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Implementation of resolutions: progress reports

Report by the Secretariat

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A. INFANT AND YOUNG CHILD NUTRITION

1. WHO continues to promote infant and young child feeding as a critical intervention for achieving the Millennium Development Goals, in particular, those relating to eradication of extreme poverty and hunger and to reduction of child mortality, in line with the Global strategy for infant and young child feeding. WHO's approach in this regard is to provide support for research and to disseminate findings, and to develop guidelines and tools while helping to ensure their use through national capacity-building.
2. The importance of exclusive breastfeeding in reducing infant mortality has been strengthened by new evidence from several countries, and a recent trial indicated that community-based counselling on breastfeeding can be effective in improving feeding practices and health outcomes. Fresh evidence also suggests that exclusive or predominant breastfeeding may be associated with lower mother-to-child transmission of HIV than is mixed feeding.¹ Results from similar studies and studies on treatment of breastfeeding mothers with highly active antiretroviral therapy will become available in 2006.
3. WHO provided support for operations research on feeding infants of HIV-positive mothers in several countries. Results were incorporated into training tools, including a five-day integrated course on infant and young child feeding, which was developed to accelerate training of health workers in counselling competencies. It was introduced in seven countries in the Western Pacific Region.
4. WHO is preparing guidance for programme managers to adapt recommendations on complementary feeding to national needs, with emphasis on improved micronutrient intakes. Standards for feeding non-breastfed children beyond six months of age have also been published.²
5. Results of WHO's Multicentre Growth Reference Study are being converted into new growth standards which will be released in 2006, together with software and training materials to support their application worldwide.
6. Regional meetings updated global criteria and related assessment and training tools in order to revitalize the Baby-friendly Hospital Initiative. Revised training, assessment and monitoring materials were field-tested.
7. WHO's Secretariat is developing a number of practical tools for programme planning and assessment in order to translate the Global strategy for infant and young child feeding into national action plans, and has intensified technical support to countries through its regional offices and partners. Emphasis is laid on collaboration between programmes responsible for nutrition, integrated management of childhood illness, maternal health, and prevention of mother-to-child transmission of HIV/AIDS.
8. During the biennium 2004-2005, the **Regional Office for Africa** organized four intercountry planning meetings and provided support for training-of-trainer courses on infant feeding counselling in 19 countries. By the end of 2004, over 250 trainers and 2000 health workers had benefited.

¹ Iliff PJ et al. Early exclusive breastfeeding reduces the risk of postnatal HIV-1 transmission and increases HIV-free survival. *AIDS* 2005 19:699-708.

² *Guiding principles for feeding non-breastfed children 6-24 months of age*. Geneva, World Health Organization, 2005.

9. The **Regional Office for the Americas** conducted two regional planning workshops and three subregional workshops, and provided support for training in HIV and infant-feeding counselling in several countries.

10. The **Regional Office for South-East Asia** organized an intercountry training course on breastfeeding, and HIV and infant-feeding counselling. The **Regional Office for Europe** adapted for the region counselling courses on breastfeeding, and HIV and infant feeding. The **Regional Office for the Eastern Mediterranean** developed training materials on child-feeding counselling and established a pool of regional facilitators. The **Western Pacific Region** provided support for planning workshops in six countries and for training of health workers in appropriate infant feeding in five countries.

11. WHO continued to provide technical support to Member States in the drafting and review of legislation to implement the International Code of Marketing of Breast-milk Substitutes.

B. REPRODUCTIVE HEALTH: STRATEGY TO ACCELERATE PROGRESS TOWARDS THE ATTAINMENT OF INTERNATIONAL DEVELOPMENT GOALS AND TARGETS (INCLUDING IMPACT ON NATIONAL ECONOMIC DEVELOPMENT)¹

12. Following its endorsement in resolution WHA57.12, WHO's strategy to accelerate progress in reproductive health² has been widely disseminated, and both Member States and the Secretariat have implemented a wide range of activities.

13. To monitor implementation of the strategy, the Secretariat sent an assessment tool to all Member States. Responses to date show that the strategy is being used as a comprehensive framework by many Member States in order further to integrate reproductive and sexual health into national development policies by strengthening existing policies and strategies or elaborating new ones. Member States are also using the strategy to identify problems, set priorities, monitor progress towards reproductive health goals, and refine survey instruments for monitoring and evaluation of national programmes. Quality of care in services has been assessed and the strategy has been used in introducing new standards for clinical practice. Some Member States have used it as the basis for measures to provide supplies for reproductive and sexual health care free and ensure security in those reproductive and sexual health commodities.³ Some have also applied the strategy to increase awareness among specific groups and communities, using the mass media for advocacy and health information. Finally, the strategy has facilitated increased collaboration among partners involved in service delivery.

¹ The reference to impact on national economic development was added after adoption of resolution WHA57.12 at the request of a Member State.

² Document WHA57/2004/REC/1, Annex 2; the strategy recognizes the crucial role of reproductive and sexual health to social and economic development and targets five priority areas: improving antenatal, perinatal, postpartum and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections, including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promoting sexual health.

³ The term reproductive health commodities refers to all medicines and devices essential for the provision of high-quality reproductive health services.

14. Initial conclusions from the assessment highlight three areas of concern: limited access to services by poor people; insufficient action to meet the needs of adolescents; and inadequate working conditions for health-care providers.

15. In order to respond to these concerns, four policy briefs are being finalized, on: financing of services, with emphasis on ensuring universal coverage; meeting the particular needs of adolescents; supportive legislation and removal of regulatory barriers; and integration of the five core components of reproductive and sexual health into health services.

16. Progress in ensuring reproductive health commodity security has been made through the Reproductive Health Supplies Coalition, of which WHO is a member. A draft comprehensive list of essential reproductive health commodities including medicines and devices was drawn up in collaboration with UNFPA. Work has also been undertaken to ensure the inclusion of reproductive health medicines on the WHO Model List of Essential Medicines. A process of prequalification of reproductive health commodities is currently being elaborated.

17. *The world health report 2005*,¹ which like World Health Day 2005 was devoted to maternal, neonatal and child health, included the most recent mortality and morbidity estimates, an expert analysis of the obstacles to progress, and comprehensive recommendations for overcoming them. It contributed substantially to the United Nations 2005 World Summit.² Five policy briefs have also been issued. The goal of achieving universal access to reproductive health by 2015 as set out at the International Conference on Population and Development (Cairo, 1994) was included in the outcome document of the Summit.³ In addition, a WHO Goodwill Ambassador for Maternal, Newborn and Child Health has been appointed. Finally, WHO headquarters is hosting the Partnership for Maternal, Newborn and Child Health, launched in September 2005.

18. The benefits of the strategy for national economic development cannot yet be assessed. Based on past experience, however, increased use of family planning, for instance, could be expected to yield positive returns: gains in maternal health and expansion of employment opportunities for women with the potential for the contribution of both parents to the family and national income.

19. Continued progress towards implementation of the strategy will require sustained efforts in high priority areas of work, such as tackling HIV/AIDS prevention and care as a reproductive and sexual health issue, and assessment of the economic impact of the strategy.

C. FAMILY AND HEALTH IN THE CONTEXT OF THE TENTH ANNIVERSARY OF THE INTERNATIONAL YEAR OF THE FAMILY

20. As part of WHO's commitment to attaining the United Nations Millennium Development Goals to reduce child mortality and improve maternal health, *The world health report 2005* and World Health Day this year were dedicated to the health of mothers, neonates and children. The report identifies exclusion as a key feature of inequity and a major constraint on progress towards universal access to care for women and children. It presents new data on causes of neonatal deaths, argues

¹ *The world health report 2005: Make every mother and child count*. Geneva, World Health Organization, 2005.

² High-level Plenary Meeting of the sixtieth session of the United Nations General Assembly, 14-16 September 2005.

³ Document A/60/L.1.

strongly for care continuing both along the life course from mother to newborn to child and across all levels of the health-delivery system from community to referral, and shows that Integrated Management of Childhood Illness is one of the most successful and cost-effective delivery strategies for newborn and child health.

21. To accompany that report, a set of policy briefs has been issued on the most pertinent and potentially difficult aspects.¹ These briefs, which had been finalized and highly commended at a high-level policy meeting of representatives of Member States and partners (Geneva, 7-8 March 2005), are being used as a basis for policy discussions at national level.

22. The Partnership for Maternal, Newborn and Child Health, launched in September 2005, brings together existing alliances, thereby uniting developing and developed countries, United Nations agencies, professional associations, academic and research institutions, foundations and nongovernmental organizations. Stakeholders in this unprecedented collaboration will promote universal coverage of the interventions that enable mothers and children to survive. Global partners are working with Member States to set up national-level partnerships to update national policies and strategies, assure complementarity and consistency among approaches, and ensure the most effective use of resources.

23. Guidance continues to be provided on the application of the Convention on the Rights of the Child as a legal and normative framework for reducing inequities in child and adolescent health. WHO staff participate in key health and human rights conferences and workshops, and countries are supported in preparing and implementing rights-based assessments and analyses of child health, in particular at district level.

24. Indicators of parental regulation of adolescent behaviour and the strength of the parent-adolescent connection (the emotional bond between the adolescent and a key carer) are being defined for parenting programmes. With the reduction of the incidence of HIV infection in young people being taken as an entry point to the larger field of adolescent health and development, adolescent-specific indicators have also been formulated for HIV prevention programmes, and their use in Member States has been supported.

25. The WHO Multi-Country Study on Women's Health and Domestic Violence against Women is the first research to gather internationally comparable data on the prevalence of such violence and its effect on women's health. The findings will be used to generate policies and strategies that respond to this global problem. WHO also works with partners to assess the impact of gender inequality (including violence) on the HIV epidemic, and to improve the health-sector response to sexual violence, including in the context of crises.

26. With more than three million child deaths each year attributable to causes and conditions related to the environment, reducing environmental risks to children's health is one of the most important contributions to attaining the relevant Millennium Development Goals. WHO's programmes on water and sanitation, vector-borne diseases, indoor air pollution, chemical safety, radiation, occupational health, food safety and injury prevention are complemented by its leadership of innovative multi-stakeholder partnerships such as the Healthy Environments for Children Alliance, the Global Initiative

¹ WHO policy briefs. 1. Integrating maternal, newborn and child health programmes. 2. Rehabilitating the workforce: the key to scaling up MNCH. 3. Access to care and financial protection for all. 4. Working with civil society organizations. Geneva, World Health Organization, 2005.

on Children's Environmental Health Indicators and the International Network to Promote Household Water Treatment and Safe Storage.

D. HEALTH ACTION IN RELATION TO CRISES AND DISASTERS

27. In resolution WHA58.1, the Health Assembly requested the Director-General to undertake several activities in order to strengthen its work on health action in crises, and to inform the Fifty-ninth World Health Assembly, through the Executive Board, of progress.

Earthquakes and tsunamis of 26 December 2004: relief and recovery

28. The Secretariat has developed and implemented a relief and recovery strategy based on the Organization's four priority functions in crises, namely assessing the health situation; supporting coordination of health-related action; filling, or ensuring that others fill, critical gaps; and building capacity within national authorities and civil society. Crucial supplies and services were also provided while public health capacity was rebuilt. The focus is now on building capacity in the priority areas of health protection and disease prevention, health policy formulation and coordination, and health-services delivery. Work continues with the Office of the United Nations Special Envoy for Tsunami Recovery, the United Nations Office for the Coordination of Humanitarian Affairs, UNDP, UNICEF, the International Federation of Red Cross and Red Crescent Societies and other agencies on the development of an impact-assessment system for relief and rehabilitation activities in Indonesia for 2005-2008. The system will be replicated in Maldives and Sri Lanka. The first results will be available by the end of 2005.

Enhanced cooperation with other international organizations

29. Within the United Nations, WHO has been designated as the lead agency for the Inter-Agency Standing Committee's Humanitarian Health Cluster, which aims to improve capacity, predictability, effectiveness and accountability in the health sector through the Joint Initiative to Improve Humanitarian Health Outcomes. WHO and the International Federation of the Red Cross and Red Crescent Societies have signed a joint letter on cooperation and strengthened collaboration, with a particular focus on emergencies. WHO and InterAction, an alliance of nongovernmental organizations, are co-chairing the Taskforce on Mental Health and Psychosocial Support in Emergency Settings recently established by the Standing Committee.

Enhanced logistics and crisis-response mechanisms

30. A working group on emergency response has been established to review the Organization's administrative policies and processes and to recommend ways of adapting them for emergencies. The expected outcome is a set of standard operating procedures for emergencies to be used at all levels of the Organization.

Mobilization of health expertise

31. WHO has been asked to establish a health emergency action response network as one component of the Joint Initiative to Improve Health Outcomes (see paragraph 29 above). The goal of the network is the creation of a pool of trained humanitarian health experts available for rapid field deployment whenever public health emergencies occur. Also, WHO's presence in countries is being

consolidated by the recruitment of around 60 additional field staff for emergency work, using funds given by donors under WHO's three-year programme to enhance its performance in crises.

Risk monitoring and health assessments

32. The Secretariat is working with Member States and other health partners to use reliable information on health threats, vulnerability factors and performance of local health systems for mitigation, preparedness, response and recovery. An overview of health risks, humanitarian needs and responses worldwide is kept up to date. Weekly updates on areas prone to, affected by, or recovering from crises are supplied directly to the United Nations humanitarian early warning system.

33. Risk mapping, when properly done, can ensure that national emergency-preparedness plans pay due attention to public health. In 2005, staff conducted risk assessments in Nepal, rapid needs assessments in Niger, health-sector analyses in Burundi and the Democratic Republic of the Congo, and crude and under-five mortality surveys in the Darfur region of Sudan and in northern Uganda. Also, the assessment of the impact of the recovery process following the south Asian tsunami and earthquakes is being supported, and WHO is participating in joint needs assessment for recovery in Somalia.

South Asia earthquake¹

34. In the immediate aftermath of the earthquake that struck south Asia on 8 October 2005, resulting in more than 73 000 deaths, WHO mobilized significant human, logistic and financial resources to support the health sector in Pakistan in its response efforts. A joint Ministry of Health/WHO Emergency Coordination Centre was established in Islamabad, supplemented by six field offices in the affected areas. A public health strategy was agreed upon and implemented by national and international partners under the aegis of the Humanitarian Health Cluster led by WHO. Urgently needed medical supplies and equipment have been delivered to the affected areas; joint efforts to expand access to health care for survivors are under way; coordination mechanisms have been established; and various technical projects are being implemented, including the setting up of a disease-surveillance system. WHO is currently supporting the Ministry of Health of Pakistan in comprehensive planning for post-disaster recovery and rehabilitation.

E. SUSTAINABLE HEALTH FINANCING, UNIVERSAL COVERAGE AND SOCIAL HEALTH INSURANCE

35. Resolution WHA58.33 urged Member States to develop sustainable health-financing systems that can ensure that all people have access to needed services without the risk of financial catastrophe. It recognized that options to achieve the goal of universal coverage needed to be designed within the macroeconomic, sociocultural and political context of countries and that a variety of options were possible.

36. In response to the resolution, the Secretariat has strengthened and re-focused its work in health-system financing, concentrating on three key questions: how to raise additional funds where they are needed; how to use them effectively, efficiently and equitably; and how to ensure that disadvantaged

¹ Fuller details are provided in document EB117/30.

groups have access to needed services without the risk of financial catastrophe or impoverishment. Information has been disseminated on health-financing policy, tools have been developed to help frame policy and technical support provided to countries.¹

37. Its efforts will now be geared to strengthening technical support to countries, building capacity, and collating and disseminating policy-relevant information and tools. Areas covered will include tracking the amounts spent on health, by whom, and for what service; determining the cost of scaling up interventions and programmes and its impact on health status; coordinating financing arrangements (including donor flows) aimed at specific diseases or interventions with the overall health financing system; identifying the economic consequences of disease, and the extent and nature of catastrophic payments for health services; and drawing policies and strategies for contracting in the health sector and for the appropriate design of health financing systems to achieve universal coverage. Discussions are under way with external partners on the best way to meet the increasing demand for technical support at country level.

38. A number of outstanding issues discussed at the Fifty-eighth World Health Assembly will also be tackled during 2006. These include gathering and disseminating evidence on the role of safety nets for the poor (such as exemption and waiver mechanism for fees) and analysing how particular methods for revenue collection, pooling of funds, and purchasing of services (e.g. payroll taxes earmarked for social health insurance, general tax revenues, mixed public/private management of insurance and provision) can be coordinated within a comprehensive health financing policy and strategic plan.

F. THE ROLE OF CONTRACTUAL ARRANGEMENTS IN IMPROVING HEALTH SYSTEMS' PERFORMANCE

39. Resolution WHA56.25 invited Member States to ensure that contracting in the health sector followed rules and principles that were coherent with national health policy; and to design contractual policies that maximized impact on the performance of health systems and harmonized the practices of all those concerned. Since its adoption, the use of contracting in health systems has increased significantly in developed and developing countries alike. Contracting takes different forms depending on the national context, from the delegation of responsibility (concession, lease contract, better association between private and public sectors, performance contracts between different levels of the system), to the purchase of health services, or contractual relations based on cooperation (franchising, networking, partnerships). Contracts may involve the public sector and both for-profit and not-for-profit entities, or different actors in the public sector. Quite complex arrangements have evolved to organize the relationships among multiple actors in the health sector especially in developed countries.

40. The Secretariat has continued its efforts to define and analyse various approaches to contracting, keeping in mind the practical needs of Member States. Several documents have been prepared, notably on the role of contracting in improving the performance of health systems.² The regional offices for Europe and for the Western Pacific have also prepared several documents related to contracting, especially with regard to the purchase of health services. These different documents were presented in several international workshops and seminars, then disseminated widely.

¹ See document EIP/HSF/HFP/2005.1 for further details.

² Document EIP/FER/DP.E.04.1.

41. Support has been provided to several countries for national workshops, where information on the different forms of contracting was presented to a variety of stakeholders (government, nongovernmental organizations, private sector, etc.), and has been continued as countries develop their own strategies to incorporate contracting in their health systems where appropriate. The Regional Office for the Eastern Mediterranean undertook studies on contractual arrangements in 10 countries, and organized a workshop in April 2005 to draw up an inventory of progress and a regional strategy for the use of contracting arrangements. Special attention has been given to providing support to countries that have decided to frame national policies on contracting, including Burkina Faso, Chad, Madagascar, Mali, Morocco, and Senegal.

42. In collaboration with the World Bank Institute and ILO, WHO organized several intercountry workshops in the African Region, to which African training institutions contributed their teaching skills. They aimed at reinforcing the technical capabilities of those using contracting instruments, to date, mostly responsible staff in ministries of health, nongovernmental organizations and micro-insurance schemes. One of these workshops was particularly designed to transfer knowledge and exchange experience of the design of national contracting policies.

43. An internet site focusing on contracting in health systems is now in operation, which allows users to access several documents on contracting, to find information on forthcoming events and training workshops and, importantly, to share their field experiences.¹

44. In the period 2006-2007 particular emphasis will be laid on assessment of innovative experiences in terms of access, efficiency, quality and equity. In addition, sufficient time has now elapsed since the first policies were introduced to warrant an evaluation of some of them in order to determine whether the strategies adopted have improved the efficiency of health systems, and allowed for their more balanced development.

G. UNITED NATIONS REFORM PROCESS AND WHO'S ROLE IN HARMONIZATION OF OPERATIONAL DEVELOPMENT ACTIVITIES AT COUNTRY LEVEL: INTERIM PROGRESS REPORT

45. Resolution WHA58.25 requested the Director-General to ensure both coordination between WHO's activities and those of other organizations of the United Nations system and adherence to the international harmonization and alignment agenda; to take into account the triennial comprehensive policy review of operational activities for development of the United Nations system;² and to submit to the Fifty-ninth World Health Assembly, through the Executive Board, an interim report on progress made in implementing the resolution.

46. Consistent with recent efforts in relation to harmonization and alignment, WHO has been constructing a new conceptual framework for its work in and with countries following the introduction of country cooperation strategies in 1999. The strategies are designed to ensure that WHO's work fully supports Member States' health sector priorities and plans as well as other national health and development frameworks in pursuit of the Millennium Development Goals. Each country cooperation strategy is developed in close consultation with the national government, organizations of the United

¹ www.who.int/contracting.

² United Nations General Assembly resolution 59/250.

Nations system and all partners working to improve health outcomes. The strategies draw from, and contribute to, the streamlining of aid coordination and partnership platforms, such as the Poverty Reduction Strategy approach and the United Nations Development Assistance Framework. Currently, there are more than 120 countries in which WHO's activities are guided by a country cooperation strategy.

47. Since becoming a member of the United Nations Development Group in 1999, WHO has consistently contributed to the elaboration of common tools and mechanisms, designed to enable the United Nations system to function in a more coherent and efficient manner at country level. The significance of the Development Group's guidance notes for health and for the United Nations country teams had been systematically reinforced by the supplementary guidance provided by WHO to its country offices. Recognizing the importance of the international harmonization and alignment agenda, WHO acts as a co-chair of the Development Group's working group on OECD/Development Assistance Committee harmonization and alignment. The Secretariat has also prepared guidance and relevant information for the country offices, including a guide to WHO's role in sector-wide approaches to health development.¹

48. In the context of the High-Level Forum on the Health MDGs (Abuja, 2004), WHO is translating the implications of the Paris Declaration on aid effectiveness² into key actions for the health sector and global health partnerships. The principles embodied in the Declaration are also being related to best practices for such partnerships. These principles have been applied in the WHO African Region by means of a cross-organizational planning effort aimed at increasing access to essential public health interventions. Direct involvement in the development of the joint assistance strategies in the United Republic of Tanzania and Zambia offered WHO useful experience of the provision of effective aid, which will serve further to streamline WHO's efforts in that area, taking into account guidance provided in the 2005 World Summit Outcome.³

49. Participation during 2004 in consultation processes relating to the triennial comprehensive policy review coordinated by the United Nations Secretariat, helped to guide the Organization's activities at country level. In response to the challenges highlighted in the policy review, the Secretariat is currently reviewing its gender policy with special emphasis on further integrating a gender dimension into country-level activities and on capacity-building in the area of gender; the Organization is also working with relevant national counterparts to generate sex-disaggregated information – a prerequisite for better analysis and understanding of gender-related issues in health development.

50. In response to the specific requests in relation to simplification and harmonization contained in resolution WHA58.25 and the United Nations General Assembly resolution on the triennial comprehensive policy review, WHO conducted a survey of its country presence. The results demonstrate WHO's active involvement in the United Nations reform processes: of the 150 WHO country offices surveyed, about 20% are now located in United Nations common premises; 85% are participating in the United Nations common country assessments and the United Nations Development Assistance Framework; 78% are supporting national processes for attaining the Millennium

¹ *A guide to WHO's role in sector-wide approaches to health development*. Geneva, World Health Organization, 2005 (in press).

² The Paris Declaration on aid effectiveness, ownership, harmonization, alignment, results and mutual accountability, issued at the High-Level Forum on Aid Effectiveness (Paris, 2005).

³ Contained in United Nations General Assembly resolution 60/1.

Development Goals; and 91% are participating in the development of a national poverty reduction strategy. Furthermore, WHO is active in the United Nations Security Management Team, chaired by the Designated Official for Security, and participates in cost-sharing with regard to local security infrastructure and global security coordination mechanisms.

ACTION BY THE EXECUTIVE BOARD

51. The Executive Board is invited to note the above report.

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