

## **Progress reports<sup>1</sup>**

### **Report by the Secretariat**

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<sup>1</sup> Sections B, G, I, J and K will be issued subsequently.

## **A. POLIOMYELITIS: MECHANISM FOR MANAGEMENT OF POTENTIAL RISKS TO ERADICATION**

1. At an urgent stakeholders consultation of the Global Polio Eradication Initiative in February 2007 participants agreed on a 24-month intensified eradication effort with specific indicators to monitor progress. In May 2008, the Health Assembly in resolution WHA61.1 urged all remaining poliomyelitis-affected Member States to engage all levels of political and civil society to ensure that every child is consistently reached and vaccinated during every supplementary immunization activity against poliomyelitis. It also urged Nigeria to undertake intensified activities to stop rapidly the outbreak of poliomyelitis in the north of the country, and Afghanistan, India and Pakistan to implement large-scale mopping-up activities to interrupt their final chains of poliovirus transmission. The Health Assembly requested the Director-General to assist in mobilizing the financial resources necessary for full implementation of the intensified eradication effort and to undertake the necessary research for managing the long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis.

2. In June 2008, the Minister of Health in Nigeria established a high-level task force in order to improve the quality of supplementary immunization activities. Two such activities were urgently undertaken across the northern states in July and August 2008. Monitoring indicates that significant gaps in coverage of these immunization activities persist, with more than 60% of children remaining not fully vaccinated (having received three or fewer doses of oral poliovirus vaccine). Because of a continuing outbreak caused by a type 2 vaccine-derived poliovirus, northern Nigeria is the only area in the world where all three poliovirus serotypes are circulating. Since June 2008, polioviruses originating in northern Nigeria have spread to Benin, Burkina Faso, Chad and Niger.

3. In October 2008, India confirmed that indigenous type 1 poliovirus had not been detected in Uttar Pradesh state for 12 consecutive months, affirming the technical feasibility of poliomyelitis eradication. However, a new outbreak due to type 1 poliovirus in western Uttar Pradesh, following importation of the virus from Bihar state in mid-2008, has highlighted the fragility of progress because of the suboptimal efficacy of oral poliovirus vaccine in this area. Mopping-up activities with monovalent oral poliovirus vaccines continue on average every six weeks in western Uttar Pradesh and central Bihar. New approaches to enhancing vaccine efficacy are being assessed in order to accelerate eradication in northern India.

4. In Pakistan, and to a lesser extent Afghanistan, poliomyelitis cases have surged since mid-2008 as a deterioration in security resulted in large-scale population movements and outbreaks in poliomyelitis-free areas, particularly in Punjab. Consequently, in late 2008 and 2009 Pakistan will increase the number of nationwide supplementary immunization activities to supplement mopping-up activities in known reservoir areas, such as Sindh province where coverage during supplementary immunization activities is still suboptimal despite good accessibility to children. In Afghanistan, poliomyelitis continues to be largely restricted to three of the country's 34 provinces, where insecurity hampers activities – a reality underscored by the recent deaths of two doctors and their driver on WHO duty for poliomyelitis eradication.

5. Responses to outbreaks are continuing in the 10 countries with cases associated with importation of poliovirus in 2008. In five of these countries, however, the outbreak has continued for more than 12 months: Angola, Chad, the Democratic Republic of the Congo, Ethiopia and Sudan. Although the risk of poliovirus importation remains high globally, 90 Member States have not maintained certification-standard surveillance for acute flaccid paralysis, as requested for global

certification, and 39 have not maintained routine immunization coverage with oral poliovirus vaccine at more than 80%, as recommended in resolution WHA61.1.

6. Resource mobilization activities have been enhanced in order to sustain the intensified eradication effort in 2009–2010. In 2008, countries where poliomyelitis was endemic and a range of new and existing donors provided additional funding for eradication activities, with important new multiyear commitments by Rotary International, the Bill & Melinda Gates Foundation and several G8 countries, the latter following a renewed commitment to poliomyelitis eradication by G8 leaders at the 2008 Summit (Hokkaido, Toyako, Japan, 7–9 July 2008). Rigorous resource mobilization activities will continue in order to ensure full funding of the intensified eradication effort.

7. New research on the management of the long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis includes: the development, field-testing and introduction of a real-time polymerase chain reaction test for more rapid detection of circulating vaccine-derived polioviruses; eight studies to characterize better the risks of chronic immunodeficiency-associated excretion of vaccine-derived polioviruses in low- and middle-income countries; investigation of the use of adjuvants, smaller doses and fewer-dose schedules in order to reduce the cost associated with the use of existing inactivated poliovirus vaccines; and, a clinical development project for the production of an inactivated poliovirus vaccine using Sabin-strain polioviruses.

8. In October 2008, the Director-General announced the commissioning of an independent review of the operational challenges to reaching all children with oral poliovirus vaccine in the remaining poliomyelitis-affected areas. The outcomes of this review will be applied as necessary to overcome these challenges.

### **C. MALARIA, INCLUDING PROPOSAL FOR ESTABLISHMENT OF WORLD MALARIA DAY**

9. WHO convened a panel in January 2008 to examine the technical issues underpinning malaria control and to review the feasibility of eradicating the disease. The achievements of the past few years demonstrate that, with a rapid expansion of effective antimalarial interventions, malaria morbidity and mortality can be significantly reduced within a relatively short period of time in all epidemiological situations. However, malaria cannot be eradicated with existing tools.

10. WHO has worked at all levels with partners such as UNICEF, the World Bank Global Strategy and Booster Program, the Malaria Initiative of the President of the United States of America, and the Roll Back Malaria Harmonization Working Group in order to support countries prepare applications to Rounds 7 and 8 of the Global Fund to Fight AIDS, Tuberculosis and Malaria. This support had an unprecedented result: some 70% of country applications for funding on malaria control and elimination were successful.

11. The United Nations Secretary-General announced the appointment of Mr Raymond G. Chambers of the United States of America as his Special Envoy for Malaria and issued a call to action on the goal of providing universal coverage of key malaria interventions to Africa by the end of 2010, and to reduce preventable malaria deaths to near zero by 2015.

12. Events took place worldwide to celebrate the first global World Malaria Day on the theme of Malaria – *a disease without borders*, with the support of all WHO regional offices. World Malaria Day

was an ideal platform for countries and regions to encourage greater awareness and to ensure that advocacy is sustained in all regions.

13. On 18 September 2008, the Director-General launched the *World malaria report*,<sup>1</sup> which noted an estimated 247 million cases of malaria and 881 000 deaths from the disease in 2006, mostly among children in Africa. A total of 91% of deaths were in Africa and 85% of deaths were in children under five. Yet the report provided strong evidence that a renewed global assault on malaria, under way since the turn of the millennium, has been accelerating in the past few years.

14. The Roll Back Malaria Partnership launched the Global Malaria Action Plan at the 2008 United Nations Millennium Development Goals Malaria Summit.

15. International funding commitments to the Global Malaria Action Plan in 2008 included US\$ 1620 million over two years from the Global Fund with a plan to distribute 100 million additional mosquito nets; US\$ 1100 million from the World Bank; US\$ 168.7 million from the Bill & Melinda Gates Foundation for vaccine research; and £40 million from the United Kingdom of Great Britain and Northern Ireland, which includes support for artemisinin combination therapy.

16. The following key resource and capacity constraints continue to require attention.

- Inadequate funding for malaria control remains an issue in some countries where there is a lack of domestic funds, or a failure to appropriately manage the available funds.
- The managerial and technical capacities in countries endemic for malaria to deliver interventions require more human resources in national malaria control programmes.
- Requests for technical support are increasing but are not matched by sufficient funding. As a result, WHO and partners are facing the crucial challenge of maintaining adequate human resources to respond to countries' needs.
- A major effort to increase the capacity of health systems should be extended beyond the health facility level to communities.
- With malaria incidence and deaths decreasing in many places, there is an additional demand on surveillance systems to monitor progress.

#### **D. IMPLEMENTATION BY WHO OF THE RECOMMENDATIONS OF THE GLOBAL TASK TEAM ON IMPROVING AIDS COORDINATION AMONG MULTILATERAL INSTITUTIONS AND INTERNATIONAL DONORS**

17. The 20th UNAIDS Programme Coordinating Board (Geneva, 25–27 June 2007) called for the establishment of a reference group for oversight and implementation of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors. WHO has been appointed to the Global Task Team Oversight Reference Group to represent the 10 UNAIDS cosponsors.

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<sup>1</sup> *The world health report 2008: World malaria report 2008*. Geneva, World Health Organization, 2008.

18. WHO has continued to work with countries to improve planning for national HIV/AIDS responses, including the development of national health-sector plans on HIV/AIDS that are aligned with the AIDS Strategy and Action Plan, the International Health Partnership and related processes, including International Health Partnership Plus (IHP+).
19. WHO has participated in the latter process in order to assist in development of the model of the Global Fund to Fight AIDS, Tuberculosis and Malaria for programmatic funding through national strategy applications.
20. WHO has reviewed its work on HIV to bring it in line with the UNAIDS Division of Labour matrix. To better define its scope of work, WHO is working with UNAIDS and UNICEF on a progress report on scaling up priority HIV/AIDS interventions towards universal access, which will summarize WHO's policy and technical recommendations for each intervention, and provides references to WHO's resources and other materials in order to support decision-making and implementation.
21. The UNAIDS Division of Labour matrix has been revised to include UNDP as lead agency on sexual minorities, including men who have sex with men, and to clarify the division of labour between UNHCR and the UNAIDS Secretariat on HIV in humanitarian emergency and security settings. This work has resulted in intensified collaboration between WHO, UNDP and the UNAIDS Secretariat on matters concerning men who have sex with men.
22. By the end of October 2008, Joint United Nations Teams on AIDS had been established in 89 countries. WHO has contributed to the development of an annual review process for monitoring the performance of these teams.
23. The Global Joint Problem Solving and Implementation Support Team reformulated its Terms of Reference in 2007 to focus on global-level issues that affect the implementation of programmes at country level. It has developed a set of principles for technical support. A global-level, web-enabled database, known as Coordinating AIDS Technical Support, is based on these principles and is designed to improve planning and coordination of technical support.
24. WHO has strengthened its technical assistance to countries in order "to make the money work". A working group has been established to coordinate WHO technical support to allow countries to access and implement grants from the Global Fund. For example, WHO country offices provided assistance to all 72 countries that submitted HIV/AIDS proposals to the Global Fund for the Round 8 call for proposals. In addition, WHO participated in technical assistance missions to 52 countries to support proposal development, including joint missions with the UNAIDS Secretariat, ILO, UNICEF and UNFPA.
25. WHO is setting up networks of technical partners, including WHO Collaborating Centres, WHO Knowledge Hubs and others, to provide coordinated technical assistance for priority health sector interventions.
26. Funding for technical support has not kept pace with the demand from countries and partners for WHO assistance. Planning for the 2010–2011 UNAIDS Unified Budget and Workplan will need to refocus resources to adequately fund technical support to countries and to be fully aligned with the UNAIDS Division of Labour.

## **E. PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED INFECTIONS**

27. From 2006 to date, the Global strategy for the prevention and control of sexually transmitted infections 2006–2015 has been presented at international, regional and national conferences, and an action plan to guide its implementation has been produced in consultation with countries and stakeholders.

28. Globally, 28 countries have reported that they had strengthened diagnosis and treatment of sexually transmitted infections and had updated national treatment guidelines. Thirty trainers from 10 Pacific island Member States were trained in management of sexually transmitted infections at a training of trainers course, held in Suva in October 2008.

29. Screening for syphilis during pregnancy has been scaled up in Brazil, China, Haiti, Indonesia, Myanmar, Madagascar, Mozambique, Papua New Guinea, Peru and Sri Lanka. The Caribbean initiative for elimination of vertical transmission of HIV and syphilis was agreed upon and will be launched in 2009. Some countries in Latin America have designated a national day for elimination of congenital syphilis. In support of these two initiatives, WHO has disseminated the rationale and strategy for elimination of congenital syphilis.

30. A post at WHO headquarters intended to guide surveillance activities at the global level has received the required funding. The process to fill the post has begun. An updated WHO guide for surveillance will be published in early 2009.

31. Monitoring of antimicrobial resistance in *Neisseria gonorrhoeae* was improved in countries of the Western Pacific and South-East Asia Regions; plans are complete for monitoring in Africa, South America and the Caribbean.

32. The Western Pacific Region standardized definitions and the minimum data set for case reporting of sexually transmitted infections. In the European Region, management training in surveillance of sexually transmitted infections was added to the tasks of the Surveillance Knowledge Hub for HIV at the WHO Collaborating Centre in Croatia. A situation analysis of sexually transmitted infections was conducted in nine countries of the Eastern Mediterranean Region. In Latin America, 20 countries reported that they had undertaken analysis of national policies on prevention and control of sexually transmitted infections. A report on the results of the analysis, in English and Spanish, will be posted on the WHO web site. Participating countries have committed to implement action on sexually transmitted infection control and congenital syphilis elimination.

33. Based on the 100% condom use programmes in Asian and Pacific countries, initiatives have been launched in Africa to improve control of sexually transmitted infections and increase use of condoms by sex workers. Viet Nam initiated periodic presumptive treatment to control sexually transmitted infections in two sites with a target population of 33 000 sex workers and men who have sex with men.

34. WHO, with UNDP and UNAIDS as cosponsors, convened a consultation on men who have sex with men and the prevention and treatment of HIV and other sexually transmitted infections (Geneva, September 2008). WHO and the cosponsors highlighted the urgency of scaling up interventions and strengthening surveillance within this population group.

35. The online Human Papillomavirus Vaccine Global Community<sup>1</sup> was launched in 2008 as a forum to exchange knowledge of and resources for vaccines. Cervical cancer screening using visual inspection with acetic acid and cryotherapy are being scaled up in Madagascar, Malawi, Nigeria, Uganda, United Republic of Tanzania and Zambia. WHO has published four guides for prevention of cervical cancer and information on human papillomavirus vaccines. These can be found on the WHO web site.

36. At the regional level, the Regional Strategy for the Prevention and Control of Sexually Transmitted Infections 2007–2015 for the South-East Asia Region and the Regional Strategic Plan for the Prevention and Control of Sexually Transmitted Infections 2008–2012 for the Western Pacific Region were published. The Asia-Pacific Operational Framework for Linking HIV/STI Services with Reproductive, Adolescent, Maternal, Newborn and Child Health Services was published in 2008. These publications can be found on the respective WHO regional web sites. The Regional Strategy for the Prevention and Control of Sexually Transmitted Infections 2009–2015 was endorsed by the Regional Committee for the Eastern Mediterranean in October 2008. The PAHO Regional Strategy and Plan of Action for Cervical Cancer Prevention and Control was presented to the Regional Committee for the Americas in September 2008. Regional action plans for prevention and control of sexually transmitted infections for the European and African Regions are in preparation.

## **F. STRENGTHENING OF HEALTH INFORMATION SYSTEMS**

37. As a founding member of the Health Metrics Network, WHO has provided ongoing support for the updating of the *Framework and Standards for Country Health Information Systems*. A second edition, published in June 2008, contains important new contributions and lessons learnt from countries and partners, particularly in the development of methods and standards for implementation.<sup>2</sup>

38. The Framework continues to evolve and new contributions will be reflected in a third edition. The updating of the Framework is also guided by the Health Metrics Network's work on implementation in six Wave One Countries (Belize, Cambodia, Ethiopia, Sierra Leone, Syrian Arab Republic and Zambia).<sup>3</sup> In this context, the Director-General and partners have supported Health Metrics Network successful efforts to revitalize Sierra Leone's health information system.

39. WHO has provided support to 46 countries in order to undertake assessments that identify gaps in their health information systems. These assessments, which involved a wide range of country stakeholders, relied on tools based on the *Framework*. In addition, 37 countries are now at advanced stages of preparing costed, long-range plans, to close gaps in their respective health information systems.

40. WHO has supported the Health Metrics Network in the establishment of a global technical assistance facility for health information systems strengthening, which began operations in October 2008. More than 65 countries from all regions are expected to benefit from this facility.

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<sup>1</sup> [http://hpv\\_vaccines.net](http://hpv_vaccines.net).

<sup>2</sup> WHO: Health Metrics Network, *Framework and Standards for Country Health Information Systems*, second edition, Geneva, World Health Organization, June 2008.

<sup>3</sup> Wave One Countries are priority countries for funding and technical assistance from the Health Metrics Network.

41. A survey of 65 countries in July 2008 found that the work of the Health Metrics Network has helped to improve in-country coordination of health information systems through application of the Framework. In particular, countries have reported improved collaboration between national statistical offices and health ministries. Better coordination will reduce fragmentation and help to foster a “one-country” health information system. Countries also reported an increase in the allocation of domestic resources for health information system strengthening between 2006 and 2008.

42. WHO regional and country offices and the Health Metrics Network have jointly supported 12 countries in preparing applications to the Global Fund to finance health information system interventions in Round 8. Similar support to countries is planned for the Global Fund’s call for proposals Round 9.

43. WHO and the Health Metrics Network have begun planning for a global meeting dedicated to Health Information, scheduled for 2010.

## **H. STRATEGY FOR INTEGRATING GENDER ANALYSIS AND ACTIONS INTO THE WORK OF WHO**

44. Significant progress has been made in implementing the four strategic directions contained in the WHO gender strategy. On the first strategic direction – Building WHO capacity for gender analysis and planning – activities were implemented to strengthen capacity on gender, women and health, including providing gender-sensitive health care. More than 215 health managers from more than 30 countries have been trained in gender analysis and in developing responsive actions; 59 people were trained using the draft gender and HIV tool, designed to help managers of HIV/AIDS programmes in the health sector to integrate gender into programmes. The training activities enabled sustainable networks to be established to support national efforts. Work is under way to finalize a computer-based course for all WHO staff on integrating gender, another on addressing gender-based violence in emergencies and a module on providing gender-sensitive health care.

45. Progress in the second strategic direction – Bringing gender into the mainstream of WHO’s management – includes integrating gender dimensions into the operational planning and systematic support and/or ongoing collaboration of 17 selected programmes and departments encompassing all the Organization’s strategic objectives. In order to support countries, in addition to training, the electronic guide for developing country cooperative strategies was updated to reflect the need to integrate gender analysis and actions. New tools for assessing human rights and gender equality dimensions in national health-sector plans are being developed and have been pilot tested in two regions.

46. Some progress has been made in the third strategic direction (Promoting use of sex-disaggregated data and gender analysis), including initialization of gender analysis of the World Health Survey, the WHO STEPS<sup>1</sup> approach to the surveillance of risk factors for chronic disease, the global school-based student health survey, and access to and use of health services. Some regions have included sex disaggregation in their health statistics review; others are building capacity within countries to collect and analyse health data that are disaggregated by sex, age and other relevant variables, such as ethnicity.

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<sup>1</sup> The WHO STEPwise approach to Surveillance (STEPS) is a simple, standardized method for collecting, analysing and disseminating data in Member States.



47. Implementation of the final strategic direction – Establishing accountability – began by developing a monitoring and evaluation framework and a baseline assessment involving more than 2000 WHO staff members from all regions and headquarters. Preliminary findings suggest that professional staff have fair knowledge of gender equality. Areas for improvement include: applying gender analysis; enhancing institutional support; systematically promoting and using sex-disaggregated data and gender analysis in key WHO publications; and ensuring that major speeches by senior management reflect the commitment to gender equality. Performance management of some senior managers incorporates objectives that reflect accountability for gender mainstreaming. Further work is required to ensure that the Organization applies this practice universally.

48. The Secretariat's gender, women and health network has facilitated the implementation of resolution WHA60.25 in the African Region, where a workshop involved 11 countries in central Africa in accelerating the implementation of the Regional Strategy for Women's Health, underpinning gender mainstreaming as an important strategy for achieving better health for women. In the Region of the Americas, the resolution is being implemented in accordance with the PAHO gender-equality policy. A regional action plan and preliminary national action plans for gender mainstreaming in 13 countries were also developed.

49. The Eastern Mediterranean Region integrated gender equality dimensions into the results-based management framework and trained health managers from nine countries in gender analysis and developing responsive actions. The European Region is focusing on ensuring that gender equality is institutionalized and addressed as an important social determinant of health. The South-East Asia Region developed regional strategic directions and trained WHO staff and key partners from eight countries in gender analysis and developing responsive actions. The Western Pacific Region focused on reproductive health, especially as it related to youth, and on training participants from 10 countries in gender and rights.

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