World Health Organization

SIXTY-FIRST WORLD HEALTH ASSEMBLY **A61/17 Add.1**
Provisional agenda item 11.14 **14 April 2008**

Progress reports on technical and health matters

Report by the Secretariat

A. CONTROL OF HUMAN AFRICAN TRYPANOSOMIASIS (resolution WHA 57.2)

1. In resolution WHA57.2, the Fifty-seventh World Health Assembly expressed its concern at the resurgence of human African trypanosomiasis, and welcomed the political commitment of government leaders to combat the disease in countries where it was endemic and recent initiatives and public–private partnerships to control the disease. It also requested the Director-General to keep the Health Assembly informed of progress in the first year of each biennium.

2. Human African trypanosomiasis caused by *Trypanosoma brucei gambiense* remains endemic in 24 countries. Between 1997 and 2006, the number of reported new cases fell by 69%. Gambia, Guinea-Bissau, Liberia, Niger, Senegal and Sierra Leone reported no cases. Benin, Burkina Faso, Ghana, Mali and Togo reported sporadic cases. Annually, Cameroon, Côte d'Ivoire, Equatorial Guinea, Gabon, Guinea and Nigeria each reported fewer than 100 new cases; Central African Republic, Chad, Congo and Uganda more than 100, but fewer than 1000, new cases each; and Angola, Democratic Republic of the Congo and Sudan more than 1000 new cases each.

3. During the same period, the reported number of new cases of human African trypanosomiasis caused by *T. b. rhodesiense* fell by 21% in 13 countries. Botswana, Burundi, Ethiopia, Namibia and Swaziland reported no cases. Kenya, Mozambique, Rwanda and Zimbabwe reported sporadic cases. Malawi and Zambia each reported fewer than 100 new cases a year. Uganda and the United Republic of Tanzania each reported more than 100, but fewer than 1000, new cases annually.

4. Access to diagnosis and treatment has improved as social upheavals came to an end and has been facilitated through capacity building, by financial and technical support for outreach activities, and by the production and free distribution of medicines for trypanosomiasis.

5. The situation has dramatically improved since 1997 when deep concerns led the Fiftieth World Health Assembly to adopt resolution WHA50.36 on African trypanosomiasis. Between 1997 and 2006, the number of people screened in surveys for human African trypanosomiasis increased from 1 345 809 to 3 014 740, while the number of cases reported for both forms of human African trypanosomiasis fell from 37 177 to 11 868.

6. Despite this progress, human African trypanosomiasis continues to threaten Africa. The low number of cases detected has, unfortunately, lowered the priority given to control of the disease. A similar situation occurred 50 years ago, when it was believed that the disease had been eliminated: awareness of human African trypanosomiasis declined, and other priorities contributed to its neglect. In order to avoid repeating this error, making surveillance and control of the disease cost-effective and sustainable is the immediate challenge.

7. Representatives of countries where the disease is endemic met at an informal consultation on sustainable control of human African trypanosomiasis (Geneva, 1–3 May 2007) and concluded that sustainable control was feasible only when surveillance and control activities were integrated into reinforced health systems. Existing diagnostic tools, however, make it difficult for health systems to control the disease. The two main technical bottlenecks are: (i) the unavailability of a sensitive and specific diagnostic test that is inexpensive, easy to perform in field conditions and acceptable for use at any level of the health system; and (ii) the need for a new oral medicine that is cheap, safe, easy to administer and able to cure both forms of the disease.

8. The most immediate challenge is to accelerate the epidemiological trend and to sustain the elimination of the disease with existing tools. Countries where the disease is endemic need support for surveillance and control activities. Reporting mechanisms need strengthening. Research must be directed towards the provision of adequate tools for sustained elimination of human African trypanosomiasis. Awareness should be maintained and advocacy should continue for fund-raising and in order to ensure that priorities are maintained. WHO's leadership in country support and coordination of stakeholders should continue.

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

9. This report updates the one submitted to the Health Assembly in 2006[1] with information on the wide range of activities that Member States and the Secretariat are undertaking in order to implement the strategy endorsed in resolution WHA57.12.

10. The strategy and four policy briefs summarizing key aspects have been widely distributed. An implementation framework,[2] elaborating areas of action and policy and programme recommendations, has been developed in consultation with countries in all regions. In addition, regional workshops have been held to provide further technical assistance to Member States. They brought together policy-makers, programme managers and others to identify bottlenecks, share lessons and define actions for accelerating progress.

11. The assessment tool for monitoring progress in strategy implementation has been updated in line with the framework and distributed among Member States. The strategy and framework are being used to define national sexual and reproductive health strategies; to design road maps to reduce maternal and newborn mortality; to inform strategic planning processes; and to revise policies and set priorities for strengthening health systems.

12. Progress has been reported by countries in each of the five key action areas:

- **strengthening health systems' capacity** – with development of policies to strengthen health systems, and assessment of human resources for health
- **improving information for priority setting** – with establishment of maternal death reviews
- **mobilizing political will** – through global and regional conferences involving policy-makers, e.g. Maputo Plan of Action for achieving universal access to comprehensive sexual and reproductive health in Africa;[3] the Women Deliver Global Conference (London, 18–20 October 2007); initiatives by some Heads of Government and State, e.g. The Global Campaign for the Health Millennium Development Goals (4, 5 and 6); ongoing support to

[1] Document A59/23.

[2] Document WHO/RHR/06.3.

[3] Special Session of the Conference of African Union Ministers of Health, Universal access to comprehensive sexual and reproductive health services in Africa: Maputo Plan of Action for the operationalisation of the continental policy framework for sexual and reproductive health and rights 2007–2010. Maputo, 18–22 September 2006.

partnerships such as the WHO-hosted Partnership for Maternal, Newborn and Child Health; dissemination of information to media; and civil society outreach programmes

- **creation of supportive legislative and regulatory frameworks** – through legislation on free provision of reproductive health services, and development of national commodity security strategies

- **strengthening monitoring and evaluation** – through incorporation of sexual and reproductive health in monitoring national development plans.

13. Specific areas reported by Member States as requiring further attention include: strengthening human resources and multisectoral collaboration; empowerment of women, families and communities; and improving monitoring and evaluation as well as quality of services.

14. The central aim of the strategy, which echoes that of the International Conference on Population and Development (Cairo, 1994), was reaffirmed at the 2005 World Summit,[1] when Heads of State and Government committed themselves to "achieving universal access to reproductive health by 2015". In October 2006, the United Nations General Assembly[2] took note of the Secretary-General's report in which he recommended the inclusion of four new targets within the Millennium Development Goal framework, including universal access to reproductive health. As a follow up in 2007, the Secretary-General presented to the General Assembly[3] a revised framework integrating into Millennium Development Goal 5 the new target "Achieve, by 2015, universal access to reproductive health", with indicators for measuring progress: contraceptive prevalence rate, adolescent birth rate, antenatal care coverage, and unmet need for family planning. WHO and UNFPA have been collaborating to define and operationalize a broader range of indicators on universal access and supporting countries in their efforts to monitor progress.

15. The subsequent endorsement of the Global strategy for the prevention and control of sexually transmitted infections, 2006–2015[4] has allowed sharper focus on this aspect of sexual and reproductive health, including the need for the elimination of congenital syphilis. Implementation of actions to reach this goal will require sustained efforts and adequate resources for this area, as well as systematic integration of syphilis screening and treatment with antenatal HIV testing.

16. Strengthening linkages between HIV prevention and sexual and reproductive health is an important element of the strategy. The Secretariat has expanded its work in this area, particularly in advocacy, research, policy and programme support. For instance, materials have been developed for Member States on how linkages between sexual and reproductive health and HIV can be incorporated in proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

17. In line with recommendations of the strategy related to monitoring and evaluation, global maternal mortality estimates have been updated by WHO, The World Bank, UNICEF and UNFPA. The new figures estimate 536 000 maternal deaths in 2005, 99% of them in developing countries. In terms of decline in the maternal mortality ratio, progress is uneven: a decline of only 0.1% a year

[1] United Nations General Assembly resolution 60/1.

[2] Decision 61/504.

[3] Document A/62/1.

[4] Document WHA59/2006/REC/1, Annex 2.

between 1990 and 2005 in sub-Saharan Africa, but greater declines in east Asia, North Africa, south-east Asia and Latin America and the Caribbean, although none of them reached the necessary rate per year (5.5%) for achieving the Millennium Development Goal target of reducing the maternal mortality ratio by three quarters between 1990 and 2015. With regard to abortion, estimates show a decline, particularly in central and eastern Europe, which is attributable to increased contraceptive prevalence rates. However, the prevalence of unsafe abortion shows no improvement: worldwide, the practice causes 68 000 maternal deaths annually.

18. As its 122nd session in January 2008, the Executive Board noted the Secretariat's report on the subject.[1] Board members recalled the commitment of Member States to achieving the health-related Millennnium Development Goals and the importance of assessing progress periodically. Concern, however, was expressed about achieving equitable access to high-quality reproductive health services; the positive but slow progress in maternal health care; and low contraceptive coverage among countries in the African Region. Support for integration of activities against HIV/AIDS into sexual and reproductive health services and for updating guidelines on family planning and sexually transmitted infections was appreciated.

F. INFANT AND YOUNG CHILD NUTRITION: BIENNIAL PROGRESS REPORT (resolution WHA58.32)

19. This report responds to the request to the Director-General in resolution WHA58.32 to report to the Health Assembly each even year, along with the report on the status of implementation of the International Code of Marketing of Breast-milk Substitutes and the relevant resolutions of the Health Assembly, on progress in the consideration of matters referred to the Codex Alimentarius Commission for its action.

The Codex Alimentarius Commission

20. In response to the first of the specific requests to the Codex Alimentarius Commission (paragraph 2(1)), the Commission has continued to give full consideration to the relevant resolutions of the Health Assembly when developing standards and related texts (see paragraphs 21 and 22 below for examples). Discussions continue in areas where specific Health Assembly resolutions identify the responsibility of the Commission, for example, the Codex Committee on Nutrition and Foods for Special Dietary Purposes, the Codex Committee on Food Labelling, the Executive Committee of the Codex Alimentarius Commission and the Codex Commission have all several times considered the WHO Strategy on Diet, Physical Activity and Health.

21. With regard to establishing standards, guidelines and recommendations on foods for infants and young children (paragraph 2(2) of the resolution), the Commission adopted at its twenty-ninth session (in July 2006) the revised Standard for Processed Cereal-Based Foods for Infants and Young Children, and at its thirtieth session (in July 2007) the revised Standard for Infant Formula and Formulas for Special Medical Purposes intended for Infants. These Standards refer to the International Code of Marketing of Breast-milk Substitutes (1981), the WHO Global Strategy for Infant and Young Child Feeding and resolution WHA54.2 on infant and young children nutrition (2001).

[1] See document EB122/2008/REC/2, summary record of the tenth meeting.

22. With regard to completing the work on addressing the risk of microbiological contamination of powdered infant formula (paragraph 2(3)), the Codex Committee on Food Hygiene at its thirty-ninth session (New Delhi, 30 October – 4 November 2007) finalized the proposed draft Code of Hygienic Practice for Powdered Formulae for Infants and Young Children, which will be considered by the Commission in July 2008. The revised Code deals with the risk of microbiological contamination of powdered infant formulae with *E.sakazakii* and other relevant organisms and makes full reference to the WHO's guidelines on the safe preparation, storage and handling of powdered infant formula.[1] The revised Code also refers to WHO's policies, in particular the Global Strategy for Infant and Young Child Feeding and the International Code of Marketing of Breast-milk Substitutes. Work continues to define microbiological criteria for powdered follow-up formula for infant and young children. The revised Code refers to WHO's guidelines on safe preparation in its guidance on the safe handling of powdered infant formula. It also recognizes the need to provide clear information to users and clear labelling messages about the potential risks due the powder not being sterile.

Actions urged on Member States

23. In increasing numbers, developing Member States are participating actively and constructively in the work of the Codex Alimentarius Commission (paragraph 1(9) of the resolution). Since its inception in 2004, the FAO/WHO Project and Fund for Enhanced Participation in Codex has provided support to 734 nationals from 100 countries to attend some of the 63 different sessions of the Commission and its associated committees and task forces and to receive training to enhance their participation. The Fund has received support totalling US$ 5.4 million from two Member States and the European Union.

Response to requests to the Director-General

24. WHO and FAO have prepared guidelines for carers on the preparation, use, handling and storage of infant formula so as to minimize risk of contamination and growth of *E. sakazakii* and other pathogens.[1] The guidelines were prepared on the basis of the outcome of the FAO/WHO risk assessment.[2] A draft was circulated through the International Food Safety Authorities Network (INFOSAN) to Member States and stakeholders for review, before the guidelines were finalized and translated into seven languages in 2007. The guidelines are presently used in several countries. They will be translated in additional languages and further disseminated in the present biennium by various means, including an INFOSAN Information Note.

25. WHO and FAO have together provided recommendations on research needed to better understand and manage the risks associated with *E. sakazakii* in powdered infant formula, and the WHO Secretariat is in the process of designating a WHO collaborating centre for research, reference and training on work on *E. sakazakii*. The outcome of the FAO/WHO assessments of the risk of *E. sakazakii* and *Salmonella* infection associated with powdered infant formula products has been published in various scientific forums, including peer-reviewed journals. In order to facilitate the management of the risks associated with *E. sakazakii* in powdered infant formula and to further guide research, WHO and FAO have jointly created and published a web-based model for risk assessment.[3] This model, the first of its kind, will be important for helping to explore and evaluate the potential of

[1] Available at http://www.who.int/foodsafety/publications/micro/pif2007/en/index.html.

[2] Available at http://www.who.int/foodsafety/micro/jemra/assessment/esakazakii/en/index.html.

[3] Available at http://www.mramodels.org/ESAK/RunModel.aspx.

alternative combinations of control measures to reduce the risks due to *E. sakazakii* in powdered infant formula.

Infant and young child nutrition

26. Malnutrition is responsible, directly or indirectly, for about half of the world's annual deaths among children under five. There are 178 million stunted children under five years old in the world, 90% of whom live in high-burden countries. A major intervention to rectify this situation is to improve infant and young child feeding practices.[1] Current data indicate that only about a third of children in the high-burden countries are exclusively breastfed for six months and for less than half breastfeeding is initiated within the first hour of life;[2] this state of affairs is far from the global recommendation on infant and young child feeding.[3]

27. WHO continues to promote infant and young child feeding as essential for achieving the Millennium Development Goals, in particular, those relating to the eradication of extreme poverty and hunger and to the reduction of child mortality. In line with the Global Strategy for Infant and Young Child Feeding, the Secretariat's approach is two-fold: to develop guidelines and tools for achieving the Strategy's operational targets, and subsequently help to ensure that they are used through national capacity building; and to provide support for research and disseminate its findings. A joint WHO/UNICEF planning guide was issued in 2007 to assist countries in translating the Strategy into national action plans.

28. Many countries have implemented or officially adopted the Child Growth Standards launched in April 2006, along with tools for ensuring implementation. Their use is prompting significant changes towards best practices, as countries standardize their guidelines for assessing child growth and revitalize their programmes for promoting child growth. The Secretariat has also scaled up its activities for creating a network of trainers for growth assessment.

29. With UNICEF, WHO in 2006 published an integrated course in order to increase the number of health workers skilled in counselling on breastfeeding, complementary feeding, and feeding infants infected with HIV. Also with UNICEF, WHO has published an updated version of baby-friendly hospital initiative materials in 2007. WHO finished a technical review of evidence on the optimal feeding of low-birth-weight infants in 2006, and completed a systematic review in 2007, from observational and randomized studies, of the long-term effects of breastfeeding. Currently, the Organization is developing techniques to design food-based dietary guidelines based on mathematical modelling with linear programming.

30. At a consultation (Washington DC, 6–8 November 2007) WHO and partners reviewed the evidence and agreed on a set of indicators for assessing feeding practices for infants and young children. These indicators will be incorporated into the WHO's Global Data Bank on Infant and Young Child Feeding.

[1] Global strategy for infant and young child feeding, document WHA55/2002/REC/1, Annex 2.

[2] WHO global database on infant and young child feeding, updated 5 December 2007.

[3] Exclusive breastfeeding for the first six months of life, with nutritionally adequate and safe complementary feeding through introduction of safe and adequate amounts of indigenous and local foods while breastfeeding continues up to the age of two years or beyond.

31. In October 2006, on behalf of the Interagency Task Team on Prevention of HIV Infections in Pregnant Women, Mothers and their Infants, WHO held a technical consultation in Geneva on HIV and infant feeding in order to review new evidence and the most recent experience in this area, and to clarify and refine existing recommendations. The consultation endorsed the general principles underpinning earlier recommendations, and issued a consensus statement on feeding options in the context of HIV.

32. In order to identify and prevent early cases of malnutrition, WHO is strengthening the integrated approach to improving management of severe malnutrition among children through an innovative approach that integrates community-based management with facility-based management. It is preparing operational guidance for emergency relief staff and programme managers. The guidelines on indicators for iodine-deficiency disorders, developed by WHO, UNICEF and the International Council for the Control of Iodine Deficiency Disorders, were updated, and a joint statement with WFP and UNICEF on preventing and controlling micronutrient deficiencies was issued. The Secretariat has produced a draft strategy for advocacy, communication and community engagement on nutrition.

33. With its partners, WHO began an analysis of readiness to act in nutrition, funded by the Bill & Melinda Gates Foundation. The analysis is assessing gaps and constraints, and identifying opportunities for action to reduce maternal and child undernutrition in the 36 countries that are home to 90% of the world's stunted children.

34. In 2006 and 2007, several countries took measures to implement the International Code of Marketing of Breast-milk Substitutes, ranging from building and strengthening the capabilities of government officials and health professionals for implementing the Code and monitoring progress to adoption of new, and reform of existing, legislation and regulations. In the Region of the Americas, Bolivia has adopted a national code. In the Western Pacific Region, participants in a regional WHO/UNICEF Consultation on Breastfeeding Protection, Promotion and Support (Manila, 19–21 June 2007) identified actions for improving implementation of the International Code and subsequent relevant resolutions at national level. In the Philippines, the Implementing Rules and Regulations of Executive Order No. 51 (the national "milk code") were substantially revised to ensure more effective implementation and monitoring of the national code, with sustained efforts to increase awareness and knowledge on breastfeeding, including the establishment of breastfeeding-support groups nationwide and increased training. In the African Region, training on implementation of the Code and its monitoring was undertaken in an eastern and southern African countries, facilitated by UNICEF and the International Code Documentation Centre, and with the participation of WHO.

35. In 2007, Member States were requested to provide up-to-date information on implementation of the International Code since 2006 (the 25th anniversary of the adoption of the International Code).

36. As part of its continuing provision of support to Member States, the Secretariat has been discussing with partners in both the United Nations system and civil society how to share knowledge about, and experience of, implementation of the Code and its monitoring, and to seek ways to improve collaboration and coordination in such areas as technical and legal support, advocacy and training.

ACTION BY THE HEALTH ASSEMBLY

37. The Health Assembly is invited to note the reports.

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