

Progress reports¹

Report by the Secretariat

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¹ See document EB130/35 for reports A, B and C, and EB130/35 Add.2 for reports D to L.

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

1. In resolution WHA57.12, the Health Assembly requested the Director-General to devote sufficient organizational priority, commitment and resources to supporting effective promotion and implementation of the reproductive health strategy, to assist Member States in ensuring reproductive health commodity security, and report at least biennially. In September 2010, the United Nations Secretary-General launched the Global Strategy for Women's and Children's Health, refocusing attention on the critical role of reproductive health in the overall health of women and children, and re-emphasizing the need to accelerate progress.

2. The Secretariat continues to collaborate with Member States in efforts to achieve universal access to and quality of sexual and reproductive health care. Regional work includes support to policy frameworks and acceleration plans on improving reproductive health and contributing to ministerial and parliamentary summit outcome documents on reproductive health and development. Technical support is being provided in a number of areas, including health-care financing, policy dialogue, human resources, and in strengthening capacity for service delivery needs in the key components of sexual and reproductive health.

3. A WHO questionnaire was administered in 2011 among Member States to assess implementation of the global reproductive health strategy. The results indicate that progress has been made. Among the 58 Member States that responded to the survey, progress had been facilitated by:

- strengthening partnerships aimed at improving health-system capacity, training and retaining skilled health workers, and increasing access to emergency obstetric care;
- updating legislative and regulatory frameworks aligned with national strategic plans;
- gaining political commitment through demonstrating the vital connection between improved reproductive health and development;
- strengthening monitoring, evaluation and accountability to improve the evidence base for priority setting; and
- allocating national resources for reproductive health: over 50% of the countries surveyed had procedures in place to monitor resource flows.

4. The results of the survey also show that increasingly interventions developed by WHO to reduce maternal mortality and improve reproductive health were being put into practice. More than 85% of countries that responded indicated that targeted antenatal care had been integrated into reproductive/maternal health programmes; in 95%, magnesium sulphate is registered for use in reducing deaths from eclampsia, which is a significant improvement compared to findings of the survey conducted in 2009; and in more than 95%, reproductive health essential medicines were in the national essential medicines list. Only about two thirds, however, included emergency contraception among contraceptive methods provided through public health programmes; and only three quarters reported screening for early detection of cervical cancer. Screening for congenital syphilis during pregnancy was still not universal.

5. At the same time, Member States identified barriers to the improvement of reproductive health services. These barriers include: political instability or crisis; poor quality of care; poor coordination of efforts; insufficient human resources and poorly motivated staff; lack of funds and commodities; poverty; low levels of community engagement; and sociocultural factors.

6. Such barriers also contribute to uneven progress and account for the observed disparities in reproductive health outcomes, including the varied rates of reducing maternal mortality across regions. Globally, the annual reduction in the maternal mortality ratio was 2.3% between 1990 and 2008. In the South-East Asia Region and Western Pacific Region, the estimated decline in the annual maternal mortality ratio was 5%. It was 1.7% and 1.5% in the African Region and the Eastern Mediterranean Region, respectively. The slower progress in reducing maternal mortality in sub-Saharan Africa relative to Asia, together with an increasing number of births, has resulted in a major regional shift in the burden of maternal mortality. In 1990, around 58% of global maternal deaths occurred in Asia and 36% in sub-Saharan Africa; in 2008, this trend had reversed, with an estimated 39% of global maternal deaths occurring in Asia and 57% in sub-Saharan Africa.

7. Access to care through pregnancy and childbirth is crucial for reducing maternal deaths and improving maternal health. The proportion of childbirths attended by skilled health personnel increased from 61% in the 1990s to 66% in the 2000s, globally. Despite the dramatic progress made in many regions, coverage (i.e. the proportion of childbirths where skilled attendants are present) remains low in the South-East Asia Region and the African Region, where the majority of maternal deaths occur. Inequities exist according to place of residence: in recent years, the median value for the proportion of births attended by a skilled health professional is 63% in rural areas compared with 89% in urban areas.

8. Family planning is a key component of sexual and reproductive health and can prevent up to a third of maternal deaths.¹ Although contraceptive use among women who are married or in union is over 60% globally, large differences are seen across regions. Women in sub-Saharan Africa have the lowest levels of contraceptive use (22% in 2008). The unmet need for family planning, that is, the gap between women who wish to delay or stop childbearing and those who do not use any contraceptive method, has been unchanged in sub-Saharan Africa since 1990: 26% in 1990, and 25% in 2008.² Within countries, the unmet need is associated with household wealth, with poorer women having a higher unmet need.²

9. Pregnancy presents a risk of adverse health and social consequences for adolescents, especially as they are less likely to have access to reproductive health services.³ Data for 22 countries in sub-Saharan Africa for 1998–2008 show that women aged 15–19 years who are married or in a union have much lower levels of contraceptive use than all women of reproductive age who are married or in a union (10% and 21%, respectively), and similar levels of unmet need for contraception (around 25%). Thus, the proportion of adolescents having their demand met for contraception is much lower than that of their older counterparts (29% compared with 45%).

¹ Cleland J, Bernstein S, Ezeh A, Faundes A, Glasier A, Innis J. Family planning: the unfinished agenda. *The Lancet*, 2006; 368:1810–1827.

² The Millennium Development Goals Report 2011. United Nations, New York, 2011, p. 33, http://www.un.org/millenniumgoals/11_MDG%20Report_EN.pdf (accessed 15 November 2011).

³ See document EB130/12 for a more detailed discussion about the birth rate among adolescents, which remains high in sub-Saharan Africa (122 births per 1000 women aged 15–19 years). Despite a decline in total fertility in Latin America, the Caribbean and southern Asia, adolescent fertility continues to be high in these regions.

10. Adolescent boys and men are also in need of sexual and reproductive health services and information. Less than 40% of young men in developing regions know that two ways of avoiding sexually transmitted infections are condom use and either abstinence or having only one, uninfected partner. The proportion of young men reporting that they had used a condom at last high-risk sex varies from 38% in southern Asia to 56% in the Caribbean.¹ Sexuality education programmes have been shown to have a significant effect on reducing high-risk sexual behaviours.²

11. The Secretariat has noted the call by Member States to devote adequate organizational resources in the area of sexual and reproductive health and is working with partners towards ensuring availability of sustainable resources. WHO and partners continue to strengthen research and technical capacity, and introduce effective interventions systematically, using the Strategic Partnership Programme approach, among others.

N. ADVANCING FOOD SAFETY INITIATIVES (resolution WHA63.3)

12. Recent foodborne disease outbreaks, such as the event in western Europe in 2011 involving *Escherichia coli* O104:H4 and the radioactive contamination of certain food items following the emergency at the Fukushima nuclear plant in Japan, have highlighted the need for consolidated global actions to ensure the safety of food for all Member States at all levels.

13. Resolution WHA63.3 recognizes the importance of full engagement on the part of the health sector, in collaboration with other sectors, in order to ensure sound food safety management and requests Member States and the Director-General to undertake key actions needed to advance food safety initiatives. An update on the Secretariat's work in the relevant areas is provided below.

14. **International Food Safety Authorities Network (INFOSAN).** The Network has become a joint programme that has been co-managed by FAO and WHO since June 2010. This partnership has increased the availability of information for food authorities and improved overall management. It has also increased the level of interaction between relevant initiatives in both organizations, ensuring synergy between them, and has provided momentum for further development of the Network.

15. The First Global Meeting of INFOSAN, held from 14 to 16 December 2010 in Abu Dhabi, gave focal points and emergency contact points the opportunity to identify practical recommendations for enhancing communication and collaboration. The activities of the INFOSAN secretariat have focused on: strengthening capacities at country and regional levels to promote participation in INFOSAN, linking with ongoing efforts to develop country core capacities to implement the International Health Regulations (2005); and assuring the continued provision of technical support.

16. During a number of food contamination events and foodborne disease outbreaks, the INFOSAN secretariat has collected and verified important information before sharing it with INFOSAN members.

¹ The Millennium Development Goals Report 2011 – Statistical Annex. United Nations, New York, 2011, p. 12, <http://mdgs.un.org/unsd/mdg/Resources/Static/Data/2011%20Stat%20Annex.pdf> (accessed 15 November 2011).

² Wellings K, Collumbien M, Slaymaker E, et al. Sexual behaviour in context: a global perspective. *The Lancet*, 2006; 368: 1706–1728.

17. In various WHO regions, the capacity of countries both to collaborate with INFOSAN and to detect, assess and manage food safety incidents and emergencies at a national level has been developed through workshops and technical support.

18. **Tools for information exchange.** Creating links between the various sources of food safety data and improving access to them can help Member States to manage food safety nationally. With this end in mind, a user-friendly, interactive online tool has been designed to integrate relevant data and information. The tool, named FOSCOLLAB, should improve data-sharing to support risk assessment and decision-making in food safety. A detailed business plan for the tool has been developed following consultation with countries.

19. **Assessment of the burden of foodborne diseases.** WHO's Foodborne Disease Burden Epidemiology Reference Group has continued to assess the global burden of foodborne diseases from all causes (whether microbiological, parasitic or chemical). Pilot country-level burden assessments have started in four countries (Albania, Japan, Thailand and Uganda). In addition, guidance has been developed on translating scientific evidence into policy-making and practice.

20. **Continued support to the work of the Codex Alimentarius Commission.** WHO has continued providing financial and technical support to the work of the Codex Alimentarius Commission and its subsidiary bodies. In addition, 10 scientific expert meetings have been held in the last biennium to evaluate chemical and biological hazards in food, largely as a basis for scientific advice for the relevant committees of the Commission.

21. The FAO/WHO Project and Fund for Enhanced Participation in Codex (the Codex Trust Fund) has provided increased support to Member States to enhance the participation of developing countries in the work of the Codex Alimentarius Commission. By the end of 2010, the Codex Trust Fund had provided support to enable 1423 participants from 132 countries to attend Codex meetings and participate in task forces and working groups. A further 336 participants have received support to participate in Codex training courses and workshops.

22. **Zoonotic diseases at the human–animal interface.** Collaboration with FAO and OIE is being intensified in support of the provision of policy guidance to tackle health risks at the human–animal–ecosystem interface. In support of this effort, the three agencies are sharing responsibilities and coordinating activities jointly, and have published details of their collaboration in a tripartite concept note.¹ A tripartite joint action plan that translates the policy guidance into concrete actions is being implemented, taking account of ongoing successful activities. The latter include the collaboration on the Global Early Warning System for Major Animal Diseases, including Zoonoses, which builds on the added value of combining and coordinating the three agencies' early warning and response capacity against animal disease threats.

23. **Capacity building.** In addition to activities carried out through the Codex Trust Fund, training workshops have been conducted in the areas of risk assessment of food contaminants, antimicrobial resistance due to antibiotic use in agriculture, and laboratory capacity. These were generally organized through the WHO regional offices.

¹ FAO, OIE, WHO. *The FAO-OIE-WHO collaboration: sharing responsibilities and coordinating global activities to address health risks at the animal-human-ecosystems interfaces. A tripartite concept note.* Food and Agriculture Organization of the United Nations, Office International des Épidémiologies, World Health Organization, 2010. (Available online at <http://www.fao.org/docrep/012/ak736e/ak736e00.pdf>, accessed 12 October 2011).

24. **Raising awareness and promoting healthy behaviours.** Public information and health promotion materials in the area of food safety have been further developed, translated into various languages, field-tested and disseminated. In this respect, WHO has continued to support Member States in developing and maintaining sustainable preventive measures, including food-safety education programmes based on the Five Keys to Safer Food concept.

25. The Regional Office for the Western Pacific has developed a draft Western Pacific Regional Food Safety Strategy (2011–2015), covering major themes requiring action by Member States to ensure food safety. The Strategy was submitted for consideration by the Regional Committee for the Western Pacific at its sixty-second session in October 2011.¹ The Committee subsequently endorsed the Strategy in resolution WPR/RC62.R5. The Regional Office for South-East Asia is in the process of finalizing a similar strategy.

O. CLIMATE CHANGE AND HEALTH (resolutions EB124.R5 and WHA61.19)

26. The present report responds to resolution EB124.R5, in which the Executive Board requested the Director-General to report on progress in implementing resolution WHA61.19 and the workplan on climate change and health. The report also updates the information provided to the Health Assembly in May 2011.²

27. **Advocacy and awareness raising.** The Secretariat has worked with Member States to emphasize the importance of health in climate change policy, and the linkages between climate change and other environmental and social determinants of health. This effort has included events at the Sixty-third World Health Assembly and the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19–21 October 2011). Further events are planned for the 17th Conference of the Parties to the United Nations Framework Convention on Climate Change (due to be held in Durban, South Africa, from 28 November to 9 December 2011). The Secretariat coordinates a contact group of national delegates to the Framework Convention in order to promote consideration of health within the negotiations, and has established a consultation group of health-professional associations and nongovernmental organizations in order to generate and disseminate information for health advocacy. The Secretariat has also updated an audit of the carbon footprint of selected WHO offices as part of the United Nations “Greening the Blue” initiative, and is now considering policy proposals to reduce emissions.

28. **Partnership with organizations of the United Nations system and other parties.** WHO has contributed the health perspective to the response of different United Nations’ bodies to climate change, including the following: the United Nations System Chief Executives Board for Coordination; the United Nations High-Level Committee on Programmes; the Conference of the Parties to the United Nations Framework Convention on Climate Change and its associated policy and technical meetings; and the High-Level Committee on Programmes Task Team on the Social Dimensions of Climate Change, which WHO co-organizes. The Organization also leads activities to design regional frameworks on climate change and health, and convenes intersectoral steering committees to implement national climate and health projects. As a result, health is now recognized as one of the core sectors in global adaptation efforts.

¹ See document WPR/RC62/7.

² Document A64/26.

29. **Promoting and supporting the generation of scientific evidence.** The Secretariat has completed its contribution to the Intergovernmental Panel on Climate Change Special Report on extreme events. It continues to work to identify the likely health benefits of strategies to reduce greenhouse gas emissions from key sectors assessed by the Panel, and has published reports on the housing¹ and transport² sectors. WHO is working with WMO and other partners to design the health component of the new Global Framework for Climate Services, and has produced new technical reports and guidance on subjects that include vulnerability and adaptation assessment³ and gender, climate change and health.⁴ A guidance package on health responses to heat waves has also been published.⁵

30. **Strengthening health systems to protect populations from the adverse impacts of climate change on health.** WHO has gained ministerial endorsement for new frameworks for protecting health from climate change in the African Region and in the Region of the Americas, which will guide national health systems' adaptation plans. The Secretariat has now completed assessments of health vulnerability and consequent adaptation needs in over 30 countries. A seven-country global pilot project on public health adaptation to climate change (involving Barbados, Bhutan, China, Fiji, Jordan, Kenya and Uzbekistan) has run its first year. In addition, the Regional Office for Europe has completed the second year of a health systems' adaptation project that it is coordinating in central Asia and eastern Europe (covering Albania, Kazakhstan, Kyrgyzstan, the Russian Federation, Tajikistan, the former Yugoslav Republic of Macedonia and Uzbekistan), while work on the health components of United Nations country team projects in China, Jordan and the Philippines is also entering its third year. Finally, WHO has initiated a new large-scale project on climate change and vector-borne disease in the Western Pacific Region.

31. The Secretariat supports these activities through a capacity-building programme including training materials, a database of national expertise, guidance on access to funding sources, a toolkit for programme managers on public health adaptation, and a clearing house of existing public health systems' adaptation projects.

¹ *Health in the green economy: health co-benefits of climate change mitigation – housing sector.* Geneva, World Health Organization, 2011 (http://whqlibdoc.who.int/publications/2011/9789241501712_eng.pdf, accessed 21 October 2011).

² Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH. WHO. *Urban transport and health: on behalf of Federal Ministry for Economic Cooperation and Development (BMZ).* Geneva, World Health Organization, 2011 (http://whqlibdoc.who.int/publications/2011/9789241502443_eng.pdf, accessed 21 October 2011).

³ Protecting health from climate change. Vulnerability and adaptation assessment. Draft for discussion. World Health Organization, Pan American Health Organization, 2010 (http://www.who.int/globalchange/VA_Guidance_Discussion.pdf, accessed 13 October 2011).

⁴ *Gender, climate change and health.* Geneva, World Health Organization, 2011 (<http://www.who.int/globalchange/GenderClimateChangeHealthfinal.pdf>, accessed 13 October 2011).

⁵ *Public health advice on preventing health effects of heat.* Copenhagen, WHO Regional Office for Europe, 2011 (http://www.euro.who.int/__data/assets/pdf_file/0007/147265/Heat_information_sheet.pdf, accessed 14 October 2011).

P. PARTNERSHIPS (resolution WHA63.10)¹

32. In 2010, the Health Assembly in resolution WHA63.10 requested the Director-General to create an operational framework for WHO's hosting of formal partnerships and to apply the policy on WHO's engagement with global health partnerships and hosting arrangements to current hosting arrangements with a view to ensuring their compliance with the principles embodied in the policy. The resolution further requested the Director-General to submit to the Executive Board any proposals for WHO to host formal partnerships for its review and decision.

33. During the past five years, there has been no new formal partnership. At the time of writing, WHO hosts 13 formal health partnerships.

34. Since 2009, as noted in this paragraph, the status has changed for four formal partnerships, reflecting the fluid nature of WHO's relationship with any partnership. Within each partnership, the governance entity can reassess the partnership's mission, size, need for greater autonomy, and its relationship with WHO. The Global Fund to Fight AIDS, Tuberculosis and Malaria separated from WHO in 2009, becoming an independent foundation under Swiss law. The Water Supply and Sanitation Collaborative Council moved from WHO to the United Nations Office for Project Services in 2009, given the better fit between the latter and the Council's work. In 2010, the Intergovernmental Forum on Chemical Safety ended and the secretariat of the Strategic Approach to International Chemicals Management was established (not hosted by WHO). In 2011, the Health and Nutrition Tracking Service was reintegrated into WHO, with completion of the Service's original mission and compatibility with a new reinforced team on epidemiological surveillance in humanitarian situations within the new WHO Polio, Emergencies and Country Support cluster.

35. In 2011, WHO developed a generic document, entitled "Terms regarding the hosting of a formal partnership by the World Health Organization (WHO), including WHO's provision of Secretariat and administrative services", that summarizes and communicates WHO Rules and Regulations² with which hosted partnerships are expected to comply. This operational framework details the various requirements for hosting a partnership and its secretariat. These terms are guided by the new "Policy on WHO engagement with global health partnerships and hosting arrangements", which was endorsed by resolution WHA63.10,³ by the current WHO Rules and Regulations, and by best practice within WHO, where appropriate.

36. Standing apart from the formal hosted partnerships noted above are two WHO special programmes, on tropical disease research, and on human reproduction research, and the Secretariat for the WHO Framework Convention on Tobacco Control. Each of these arrangements was specifically

¹ A definition of the term "global health partnership" is provided in document A63/44, paragraph 1, footnote 2, as often referring to "a collaborative and formal relationship among multiple organizations in which risks and benefits are shared in pursuit of a shared goal. Such partnerships have their own, separate governance body." Within WHO, these partnerships do not have a separate legal identity. In the Policy on WHO engagement with global health partnerships and hosting arrangements (WHA63/2010/REC/1, Annex 1), paragraph 6 states: "the term 'formal partnerships' refers to those partnerships with or without a separate legal personality but with a governance structure (for example, a board or steering committee) that takes decisions on direction, workplans and budgets".

² These refer to the WHO Constitution, WHO's Financial Regulations and Financial Rules, Staff Regulations and Staff Rules, and other administrative rules, policies, procedures, practices and guidelines, including WHO technical norms, guidelines and procedures, and any relevant resolutions of WHO's governing bodies.

³ See WHA63/2010/REC/1, Annex 1.

mandated by the Health Assembly, with WHO as the executing agency. The two special programmes are within the programme budget.

37. In mid-2011, there were some 470 fixed-term and short-term staff employed in WHO-hosted partnerships, special programmes and the Secretariat for the WHO Framework Convention on Tobacco Control. Recorded income for these partnerships and special programmes in 2010 was about US\$ 550 million, of which UNITAID and the African Programme for Onchocerciasis Control account for US\$ 345 million. In line with the Policy on engagement, WHO is developing an approach to ensure it is “reimbursed for all administrative and technical support costs incurred in providing hosting functions for partnerships and implementing or supporting their activities”,¹ taking into consideration existing programme support costs and post-occupancy charge retentions.

38. As WHO will fully apply the International Public Sector Accounting Standards to its financial reporting from 1 January 2012, the hosted formal partnerships were reviewed to ensure compliance. All partnerships, with the exception of UNITAID and the African Programme for Onchocerciasis Control, will continue to be consolidated in WHO’s financial report in line with International Public Sector Accounting Standards requirements.

39. In November 2010, the Office of Internal Oversight Services evaluated the Organization’s engagement with selected partnerships. In 2011, the Independent Expert Oversight Advisory Committee began reviewing WHO’s hosting arrangements for partnerships. Both bodies reviewed the hosting relationship between WHO and the partnerships, and supported the need for partnerships to comply with WHO’s Rules and Regulations. Whereas some partnerships commission their own independent evaluations, the Secretariat is developing a simple, standard approach to monitoring and evaluating the effectiveness, synergy and concurrence of partnership secretariats with WHO Rules and Regulations.

40. In addition to formal partnerships, WHO continues to engage with diverse United Nations organizations and non-State stakeholders in its implementation of the Medium-term strategic plan 2008–2013. Some of these actions are recorded in the report by the Secretariat on collaboration² and was noted by the Health Assembly,³ and in the annual reports of the Standing Committee on Nongovernmental Organizations to the Executive Board. WHO’s management of more than 60 networks and alliances (those that lack their own governance arrangements) allows the Organization to convene stakeholders and facilitate the attainment of goals, including: the promotion of health outcomes; the assurance that there is optimal coordination of field-level activities; and the reassurance that services are delivered in a coherent and effective way. Examples of successful alliances include the International Health Partnership (WHO–World Bank joint secretariat), the Global Polio Eradication Initiative, and the Harmonization for Health in Africa initiative.

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¹ WHA63/2010/REC/1, Annex 1, paragraph 23.

² Document A64/42.

³ See the summary record of the Sixty-fourth World Health Assembly, A64/B/PSR/4, section 3.