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Progress reports[1]

Report by the Secretariat

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[1] Sections A, D, E, I and J will be issued subsequently.

B. CONTROL OF HUMAN AFRICAN TRYPANOSOMIASIS

1. The chronic form of human African trypanosomiasis, caused by *Trypanosoma brucei gambiense*, is endemic in 24 countries. Between 2004 and 2008, the reported number of new cases fell by 40% to 10 235. Eleven countries (Benin, Burkina Faso, Gambia, Ghana, Guinea-Bissau, Liberia, Mali, Niger, Senegal, Sierra Leone and Togo) reported no case and six (Cameroon, Côte d'Ivoire, Equatorial Guinea, Gabon, Guinea and Nigeria) reported an average of less than 100 new cases annually. The Central African Republic, Chad, Congo and Uganda reported between 100 and 1000 new cases annually. Angola, Democratic Republic of the Congo and Sudan are the most affected countries, with each reporting an average of more than 1000 new cases each year.

2. During the same period, the number of newly reported cases of the acute form of human African trypanosomiasis, caused by *T. b. rhodesiense* which is endemic in 13 countries, fell by 56% to 259. Botswana, Burundi, Ethiopia, Namibia and Swaziland reported no case. Kenya, Mozambique, Rwanda and Zimbabwe reported sporadic cases; Malawi and Zambia reported fewer than 100 new cases each year; and Uganda and the United Republic of Tanzania reported between 100 and 1000 new cases annually.

3. Public–private partnerships have allowed countries in which human African trypanosomiasis is endemic to use the best available treatment options. In 2004 the proportion of cases of second-stage disease due to *T. b. gambiense* treated with the toxic melarsoprol was 86% whereas in 2008 this figure had been reduced to 51%; the remaining cases were treated with eflornithine, which is safer.

4. In response to resolution WHA50.36 on African trypanosomiasis, WHO signed a Memorandum of Understanding with the African Union Commission agreeing to join forces to fight African trypanosomiasis within the framework of the Pan African Tsetse and Trypanosomiasis Eradication Campaign. Also, with FAO, WHO has launched an initiative to map the distribution of the disease within the framework of the multi-institutional Programme Against African Trypanosomiasis.

5. Access of patients with human African trypanosomiasis to diagnosis and treatment has been facilitated by: the diminution of social upheavals; capacity building; increased technical and financial support for control and surveillance; and the free provision of diagnostic reagents and medicines for trypanosomiasis.

6. Despite progress, human African trypanosomiasis continues to be a threat in Africa, in particular in areas of the Central African Republic and Democratic Republic of the Congo where security constraints hamper control activities. Countries in which the disease is endemic should be supported to strengthen control and surveillance activities through identification of isolated pockets of disease transmission and improvement of reporting. The decrease in the number of cases detected has, unfortunately, lowered the priority given to control of the disease, mirroring the situation 50 years ago when it was believed that the disease had been eliminated. Subsequently, the awareness of human African trypanosomiasis declined and the setting of other public health priorities contributed to its neglect. To avoid a repeat of history, it is important to find cost-effective and sustainable means for surveillance and control of human African trypanosomiasis.

7. Sustainable control of human African trypanosomiasis is feasible only through an integrated approach whereby surveillance and control activities are undertaken within reinforced and operational health systems. The two main technical obstacles are: 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 the lack of a new antitrypanosomal agent that is cheaper, safer, easier to administer than existing medicines and able to cure both forms of the disease.

8. The most immediate challenge is to expand and sustain current control and surveillance using the best tools available. Research into new tools should be accelerated. Awareness about the disease should be raised and priority-setting and fundraising advocated. WHO should continue to lead provision of support to countries and to coordinate the work of all parties concerned with control of, and research into, human African trypanosomiasis.

C. REPRODUCTIVE HEALTH: STRATEGY TO ACCELERATE PROGRESS TOWARDS THE ATTAINMENT OF INTERNATIONAL DEVELOPMENT GOALS AND TARGETS

9. Implementation of the strategy has been reinforced by the incorporation within the Millennium Development Goals framework of the target of achieving universal access to reproductive health by 2015. This was set out in the Report of the Secretary-General, which was noted by the United Nations General Assembly at its sixty-second session in 2007.[1]

10. Regional activities undertaken in collaboration with partners, in particular UNFPA, include adapting the strategy to regional contexts in order to respond best to local reproductive health needs; developing policy frameworks to accelerate universal access to reproductive health services and commodities; assessing the feasibility of recommended indicators;[2] holding technical consultations on sociocultural approaches to accelerate the achievement of Millennium Development Goals 4 and 5; strengthening national capacities to develop responsive strategies and policies, and to implement and monitor interventions for improving sexual and reproductive health; developing and adopting evidence-based planning tools and guidelines; and conducting workshops to strengthen family planning, prevention of cervical cancer, post-natal care, postpartum care and prevention of unsafe abortion; and improving adolescent reproductive health.

11. Progress has been made in the five key action areas.

- **Strengthening health systems capacity.** Strategies have been developed to expand rural reproductive health services and infrastructure for emergency obstetric care; to attract health-care providers to hard-to-reach areas; and to enhance preventive health care. In addition, reproductive health commodities have been included in the essential medicines list.

- **Improving information for priority setting.** Reproductive health issues have been covered in population surveys and censuses.

- **Mobilizing political will.** Workshops targeting parliamentarians have been organized and advocacy has been undertaken on the importance of improved reproductive health in achieving the Millennium Development Goals.

[1] Document A/62/PV.22.

[2] See the strategy implementation framework, "*Accelerating progress towards the attainment of international reproductive health goals: a framework for implementing the WHO Global Reproductive Health Strategy*". Geneva, World Health Organization, 2006.

- **Creating supportive legislative and regulatory frameworks.** Support has been provided to Member States to review and update legislation on the promotion and provision of reproductive health services to women and infants.

- **Strengthening monitoring and evaluation.** Reproductive health indicators have been included in national monitoring mechanisms; and maternal death reviews have been conducted.

12. Member States have identified barriers to improving reproductive health services, which include the following: sociocultural or traditional factors; conflict; poor case reporting from health facilities; poor access to vulnerable groups, including adolescents; shortages of equipment and personnel; the unwillingness of health providers to work in remote areas; and low public awareness about the range of family planning methods available.

13. Reports on key interventions developed by WHO to reduce maternal mortality and improve reproductive health have been made. In over 85% of countries surveyed, focused antenatal care is integrated in reproductive health programmes, and magnesium sulphate is registered for use in pre-eclampsia. Over 50% of countries surveyed have emergency contraception as part of the mix of family planning methods, but the reports indicate that the implementation of screening programmes for cervical cancer has been limited.

14. Data indicate that progress in reducing maternal mortality in the developing world has been uneven. Eastern Asia, North Africa, and South-East Asia showed declines of over 30% in maternal deaths per 100 000 live births between 1990 and 2005, whereas southern Asia is reporting a decline of more than 20%. In sub-Saharan Africa the risk of dying in pregnancy or childbirth remains high. The proportion of births attended by a skilled health provider has increased in developing regions, rising from 57% in the mid-1990s to 62% in 2005. However, unmet need for family planning remains moderate to high in most of the regions despite increased use of family planning methods. In sub-Saharan Africa, every fourth woman who is married or in union has an unmet need for family planning.

15. Greater global attention is now being paid to reducing maternal deaths. At the most recent G8 Summit (L'Aquila, Italy, 8–10 July 2009), commitment was expressed for promoting a comprehensive and integrated approach to the achievement of the health-related Millennium Development Goals. In a joint statement, WHO, UNICEF, UNFPA and the World Bank undertook to "work with governments and civil society to … scale up quality health services to ensure universal access to reproductive health … ensuring linkages with HIV prevention and treatment".

F. SUSTAINING THE ELIMINATION OF IODINE DEFICIENCY DISORDERS

16. Iodine deficiency disorders are an important cause of preventable cognitive impairment. Elimination of those disorders, as a public health problem, has been addressed by the Health Assembly in resolution WHA43.2 in 1990 and subsequently reaffirmed.[1] Recent Health Assemblies have urged greater efforts towards achieving the goal,[2] and this report describes progress since 2007.

[1] Resolutions WHA49.13 and WHA52.24.

[2] Resolutions WHA58.24 and WHA60.21.

17. A great investment has been made in mapping the iodine status of populations through the assessment of school-age children's urinary excretion of iodine. In the period 2004–2008, 37 countries have provided national data, covering 36.3% of the world's school-age population, and 15 of these have reported new national data since 2007. Data for nine countries show an iodine status sufficiently low to be considered significant for public health; in 17 countries iodine intakes are adequate[1] and in eight they are excessive. Three countries have documented increased risk of thyroid disorders in susceptible groups. Between 1993 and 2007, the number of countries in which iodine deficiency disorders were a public health concern fell by more than half, from 110 to 47. The downward trend continues; full details will be published in 2010 in WHO's global report on the progress.

Control strategy

18. The preferred strategy for control of iodine deficiency disorders remains universal salt iodization. Salt has been chosen as a vehicle for fortification because its consumption is fairly stable throughout the year and iodization technology is inexpensive and easy to implement. Additionally, the amount of iodine in salt can easily be adjusted to meet policies aimed at reducing human consumption of salt in order to prevent chronic diseases.[2] Salt iodization is more effective when established by law.

19. Iodine supplementation is also recommended, especially for susceptible groups such as pregnant women and young children living in high-risk communities that are unlikely to have access to iodized salt[3] or as temporary strategy when salt iodization is not successfully implemented. The number of countries with at least 90% of households having access to adequately iodized salt is now 36,[4] compared to 33 in 2006[5] and 28 in 2004.[6] Worldwide, 70% of households are estimated to have access to iodized salt.

20. WHO's expert consultation in 2007 on salt as a vehicle for fortification[2] concluded that policies for salt iodization and reduction of consumption of salt in order to prevent cardiovascular diseases are compatible. The currently recommended level of fortification of salt with iodine (20–40 ppm) needs to be adjusted by national authorities in light of their own data on dietary salt intake and the median urinary iodine concentration of the population.

21. Monitoring and evaluation of the impact of programmes to control iodine deficiency disorders are crucial for ensuring that interventions are both effective and safe. Guidelines on indicators to assess and monitor these programmes were revised and published in 2007 by WHO, UNICEF and the

[1] Median urinary iodine concentration (UI) is an indicator of iodine intake. Countries are divided into three groups of iodine intake: "adequate" » (100 µg/l < UI < 199 µg/l), "above recommended nutrient intakes" (200 µg/l < UI < 299 µg/l) and "excessive" (UI > 300 µg/l) i.e. in excess of the amount required to prevent and control iodine deficiency disorders.

[2] World Health Organization. *Salt as a vehicle for fortification. Report of a WHO Expert Consultation, Luxembourg, 21–22 March 2007*. Geneva, World Health Organization, 2008.

[3] 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.

[4] UNICEF. State of the World's Children. New York, 2010. http://www.childinfo.org/idd_progress.html.

[5] UNICEF. State of the World's Children. New York, 2007. http://www.childinfo.org/files/The_State_of_the_Worlds_Children_2007_Executive_Summary_E.pdf.

[6] UNICEF. State of the World's Children. New York, 2004. http://www.childinfo.org/files/The_State_of_the_Worlds_Children_2004.pdf.

International Council for the Control of Iodine Deficiency Disorders,[1] and WHO and UNICEF issued a joint statement on reaching optimal levels of iodine nutrition in pregnant and lactating women and young children in 2007.[2]

22. The Network for Sustained Elimination of Iodine Deficiency, of which WHO is a member, supports national efforts to accelerate achievement of the goal of elimination by promoting collaboration among public and private sectors and scientific and civic organizations.

G. MULTILINGUALISM: IMPLEMENTATION OF ACTION PLAN

23. In May 2009, the Health Assembly noted the progress report on the plan of action on multilingualism.[3] This report provides a further update on activities to implement the plan.

24. Work to ensure that WHO's information products are available in official and non-official languages has continued to progress. In the first three quarters of 2009, WHO produced 237 **multilingual publications**. Although there is still a predominance of publications in English, strengthened collaboration with external partners is increasing the number of publications in other languages. As of September 2009, an additional 122 multilingual publications had been produced in 29 languages through these partnerships.

25. The Regional Office for Africa has continued to record and increase access to multilingual information products in its three official languages, while the Regional Office for Europe granted 54 requests for translation rights in 2009. Since January 2009, the Regional Office for the Americas has translated 12 publications, while 22 multilingual publications have been produced by the Regional Office for the Eastern Mediterranean and partners. In the Regional Office for the Western Pacific, translations into non-official languages have been integrated into regional planning.

26. Efforts have continued in support of accessible **multilingual content on WHO's web site**. Between January and September 2009, a significant number of additional pages were published on the headquarters web site: in Arabic, 418; in Chinese, 344; in English, 5526; in French, 690; in Russian, 359; and in Spanish, 504. Progress is being made to update and edit certain pages in order to improve the quality of multilingual information.

27. In the Regional Office for Europe, additional web pages have been created in English, French, German and Russian; a new content management system, due to be launched in early 2010, will ensure that these pages benefit from greater visibility. Similarly, the Regional Office for the Eastern Mediterranean has improved the accessibility of its Arabic web pages and has offered training to two staff members at headquarters in order to produce the *Bulletin of the World Health Organization* in-house in Arabic.

28. Progress has been made in establishing a mechanism for setting **translation priorities**. The WHO regional offices for the Eastern Mediterranean and the Western Pacific have begun consultations

[1] World Health Organization. *Assessment of iodine deficiency disorders and monitoring their elimination: a guide for programme managers.* 3rd edition. Geneva, World Health Organization, 2007.

[2] http://www.who.int/nutrition/publications/micronutrients/WHOStatement__IDD_pregnancy.pdf.

[3] See document WHA62/2009/REC/3, summary record of the fifth meeting of Committee B, section 1.

with Member States in order to establish a clear and effective strategy for setting translation priorities, and to identify topics and titles of major importance. A master list of information products approved for publication is now accessible on an electronic platform known as "e-Pub". Member States can use the platform in order to consult the list, which includes planned language translations, and to suggest priority products for translation. The platform is now active and accessible by the entire Organization and training has been provided to staff members at headquarters and in the regional offices.

29. At headquarters, **web style guides** have been completed in all official languages; however, one additional web editor is still needed. A terminology section and a terminologist position have been created within the Regional Office for Africa in order to harmonize style. In the Regional Office for Europe, a style guide is being adapted into French, German and Russian.

30. The plan of action proposed that a **global institutional repository** should be established in order to collect and store WHO's intellectual output in digital form. A workshop was held in October 2009 to evaluate and select a repository system as the first stage of work to deploy a repository at headquarters and regional offices before January 2010.

31. In resolution WHA61.12 the Health Assembly requested the Director-General to ensure the establishment of a **database of official languages mastered by staff in the professional category**. In response, a pilot survey has been undertaken in one department at headquarters in order to identify staff language competencies. Similar surveys are planned for other departments; these will then be followed by an Organization-wide assessment.

H. HEALTH OF MIGRANTS

32. Since the adoption of resolution WHA61.17 the global economic crisis has had a major impact on the migrant population, raising concerns about the effect on migrants' health of unemployment, falling wages and poorer working conditions. Unauthorized migration flows, mainly triggered by poverty and lack of employment, have continued to have considerable health consequences, with many migrants in an irregular situation lacking access to health services. In addition, natural disasters, armed conflict and food insecurity have generated millions of displaced people whose health is threatened as a result. The pandemic of influenza due to the A (H1N1) virus 2009 has reemphasized the links between population mobility and the spread of disease; in response, universal access is needed to preventive measures and care irrespective of a person's migrant status.

33. In the area of forced population displacement, WHO has continued its work as lead agency for the Health Cluster, working with partners, governments and communities in order to reduce avoidable loss of life, burden of disease, and disability in countries affected by crises or vulnerable to them.

34. The Organization has mobilized resources to facilitate the access to health services of populations displaced or otherwise affected as a result of crises. The following groups are among those targeted: refugees, internally displaced people, returnees, and host communities, in particular in Afghanistan, Cameroon, Central African Republic, Chad, Colombia, Democratic Republic of the Congo, Jordan, Pakistan, Sudan, and Syrian Arab Republic. Efforts have also been made to integrate information concerning the health of displaced people into national health information systems.

35. WHO has provided support to Member States and partners in generating data on some hard-to-reach migrant groups, for instance those in southern Mexico and in the border provinces in Thailand. In such cases, the Organization's role has been to document migrants' health status and the barriers

impeding their access to health services. In the WHO European Region, research conducted among migrant women in support of promoting reproductive health rights has permitted the documentation of measures to improve health access and address the determinants of migrant health.

36. In the European Region a migrant health working group has mapped activities undertaken in the Region in respect of the health of migrants; the group shared information among country offices, and coordinated technical input into relevant processes. As part of the multi-stakeholder EU-level Consultation on Migrants Health – "Better Health for All" (Lisbon, 24 and 25 September 2009), WHO coauthored recommendations on moving towards a migrant-sensitive workforce.

37. In collaboration with partners, preventing the spread of infectious diseases and ensuring access to health services for migrant workers were central to various European based initiatives, supporting discussions between the Russian Prime Minister and the Director-General held in June 2009.

38. WHO and the International Organization for Migration jointly promoted migrant health in several platforms: the 16th Migration Dialogue for Southern Africa; a Ministerial Roundtable Breakfast organized by the United Nations Economic and Social Council on migrant women's health needs; and the 7th Global Conference on Health Promotion (Nairobi, 26–30 October 2009). Recommendations covered subjects including the need to reinforce the rights of migrants to access health and social services; multiregional and multisectoral collaboration; the integration of health into policy dialogues on migration, in particular the Global Forum on Migration and Development; and the integration of migration issues into debates on foreign policy and global health.

39. In 2009, in order to enhance their capacity in the domain of migration and health and improve joint programmes, the International Organization for Migration and WHO entered into a cooperation agreement, which included the secondment of a staff member to WHO as Senior Migrant Health Officer.

40. WHO took part in the 24th Meeting of the Programme Coordinating Board of UNAIDS, whose theme was "People on the move – forced displacement and migrant populations"; the Organization also participated in the International Task Team on HIV-related Travel Restrictions, which considered universal access and human rights issues.

41. In order to ensure that health systems in all regions bring equitable services that respond to today's multiethnic societies, there is still a need for the following actions: the conducting of systematic analyses of migrants' health, based on relevant disaggregated data and including gender and age; the fostering of multicountry and multisectoral cooperation; and the development of cohesive policies.

42. WHO is organizing, in collaboration with the International Organization for Migration, a multi-stakeholder global consultation to map actions, good practices and policy recommendations from all regions in the field of migrant health, and to consolidate a technical network across sectors. The outcome of the consultation, which is planned for early 2010, will be reported to the Health Assembly.

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