 16 March 2016).

such as pregnant women who are particularly vulnerable to iodine deficiency.¹ More surveys are starting to assess the iodine status of pregnant women but data from most countries are currently limited.

14. Although the number of countries where iodine deficiency is a public health problem has been reduced, the number of countries whose populations have excessive iodine intakes (median urinary iodine concentration ≥ 300 $\mu\text{g/L}$) has been rising – from 7 in 2007 to 13 in 2015.¹ Susceptible groups within these countries may be at risk of adverse health consequences, such as iodine-induced hyperthyroidism and autoimmune thyroid disease.²

Control strategy

15. The preferred strategy for the control of iodine deficiency disorders remains universal salt iodization. In 2014, WHO released updated guidance on salt iodization recommending that all food-grade salt, which is used in households and food processing, be fortified with iodine for the prevention and control of iodine deficiency disorders.³ It was recognized that strategies for salt reduction and salt iodization are compatible and that monitoring of both salt/sodium intake and iodine intake at the country level is needed to ensure that individuals consume sufficient iodine despite reductions in salt intake. The concentration of iodine should be adjusted by each country in the light of their own data regarding dietary salt intake. Data on household coverage with iodized salt are summarized each year by UNICEF in its annual reports on the state of the world's children. According to the 2015 report,⁴ primarily reflecting data from the period 2009–2013, 75% of households worldwide are estimated to have access to iodized table salt.

16. Iodine supplementation is also an option for the control of iodine deficiency disorders, particularly for vulnerable groups such as pregnant women and young children living in high-risk communities who are unlikely to have access to iodized salt⁵ or as a temporary strategy when salt iodization is not successfully implemented. WHO has commissioned an updated systematic review on the effects of iodine supplementation for women during the preconception, pregnancy and postpartum periods and is updating guidance on the use of iodine supplements as part of routine antenatal care in 2016.⁶

¹ Wong EM, Sullivan KM, Perrine CG, Rogers L, Peña-Rosas JP. Comparison of median urinary iodine concentration as an indicator of iodine status among pregnant women, school-age children, and nonpregnant women. *Food Nutr Bull.* 2011;32(3):206–12.

² Urinary iodine concentrations for determining iodine status in populations. *Vitamin and Mineral Nutrition Information System.* Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/85972/1/WHO_NMH_NHD_EPG_13.1_eng.pdf?ua=1, accessed 16 March 2016).

³ Guideline: fortification of food-grade salt with iodine for the prevention and control of iodine deficiency disorders. Geneva: World Health Organization; 2014.

⁴ The state of the world's children 2015: reimagine the future: innovation for every child. New York (NY): United Nations Children's Fund; 2015 (http://www.unicef.org/publications/files/SOWC_2015_Summary_and_Tables.pdf, accessed 16 March 2016).

⁵ World Health Organization, United Nations Children's Fund. Joint statement: Reaching optimal iodine nutrition in pregnant and lactating women and young children. Geneva: World Health Organization; 2007.

⁶ De-Regil LM, Harding KB, Peña-Rosas JP, Webster AC. Iodine supplementation for women during the preconception, pregnancy and postpartum period (Protocol). *Cochrane Database of Systematic Reviews* 2015, Issue 6. Art. No.: CD011761. doi:10.1002/14651858.CD011761.

17. Monitoring and evaluating the impact of programmes to control iodine deficiency disorders are crucial for ensuring that interventions are effective, safe and equitable. It is recognized that there is a need for updated guidance on the use and interpretation of biomarkers for assessing iodine status. In 2016, WHO will review the accuracy of commonly used biomarkers in screening and diagnostic tests for assessing the iodine status in different populations. These reviews are expected to inform updated guidance.

Promoting health through the life course

C. STRENGTHENING OF PALLIATIVE CARE AS A COMPONENT OF COMPREHENSIVE CARE THROUGHOUT THE LIFE COURSE (resolution WHA67.19)

18. Resolution WHA67.19, adopted in 2014, set out a range of actions for Member States and the Secretariat. In response, a number of initiatives have been undertaken.

19. **Strengthening palliative care policies, services and funding.** The Secretariat has supported Member States to include palliative care in national action plans for noncommunicable diseases, and has provided support to countries developing specific national strategies and guidelines on palliative care, including Botswana, India and Lebanon. The Secretariat provided support to South Africa for the development of national guidelines for palliative care for people with multidrug-resistant tuberculosis, and specific technical support to Tajikistan and Ukraine. Joint IAEA/IARC/WHO assessment missions for comprehensive cancer control have assessed palliative care capacity in a number of countries. Two new initiatives of the United Nations Inter-Agency Taskforce on the Prevention and Control of Non-communicable Diseases will enable the Secretariat to support a number of Member States to strengthen palliative care, through the entry-point of cancer control. Implementation of resolution WHA67.19 has now enabled a number of countries to progress in developing palliative care policies or in including palliative care in core national health strategies. In the 2015 WHO country capacity survey for noncommunicable diseases, 64% of Member States reported that some form of funding was available for palliative care, and 52% had a national strategy for noncommunicable diseases that included palliative care. Since 2014, a number of Member States have developed new national strategies for palliative care, including France, Malawi, the United Republic of Tanzania and Zimbabwe.

20. **Guidance and tools.** The Secretariat is working on a range of tools to support Member States in implementing resolution WHA67.19. In 2015, a series of communication tools was produced in all six official languages, including a corporate fact-sheet and an infographic. In addition, the dedicated WHO webpage has been updated. A manual providing practical guidance on planning, implementing, and evaluating palliative care policies and services was tested with Member States through regional consultations in 2015 and is in the final stages of production. This will be accompanied by a shorter advocacy document targeted at decision-makers. Guidance on palliative care, including ethical aspects thereof, is included in the revised *Companion handbook to the WHO guidelines for the programmatic management of drug-resistant tuberculosis*.¹ New tools will be developed focusing on palliative care in the framework of universal health coverage, palliative care for children and monitoring quality of care.

¹ Companion handbook to the WHO guidelines for the programmatic management of drug-resistant tuberculosis. Geneva: World Health Organization; 2014.

21. **Training.** The Secretariat conducted a global stocktake of online palliative care training courses in 2015. WHO collaborating centres on palliative care and pain have supported training in palliative care in a number of regions, including through fellowships and courses for health professionals and volunteers. Members of the WHO ad hoc technical advisory group for palliative care and long-term care supported the Secretariat in conducting multicountry policy dialogues and capacity building workshops in four WHO regions in 2015. The Secretariat has supported an annual palliative care train-the-trainers course in Kuwait for countries of the Eastern Mediterranean Region.

22. **Access to essential medicines.** In the 2015 country capacity survey for noncommunicable diseases, 43% of Member States reported that oral morphine was available in more than 50% of pharmacies. In September 2015, WHO was invited to make a presentation on access to controlled medicines for pain and palliative care at a special event organized by the Commission on Narcotic Drugs in Vienna and at a side event at the 30th Regular Session of the United Nations Human Rights Council as part of the preparation of the Special Session of the United Nations General Assembly on the World Drug Problem. WHO supported and contributed to the organization of a national workshop in Senegal on access to opioids, including quantification methods. Scoping missions were conducted in Ethiopia, Kenya and Uganda to assess needs for improving quantification of and capacity building for use of opioid analgesics. The Organization is preparing to collaborate with the Democratic Republic of the Congo and Timor-Leste, as part of the Union for International Cancer Control/United Nations Office on Drugs and Crime/WHO joint global programme for improving access to controlled medicines for pain and palliative care. The Secretariat has been working with the United Nations Office on Drugs and Crime on the development of a model law related to the availability and accessibility of controlled medicines, while preventing misuse and diversion.

23. **Integrating palliative care into global disease control and health system plans.** The Secretariat continues to ensure that palliative care is included as a core component of global disease control and health system plans. In 2015, palliative care was included in the *World report on ageing and health*,¹ WHO's new End TB strategy,² and WHO's draft global health sector strategy on HIV, 2016–2021, which will be considered for adoption by the Sixty-ninth World Health Assembly, in line with the decision of the Executive Board at its 138th session.³ An internal WHO working group on palliative care has also been established to improve the integration of palliative care across WHO's areas of work.

24. **Building the evidence base and monitoring progress.** A web platform on integrated, people-centred health services will be launched in May 2016 with a community of practice on palliative care. Special interest will be paid to palliative care at primary health care level, promising service delivery models and evaluation of quality of care. The Secretariat is in the process of identifying demonstration projects on palliative care, which will be independently evaluated to build the evidence base of models that are effective, especially in low-resource settings. In the Region of the Americas, a policy case-study on effective palliative care policies in Chile, Costa Rica and Mexico is currently being developed.

¹ World report on ageing and health. Geneva: World Health Organization; 2015 (http://apps.who.int/iris/bitstream/10665/186463/1/9789240694811_eng.pdf, accessed 8 February 2016).

² The End TB Strategy is available at: <http://www.who.int/tb/strategy/en/> (accessed 8 February 2016).

³ See the summary record of the Executive Board at its 138th session, ninth meeting (document EB138/2016/REC/2).

D. CONTRIBUTING TO SOCIAL AND ECONOMIC DEVELOPMENT: SUSTAINABLE ACTION ACROSS SECTORS TO IMPROVE HEALTH AND HEALTH EQUITY (resolution WHA67.12)

25. In resolution WHA67.12 (2014), the Health Assembly requested the Director-General to prepare a Framework for Country Action across sectors for health and health equity; provide guidance and technical assistance, upon request, to Member States; strengthen WHO's role, capacities and knowledge resources to give guidance and technical assistance for implementation of policies across sectors; and continue to work with and provide leadership for the organizations in the United Nations system, development banks, other international organizations and foundations to promote coherence and synergy.

26. Through two rounds of web-based consultations and a technical meeting with experts from Member States, the Secretariat developed a draft framework for country action across sectors for health and health equity.¹ The framework was approved at the Sixty-eighth World Health Assembly,² and is being used at the regional and country levels.

27. To provide Member States with guidance and technical support for implementation of action across sectors/Health in All Policies, a four-pronged approach has been used by the Secretariat:

- **Building capacity to promote action across sectors and Health in All Policies through education and training.** Examples include training of trainers workshops on Health in All Policies and social determinants of health in the African Region, the Region of the Americas and the South-East Asia Region; online and formal courses on social determinants of health/action across sectors/Health in All Policies in public health institutes and universities in the African Region and the Region of the Americas; and an online Health in All Policies course in the European Region.
- **Scaling up country action through Health in All Policies projects.** A few projects were initiated and completed in the European, Eastern Mediterranean and Western Pacific regions in the Programme budget 2014–2015.
- **Facilitating country action and advancing the science base on how to promote action across sectors and develop tools for Health in All Policies.** Examples include resource development for Health in All Policies implementation in the Eastern Mediterranean Region; a review of the Health in All Policies Framework for Country Action that resulted from the 8th Global Conference on Health Promotion, held in Helsinki in 2013, during a roundtable among countries of the Commonwealth of Independent States in the European Region; development of a health impact assessment application in the South-East Asia Region; as well as tools for developing, implementing and monitoring national multisectoral plans, and for their prioritization by the WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases. A document providing guidance on how to operationalize Health in All Policies in the context of the Sustainable Development Goals is also being developed in the Regional Office for the Americas.

¹ See document A68/17, Annex.

² See document WHA68/2015/REC/3, summary record of the twelfth meeting (section 2) of Committee A.

- **Securing country commitment through regional plans, statements and dialogues.** Examples include the Regional Plan of Action on Health in All Policies, as well as a road map guiding implementation and a white paper on Health in All Policies, in the Regional Office for the Americas; the Southeast Asian Ministers of Education Organization statement on achieving health and education outcomes in schools; decision EUR/RC65(1) adopted by the Regional Committee for Europe in 2015 entitled “Promoting intersectoral action for health and well-being: health is a political choice”; and the dialogues held under the auspices of the WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases on how to strengthen international cooperation on the prevention and control of noncommunicable diseases within the framework of North–South, South–South and triangular cooperation.

28. Efforts to strengthen WHO’s role, capacities and knowledge resources to give guidance and technical assistance, and to ensure coherence and collaboration across programmes and initiatives within WHO, include the following:

- Taking stock of the tools available across WHO to find out what is available and what is missing, as well as how the available tools are being used, in order to pool resources and avoid duplicates.
- Compiling a casebook on action across sectors/Health in All Policies to inform country action. The casebook is being compiled jointly by WHO headquarters, the Regional Office for the Americas and the Regional Office for Europe, building on the experience gathered by the regional offices for Africa, the Americas and South-East Asia, and by the WHO Kobe Centre, in recent years.
- Strengthening coordination among different units across the Organization. Focal point meetings were held across headquarters departments as well as between WHO headquarters and regional offices.

29. In order to work with and provide leadership for organizations within the United Nations system, the United Nations Interagency Task Force on the Prevention and Control of Noncommunicable Diseases undertook joint programming missions in 2014 and 2015 in Barbados, Belarus, the Democratic Republic of the Congo, Kenya, India, Mongolia, Mozambique, Sri Lanka and Tonga. The focus of these missions was to build capacity in the United Nations country teams to enhance support for governments in undertaking multisectoral action for the prevention and control of noncommunicable diseases, including through a Health in All Policies strategy. The missions engaged with a number of government ministries and their development partners. Guidance on how to include noncommunicable diseases in the United Nations Development Assistance Framework, highlighting the need for multisectoral action, was published in 2015 and has been widely disseminated across the United Nations system and among governments and development partners. The Regional Office for the Eastern Mediterranean also launched an “Arab Decade for Civil Society Organizations 2015–2025” to strengthen the engagement of civil society organizations in advancing health within the Sustainable Development Goals agenda. It will also involve the participation of the United Nations Development Programme, UN Women, the United Nations Human Settlements Programme, WHO and the United Nations Office on Drugs and Crime.

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

30. In resolution WHA57.12 (2004), the Health Assembly requested the Director-General to devote sufficient organizational priority, commitment and resources to supporting the effective promotion and implementation of the reproductive health strategy, to assist Member States in ensuring reproductive health commodity security, and report at least biennially. As part of efforts to monitor progress, the Secretariat conducted a survey in 2015 among Member States. All 53 respondents¹ were aware of Sustainable Development Goal target 3.7² and more than 90% of them of the new Global Strategy for Women's, Children's and Adolescents' Health, 2016–2030, and the WHO Global Reproductive Health Strategy, which they reported to have been instrumental in informing national health strategies and regulations since 2004.

31. More than 90% of respondents had a national reproductive health strategy. Respondents highlighted the role of logistic and economic factors, traditional beliefs and practices, inadequate skilled human resources, stock-out of essential commodities, legislation and the political context as barriers to improving sexual and reproductive health.³ Facilitating factors included political commitment, national prioritization, parliamentary action, community awareness, improved quality of services, increasing resource allocation and investments in capacity-building.

32. Over 60% of respondents reported sexual and reproductive health issues to be covered by existing or draft legislation, with a focus on topics such as safe abortion, family planning and the protection of reproductive health and rights; 49% had parliamentary commissions or committees devoted to sexual and reproductive health issues.

33. Uneven progress and inequalities were noted in reproductive health outcomes. Maternal mortality fell by almost 44% from approximately 532 000 in 1990 to an estimated 303 000 in 2015. Despite improvements at the global level, there were stark differences among regions and countries. In 2015, approximately 99% of the world's maternal deaths occurred in developing regions, with sub-Saharan Africa alone accounting for 66% of cases. The greatest improvement was recorded in East Asia, where maternal mortality decreased by 72% between 1990 and 2015.⁴

34. Access to pregnancy and delivery care was crucial for reducing maternal deaths and morbidities. The proportion of deliveries attended by skilled health personnel worldwide increased from 61% in

¹ Afghanistan, Argentina, Armenia, Bahrain, Barbados, Belize, Bhutan, Botswana, Brazil, Bulgaria, Burundi, Colombia, Costa Rica, Côte d'Ivoire, Cuba, Dominican Republic, Equatorial Guinea, Eritrea, Estonia, Guatemala, Guyana, Haiti, Honduras, India, Iraq, Kyrgyzstan, Lesotho, Liberia, Malawi, Maldives, Mauritania, Morocco, Myanmar, Nepal, Nicaragua, Paraguay, South Sudan, Republic of Moldova, Romania, Sao Tome and Principe, Slovakia, Sri Lanka, Suriname, Syrian Arab Republic, the former Yugoslav Republic of Macedonia, Timor-Leste, Togo, Tunisia, Uganda, United Republic of Tanzania, Uruguay, Uzbekistan and Zambia.

² By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

³ As referred to (a) maternal health, (b) family planning/contraception use, (c) sexually transmitted diseases, (d) prevention of unsafe abortion and (e) adolescents' sexual and reproductive health.

⁴ Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. <http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/> (accessed 10 March 2016).

the 1990s¹ to 74% during the period 2007–2014.² Inequalities exist among population groups: 68% of births in rural areas were attended by a skilled health professional compared to 91% in urban areas.³

35. In 2015, 64% of married or in-union women of reproductive age worldwide were using some form of contraception. However, the use of modern contraception was much lower (34%) in least developed countries. Twelve per cent of married or in-union women worldwide and 22% in least developed countries were estimated to have unmet needs for modern contraception.

36. The essential medicines list in more than 85% of the respondent Member States included contraceptives, and there was a national budget line for their procurement in 65% of countries. However, emergency contraception was included in the contraceptive method-mix in only 25% of countries.

37. Approximately 35% of women worldwide have experienced physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime. Most such violence was intimate partner violence. Globally, as many as 38% of all murders of women were committed by an intimate partner.

38. The Secretariat has recently developed a draft global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children,⁴ as requested by resolution WHA67.15 (2014). Some Member States are already addressing violence against women, including through strengthening health workers' capacity. The global plan of action, along with the tools developed by the Secretariat,⁵ provides a starting point and will support Member States in implementing and monitoring their work in this area.

39. The Secretariat is developing global health sector strategies on sexually transmitted infections, 2016–2021, HIV and hepatitis. The strategy on sexually transmitted infections will position the health sector response to sexually transmitted infection epidemics as critical to the achievement of universal health coverage – one of the key health targets of the Sustainable Development Goals. Notable achievements have been made in advancing the sexually transmitted infection response in recent years, and further accelerating the global response will sustain and build on these achievements and trigger further successes in sexually transmitted infection management and reduction.

40. The Secretariat supports Member States in strengthening different aspects of sexual and reproductive health programmes by providing evidence-based guidelines, including on: ensuring a

¹ World health statistics 2010. Geneva: World Health Organization; 2010.
http://apps.who.int/iris/bitstream/10665/44292/1/9789241563987_eng.pdf (accessed 10 March 2016).

² World health statistics 2015. Geneva: World Health Organization; 2015.

³ By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

⁴ http://apps.who.int/gb/ebwha/pdf_files/WHA67-REC1/A67_2014_REC1-en.pdf#page=25 (accessed 10 March 2016).

⁵ Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines <http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/> (accessed 22 February 2016); Health care for women subjected to intimate partner violence or sexual violence: a clinical Handbook http://apps.who.int/iris/bitstream/10665/136101/1/WHO_RHR_14.26_eng.pdf (accessed 10 March 2016).

human rights-based approach to contraceptive information and services; the screening and treatment of precancerous lesions for cervical cancer prevention; improving preterm birth outcomes; and health worker roles in providing safe abortion care and post-abortion contraception.

41. The Secretariat will continue to collaborate with Member States in their efforts to improve the sexual and reproductive health of their populations, especially those supporting the achievement of the Sustainable Development Goals and in the context of the Global Strategy for Women's, Children's and Adolescents' Health, 2016–2030.¹

Health systems

F. HEALTH INTERVENTION AND TECHNOLOGY ASSESSMENT IN SUPPORT OF UNIVERSAL HEALTH COVERAGE (resolution WHA67.23)

42. In May 2014, the Sixty-seventh World Health Assembly adopted resolution WHA67.23, in which it requested the Director-General: to assess the status of health intervention and technology assessment in Member States; to raise awareness of such assessment among national policy-makers; to integrate concepts and principles relating to such assessment into the relevant areas of work of WHO; to provide technical support on the topic to Member States; to ensure adequate capacity throughout WHO to support evidence-based policy decisions in Member States; and to support the exchange of information on health intervention and technology assessment through various mechanisms. This report summarizes progress to date on these areas of work.

43. An assessment of the status of health technology assessment in Member States has been completed by the Secretariat, based on information generated through a global survey on the topic, to which 111 Member States responded. The findings of the survey are reported on the WHO website.² Surveys were also carried out by the Regional Office for the Americas and the Regional Office for the Eastern Mediterranean.

44. The results of the survey suggest that, in most responding countries, assessments focus primarily on safety and clinical effectiveness, followed by economic and budgetary considerations. Little consideration is given to issues of ethics, equity and feasibility. The results also suggest that the findings of assessments are generally used to inform decision-making.

45. A lack of qualified human resources was identified as being the main barrier to producing and using health technology assessment more comprehensively. Most countries that responded to the global survey reported a lack of academic or training programmes to build assessment capacity. Activities in the WHO regions to support this capacity development have included: the strengthening of the Network of Health Technology Assessments for the Americas and its capacity-building activities in the Region of the Americas; the ongoing work on collaboration, led by the European Network for Health Technology Assessment, in the European Region; the development of a health technology assessment network in the Eastern Mediterranean Region; and similar activities in the South-East Asia and Western Pacific Regions.

¹ http://globalstrategy.everywomaneverychild.org/pdf/EWEC_globalstrategyreport_200915_FINAL_WEB.pdf (accessed 10 March 2016).

² http://www.who.int/health-technology-assessment/MD_HTA_oct2015_final_web2.pdf?ua=1 (accessed 15 February 2016).

46. The Secretariat is providing information to Member States to continue to raise awareness of health technology assessment. In 2015, to support the exchange of information and capacity building, WHO hosted two consultations on the topic. The reports of these meetings are available on the WHO website and are being used to guide ongoing and future activities.¹

47. As indicated by the findings of the global and other surveys, the needs for capacity building in the area of health technology assessment are significant. To ensure optimal use of the resources available to the Secretariat in this regard, and in recognition of the broad and cross-cutting impact of appropriate use of such assessment, the work in this area is envisaged as a cross-cluster and cross-regional effort. There is also an ongoing effort to support capacity development in this regard in WHO country offices. A training programme for this purpose is in development.

48. The Secretariat continues to work with many partners to provide technical support to Member States on this topic, for example by providing support to update national essential medicines lists. The importance of ensuring that national systems develop in a way that meets the needs of individual Member States is a guiding principle in defining appropriate technical support.

49. To ensure that the principles of health technology assessment are appropriately integrated into the relevant areas of work of WHO, a number of activities are ongoing. To support the dissemination of the evidence-based selection methods used for the WHO Model Lists of Essential Medicines, draft guidance on selecting essential medicines using the principles of health technology assessment has been prepared for piloting in Member States. WHO continues to work with countries using the WHO-CHOICE model for assessing cost-effective interventions. Considerations of affordability and opportunity cost are key to making such assessments. The *WHO Handbook for Guideline Development* (second edition)² is being updated to include guidance on using aspects of health technology assessment, such as economic modelling, in guidelines. Furthermore, a document setting standards for cost-effectiveness evaluations and economic models that are commissioned by the Secretariat is being prepared.

50. The 2015 update of the WHO Model List of Essential Medicines, with the addition of a number of new high-priced medicines for the treatment of hepatitis C and of cancer, highlighted that more assistance is needed in using health technology assessment at both the international and the country levels as a tool to support decision-making on which medicines should be paid for by the health system, under what conditions, and what would be a fair price to pay. The Secretariat will define a programme of work in this regard and expand its cooperation with Member States in order to address these challenges.

G. ACCESS TO ESSENTIAL MEDICINES (resolution WHA67.22)

51. In May 2014, the Sixty-seventh World Health Assembly adopted resolution WHA67.22, in which it requested the Director-General: to urge Member States to recognize the importance of effective national medicines policies, and their implementation under good governance; to facilitate collaboration among Member States on how to implement medicines policies most effectively; to support Member States in the selection of essential medicines and in ensuring a supply of affordable

¹ http://www.who.int/medicines/areas/access/WHO_EMP_PAU_2015_5/en/ and http://www.who.int/health-technology-assessment/HTA_November_meeting_report_Final.pdf (accessed 15 February 2016).

² WHO Handbook for Guideline Development. Geneva, World Health Organization; 2014. Available at http://www.who.int/kms/handbook_2nd_ed.pdf?ua=1 (accessed 15 February 2016).

and effective essential medicines; to support Member States in monitoring essential medicines shortages; to urge Member States to expedite progress towards the achievement of the Millennium Development Goals; and to provide, on request, in collaboration with other international organizations, technical support on issues relating to intellectual property and access.

52. The continuing importance of ensuring access to essential medicines has been recognized in target 3.8 of the Sustainable Development Goals, which is to achieve universal health coverage, including access to safe, effective, quality and affordable essential medicines for all. In 2015, some 140 countries had defined national essential medicines lists and more than 100 countries had incorporated good manufacturing practices into their national medicines laws.¹ Expenditure on medicines continues to be the largest component of health expenditure in low- and middle-income countries, most of which is in the form of out-of-pocket spending by patients.

53. Through its guideline development process, the Secretariat has continued to support Member States in promoting the rational use of medicines; for example, since 2014, guidelines on the use of antimalarials, contraceptives, medicines for the treatment of maternal infections and other medicines have been published. A full list of guidelines published by WHO is provided on the Organization's website.²

54. Technical support has been provided to countries to harmonize the regulation of essential medicines for HIV/AIDS, malaria, tuberculosis, maternal and reproductive health and for public health emergencies. In addition, support for market shaping and procurement activities to promote sustainability has been provided.

55. There are, however, a number of pressing challenges. The 2015 WHO Model List of Essential Medicines includes medicines for hepatitis C and cancer that are not affordable for many countries at current prices. In addition, a recent analysis³ of the availability and affordability of medicines for cardiovascular disease suggests that generic medicines for prevention of that disease are unaffordable for a large proportion of patients. The *WHO Guideline on Country Pharmaceutical Pricing Policies* is available to help Member States in managing pharmaceutical prices; however more work needs to be done on how best to implement these policies.

56. WHO has published updated information⁴ on the patent situation of new medicines for the treatment of hepatitis C and has provided technical assistance to Member States on how to access these new treatments at affordable prices, continuing its trilateral collaboration with the World Trade Organization and the World Intellectual Property Organization on areas of intersection between trade, health and intellectual property policies.

57. Access to essential medicines for noncommunicable diseases and for other diseases remains problematic in many countries. Access to opioids for pain management continues to be hampered by regulatory and legislative policies as well as by poor prescribing practices; the same can be said for

¹ Health in 2015: from MDGs, Millennium Development Goals to SDGs, Sustainable Development Goals. Geneva: World Health Organization; 2015.

² <http://www.who.int/publications/guidelines/year/en/> (accessed 16 February 2016).

³ Khatib et al. Availability and affordability of cardiovascular disease medicines and their effect on use in high-income, middle-income, and low-income countries: an analysis of the PURE study data. *Lancet*. 2016; 387:61–69. doi:10.1016/S0140-6736(15)00469-9.

⁴ See http://www.who.int/phi/implementation/ip_trade/ip_patent_landscapes/en/ (accessed 17 February 2016).

medicines for epilepsy. The Secretariat continues to work with Member States to ensure that public health needs with regard to access to palliative care medicines are met.

58. To help improve understanding of the causes of medicine shortages, a consultation was convened by the Secretariat in December 2015. Experiences from a number of Member States that have introduced systematic monitoring mechanisms to prevent and mitigate the impact of shortages of products were reviewed and the value of adopting a coordinated global approach in this regard was recognized. Efforts to identify the essential medicines that are subject to global supply problems are ongoing.

59. If countries are to reach target 3.8 of the Sustainable Development Goals, the methods used for the routine monitoring of access to and availability of essential medicines need to be developed further. At present, most estimates are based on surveys that require significant resources. The Secretariat is working with countries that have developed systems to track the supply and use of, and expenditure on, medicines to share these experiences with other Member States, to ensure that routine monitoring can be achieved.

H. ACCESS TO BIOTHERAPEUTIC PRODUCTS, INCLUDING SIMILAR BIOTHERAPEUTIC PRODUCTS,¹ AND ENSURING THEIR QUALITY, SAFETY AND EFFICACY (resolution WHA67.21)

60. Pursuant to resolution WHA67.21 (2014), the Secretariat supported Member States in strengthening their capacity in the health regulation of biotherapeutic products, including similar biotherapeutic products. Ever more countries are building the necessary scientific expertise to facilitate the development of solid, science-based regulatory frameworks that promote access to quality, affordable, safe and efficacious biotherapeutic products, taking note of relevant WHO guidelines, which may be adapted to national contexts and capacities.

61. The 16th International Conference of Drug Regulatory Authorities gathered government officials and drug regulatory authorities in Rio de Janeiro in August 2014 to discuss global issues and ways to enhance collaboration among regulatory authorities regarding the quality, safety and efficacy of medicines. Experts from drug regulatory authorities, academia, international and nongovernmental organizations and the pharmaceutical industry participated in a pre-conference meeting on the theme “Ensuring Quality and Safety of Biosimilars for Patients Worldwide”. The meetings encouraged and promoted cooperation and information exchange among Member States in this area and issued recommendations to Member States and WHO on the regulation of biotherapeutics and its impact on access to affordable, safe and efficacious biotherapeutics.²

62. WHO held an informal consultation with regulators, manufacturers and other experts in April 2015 to review draft WHO guidelines on the regulatory assessment of approved biotherapeutics. Following this, the WHO Expert Committee on Biological Standardization was able to finalize and adopt new WHO guidelines on regulatory assessment of approved rDNA-derived biotherapeutics.

¹ Acknowledging that national authorities may use different terminologies when referring to similar biotherapeutic products.

² See http://www.who.int/medicines/areas/quality_safety/regulation_legislation/icdra/16_ICDRA_Recommendations2014.pdf?ua=1, accessed 25 February 2016.

Addendum to: WHO TRS 987, Annex 4¹ in October 2015. Information on this work will be submitted to the Executive Board at its session in January 2017 as part of the reports of advisory bodies.

63. WHO held an informal consultation in April 2015 on the regulatory evaluation of monoclonal antibodies developed as similar biotherapeutic products. It was agreed to develop proposed WHO guidelines on the subject for submission to the 2016 Expert Committee on Biological Standardization. The public consultation phase for the document will begin in early 2016 with its posting to the WHO website² for comments, followed by a technical meeting hosted by the National Institutes for Food and Drug Control of China, a WHO Collaborating Centre, in April 2016.

64. The 2014 International Conference of Drug Regulatory Authorities meeting requested that WHO organize a workshop on implementing the 2009 WHO guidelines on evaluation of similar biotherapeutic products in the African Region, which it did in Accra in collaboration with the Food and Drug Authority of Ghana, in September 2015. The 40 experts participating, including 27 regulators from 16 countries in the African Region, recognized the WHO guidelines as a standard providing science-based principles in establishing national requirements for such products and requested strong, consistent support from WHO for their implementation.

65. WHO, through the Expert Committee on Biological Standardization, establishes international biological reference preparations, and convened an informal consultation in 2015 on reference preparations for biotherapeutic products. WHO reference preparations are used as benchmarks for biological activity, method development and system suitability assessment of biotherapeutic products, and, when linked with a specific and well-validated national, pharmacopoeial or manufacturer's reference standard, facilitate the assessment of the potency of multisource products, support product surveillance, enable product life-cycle management and support the development of novel methods. The Expert Committee recommended that WHO enhance communication on the appropriate use of such standards and advocate for the continued provision by manufacturers of source materials as a public good for the development of WHO standards as public reference materials.

66. The International Nonproprietary Names system administered by WHO provides pharmaceutical substances a unique and universally available designated name for the clear identification, safe prescription and dispensing of medicines, and for communication and exchange of information among health professionals and scientists worldwide. The cumulative list contains approximately 10 000 names. Geneva hosted four consultations on International Nonproprietary Names during 2014 and 2015, where 552 name requests were discussed and 358 new proposed names published, 60% of which were chemicals and 40% biologicals, up from only 5% in 2000. The proportion of International Nonproprietary Names assigned to biologicals has increased from 5% to 40% since 2000.

67. Following requests from some drug regulatory authorities, the International Nonproprietary Names Expert Group considered how WHO might develop a system for assigning biological qualifiers. Following discussions among interested parties, including through a web consultation, the Expert Group at the 61st Consultation on International Nonproprietary Names (Geneva, 13–16 October 2015) recommended a voluntary scheme³ whereby application for a biological

¹ See [http://www.who.int/biologicals/RA_for_BTP_for_WHO_web_editor_2_Nov_2015\(3\).pdf?ua=1](http://www.who.int/biologicals/RA_for_BTP_for_WHO_web_editor_2_Nov_2015(3).pdf?ua=1), accessed 29 February 2016.

² See <http://www.who.int/biologicals>, accessed 29 February 2016.

³ See http://www.who.int/medicines/services/inn/61st_Executive_Summary.pdf?ua=1, accessed 25 February 2016.

qualifier could be made to the International Nonproprietary Names secretariat.¹ The biological qualifier code would not be a constituent part of the International Nonproprietary Names, but an additional and independent element used in conjunction with it. The Secretariat subsequently initiated an impact assessment study, to report to the International Nonproprietary Names Expert Group in 2016, on whether introducing such biological qualifiers would influence access or affect other aspects of public health.

68. WHO collaborated with the International Pharmaceutical Regulators Forum in 2015 and agreed on three deliverables for joint work in 2016: information regarding the public assessment of biotherapeutics to ensure the consistency and transparency of the review process; a reflection paper on the extrapolation of biosimilar indications; and a training manual on the analytical comparability of monoclonal antibodies developed as similar biotherapeutic products.

I. WHO STRATEGY ON RESEARCH FOR HEALTH (resolution WHA63.21)

69. During the biennium 2014–2015, implementation of the WHO strategy on research for health was harmonized with that of the global strategy and plan of action on public health, innovation and intellectual property, and in particular the work to establish the WHO global observatory on health research and development. Several activities have been undertaken to inform this process.

70. At the World Health Summit (Berlin, 19–22 October 2014), WHO co-organized a workshop with a group of major international funders of public health research entitled “Global health research & development: mapping funding flows – working towards a common approach”. During the discussion there was consensus among attendees regarding the need for improved quality of and public access to research funding data. Participants were keen to move beyond manual classification of research grants to more automated text-mining solutions that guarantee accuracy.

71. In April 2015, a meeting was held with the WHO regional focal points on research in order to: (i) find ways of collaborating to strengthen countries’ capacity to collect and use relevant data on health research and development; and (ii) consider how such data can be integrated in the global observatory on health research and development.

72. In addition, the Secretariat is participating in the work of a subgroup of the informal policy organization, Heads of International Research Organizations. The members of the subgroup have made a commitment to work together to develop standards for collecting and reporting the data emerging from research they have funded. The result of this work will enrich the data presented and analysed by the global observatory on health research and development. The first meeting was held in April 2015 at the National Institutes of Health in the United States of America; since then, a number of virtual follow-up meetings have been organized.

73. The work to establish the platform for the global observatory on health research and development is progressing well. A demonstration version was made available online in January 2016.² The feedback obtained will enable functionality to be refined before the formal launch. The observatory will continue to be expanded in phases. The first phase includes data on funding for health research and development, health products in the pipeline, clinical trials and research publications.

¹ See http://www.who.int/medicines/services/inn/inn_bio_bq/en/, accessed 25 February 2016.

² See: www.who.int/research-observatory (accessed 9 February 2016).

74. One of the sources of the research and development observatory is the International Clinical Trials Registry Platform, which is maintained by the Secretariat. The number of countries working on the Platform is gradually increasing, with 16 countries active by January 2016. In addition to providing relevant data, the Registry Platform is intended to increase the use of standards and improve the comparability of clinical trials.

75. The Secretariat has compiled the results of multiple mapping exercises in order to inform the establishment of the observatory. This effort has included online databases, registries and observatories with a focus on health research and development. The results, along with other relevant resources and publications, are available from the dedicated WHO webpage for the global observatory on health research and development.¹

76. In addition, an open Call for Papers was issued in January 2015² in order to provide global stakeholders with up-to-date knowledge on methods, strategies, tools, experiences, and applications to draw from when developing future investment decisions and implementation plans for new health research and development. The first papers have been published and the remaining papers will continue to be published in the course of the period 2016–2017.

77. Regional offices have continued to be active in implementing the health research strategy. Advisory Committees on Health Research remained active in several regions, including the African, European and Eastern Mediterranean regions. WHO's Evidence-Informed Policy networks (EVIPnet) were active in many countries and regionally (African Region, Region of the Americas, European Region and Eastern Mediterranean Region). Over the last three years, the Regional Office for the Western Pacific has provided technical support to enable six countries in the Western Pacific Region to establish national research and development registries. This effort included technical support to Lao People's Democratic Republic, Mongolia and Papua New Guinea in upgrading their systems to provide better analyses of health research data.

78. Lastly, the Secretariat undertook a review of structures at headquarters that support research, in line with the core functions of shaping the research agenda and articulating policy options. A new unit has been established at headquarters to facilitate coordinated support to research-related work at all levels of WHO.

Corporate services/enabling functions

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

79. Efforts to increase multilingual content on WHO's website have continued. The multilingual team of web editors, working with the Secretariat's translation service, has reduced the gap in availability of technical content between English and the other five official languages of the Organization. The team has also made all corporate web content available in the six official languages. During the biennium 2014–2015, 3069 webpages were added in Arabic, 2087 in Chinese, 13 708 in English, 4266 in French, 2265 in Russian and 2007 in Spanish.

¹ See <http://www.who.int/research-observatory/en/> (accessed 8 February 2016).

² See <http://health-policy-systems.biomedcentral.com/articles/10.1186/1478-4505-13-9> (accessed 11 February 2016).

80. As at February 2016, WHO's Institutional Repository for Information Sharing (IRIS)¹ included more than 161 000 records in the official languages, comprising WHO information products and governing bodies documentation (including Health Assembly and Executive Board documentation from 1948 onwards).

81. In 2012, the Russian Federation provided funds to support a two-year project for increasing the quality and quantity of WHO's technical and scientific information products available in Russian, and for improving their dissemination to Russian-speaking audiences. As at December 2015, 44 major publications have been translated and published in Russian at headquarters and in the Regional Office for Europe. A total of 809 existing print publications in Russian have been digitized and stored in IRIS. Five special issues of the *Bulletin of the World Health Organization* in Russian have been published. Forty-nine new technical websites in Russian have been created or updated on the main WHO website, and 12 country profiles and three topic collections in Russian have been created on the website of the Regional Office for Europe.

82. Work to ensure that WHO's information products are available in official and non-official languages has continued to progress. During the biennium 2014–2015, WHO Press authorized external partners and regional offices to undertake 355 translations of 221 headquarters' products into 50 languages (five official and 45 non-official). The WHO Regional Office for Europe authorized external partners to undertake 50 translations from English into the Region's other official languages (French, German and Russian).

83. WHO offers a distance-learning language programme in the official languages of the Organization, as well as in German and Portuguese; during the biennium 2014–2015, 4226 staff from all WHO regions enrolled. During the biennium 2014–2015, enrolments in face-to-face language courses at headquarters totalled 338: 13 were for Arabic, five for Chinese, 36 for English, 167 for French, five for Russian and 112 for Spanish.

84. In the biennium 2014–2015, WHO continued to publish the following serials with multilingual content: *Bulletin of the World Health Organization* (English full text; abstracts in Arabic, Chinese, French, Russian and Spanish); *Eastern Mediterranean Health Journal* (Arabic, English or French full text; abstracts in Arabic, English and French); *African Health Monitor* (English, French or Portuguese full text; abstracts in English, French and Portuguese); *Public Health Panorama* (English and Russian); *Weekly Epidemiological Record* (English and French); *Pan American Journal of Public Health* (English, Portuguese and Spanish); *Western Pacific Surveillance and Response* (Chinese and English); *WHO Drug Information* (English, with International Nonproprietary Names in English, French, Latin and Spanish).

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¹ Available at <http://www.who.int/iris> (accessed 17 March 2016).