

Progress reports¹

Report by the Secretariat

CONTENTS

Preparedness, surveillance and response

D.	Strengthening national health emergency and disaster management capacities and the resilience of health systems (resolution WHA64.10).....	2
E.	Climate change and health (resolutions EB124.R5 and WHA61.19).....	3

Communicable diseases

F.	Malaria (resolution WHA64.17)	4
G.	Eradication of dracunculiasis (resolution WHA64.16).....	6
H.	Smallpox eradication: destruction of variola virus stocks (resolution WHA60.1)	7

¹ See document EB132/42 for reports A to C, and I to N.

Preparedness, surveillance and response

D. STRENGTHENING NATIONAL HEALTH EMERGENCY AND DISASTER MANAGEMENT CAPACITIES AND THE RESILIENCE OF HEALTH SYSTEMS (resolution WHA64.10)

1. In 2011, the Sixty-fourth World Health Assembly in resolution WHA64.10 urged Member States, *inter alia*, to strengthen all-hazards health emergency and disaster risk-management programmes; called on Member States, donors and development cooperation partners to allocate sufficient resources for this purpose; and requested the Director-General, *inter alia*, to ensure that WHO had enhanced capacity to provide the necessary technical guidance and support.

2. Since 2011, Member States have continued to strengthen national capacity for managing the health risks of emergencies, both through the International Health Regulations (2005) and through specific programmes in the following areas: natural hazards, communicable diseases, chemical safety, food safety, radiation, mass gatherings and climate variability and change. In 2011, more than 130 Member States reported having national plans on emergency preparedness, while 46 had active programmes for reducing the vulnerability of health facilities. As at 1 November 2012, 40 States Parties to the International Health Regulations (2005) are understood to have established the necessary core capacities.¹

3. In 2012, health emergency and disaster risk management has been on the agendas of the regional committees for Africa, the Americas and South-East Asia; notably, the Regional Committee for Africa has adopted a resolution on the African Regional Strategy on Disaster Risk Management for the Health Sector.² In addition, all WHO regions are implementing strategies for the development of national capacities to manage risks to health posed by emergencies. In 2013 WHO will publish a global report on the status of national health emergency and disaster risk-management capacities.

4. Although evidence in support of investing in prevention and preparedness continues to accumulate,³ preparedness continues to receive less than 5% of humanitarian funding.⁴ In the 20 countries that receive the most humanitarian assistance, of every US\$ 100 provided, only 62 cents have gone to preparedness. The impact of such underinvestment was evident in the recent food security crises in the Horn of Africa and the Sahel; in the latter region the problem was compounded by the underfinancing of the health sector, which was only funded to 21% of its appeal.

5. The Secretariat has provided support to Member States in all regions with assessments of national capacity for health emergency risk management and related action plans, and has supported action on safer hospitals in more than 40 countries. Regional hazard atlases have been developed for the African, European and Eastern Mediterranean regions in order to facilitate country-level risk

¹ See document EB132/15.

² See resolution AFR/RC62/R1 for the African Region, resolution CSP28.R19 for the Region of the Americas and document SEA/RC65/9 for the South-East Asia Region.

³ *Natural hazards, unnatural disasters: the economics of effective prevention*. World Bank and United Nations, Washington, DC, 2010.

⁴ See the second tracking report commissioned for the United Nations Inter-Agency Standing Committee's task team on funding preparedness. Available at <http://www.devinit.org/wp-content/uploads/Emergency-preparedness-study-tracking-report-2-for-FAO-on-behalf-of-the-IASC.doc> (accessed 12 November 2012).

assessments. Evaluations such as those of the Haiti earthquake¹ and the Horn of Africa drought are being integrated into regional and national approaches to health emergency management. WHO continues to advocate for health in intersectoral forums. In 2011, the global platform for disaster risk reduction highlighted safe hospitals as a priority area for action, and health was incorporated into regional disaster risk-reduction strategies for Africa, Arab States, Asia and the Americas. In 2012, health emergency risk management was included in WHO submissions to the United Nations Conference on Sustainable Development, Rio+20 (Rio de Janeiro, Brazil, 20–22 June 2012) and, with WMO, to the Global Framework for Climate Services mechanism.

6. The Secretariat's continuing work on the WHO reform agenda is facilitating enhanced collaboration on health emergency and disaster risk management within and across all levels of the Organization for all hazards, and for technical areas such as mental health, disability, and reproductive health. Capacity development activities associated with the International Health Regulations (2005) and with all-hazards health emergency risk management are increasingly aligned at regional and country levels. Most significantly, a new WHO all-hazards health emergency risk-management framework is under development to serve as a basis: (i) for providing guidance on relevant policy, assessments, planning, development and implementation; (ii) for prioritizing the work of WHO in this area; and (iii) for monitoring emergency risk-management capacities and activities at national and international levels.

7. Continued action is needed to establish stronger partnerships for health emergency risk management at national and international levels; to ensure that health emergency risk management is recognized as an essential public health function and integrated into multisectoral emergency risk-management policies and plans; to address the shortage of expertise in this area; and to increase investment in developing the necessary core capacities in all countries.

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

8. **Advocacy and awareness raising.** The Secretariat has worked with Member States to emphasize the importance of health in climate change and sustainable development policy. The Secretariat in collaboration with WMO has produced an "Atlas of Health and Climate", which was launched by the Director-General and the Secretary-General of WMO at the WMO's Extraordinary Congress (Geneva, 29–31 October 2012). It also published, in June 2012, a discussion paper on "Our planet, our health, our future – human health and the Rio Conventions: Biological Diversity, Climate Change and Desertification" in collaboration with the respective convention secretariats. The Organization has recently coordinated a six-part global webinar series on health and climate change.

9. **Partnership with organizations of the United Nations system and other parties.** WHO has contributed the health perspective to the following United Nations' bodies dealing with climate change: the Chief Executives Board for Coordination and its 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. The Organization is working with the Framework Convention's secretariat and least developed countries expert group to prepare new guidance on developing the health components of national adaptation plans. The Secretariat has updated an audit of the carbon footprint of selected WHO offices, as part of the United Nations "Greening the Blue" initiative.

¹ *Health response to the earthquake in Haiti: January 2010: Lessons to be learned for the next massive sudden-onset disaster.* Pan American Health Organization, Washington DC, 2011.

10. **Promoting and supporting the generation of scientific evidence.** Secretariat staff members are contributing as authors and reviewers of the forthcoming Fifth Assessment Report of the Intergovernmental Panel on Climate Change. Assessment continues of the likely health benefits of strategies to reduce greenhouse gas emissions, with new reports on the health sector (in preparation) and the health effects of black carbon,¹ which is both an important pollutant and strong warming agent. WHO has collaborated with WMO at global and regional levels to design the health implementation plan for a new global framework for climate services.²

11. **Strengthening health systems to protect populations from the adverse impacts of climate change on health.** The Secretariat has defined a new operational framework for health protection from climate change in the South-East Asia Region, and monitored and supported the implementation of existing frameworks in WHO's other five regions. The Secretariat has completed assessments of health vulnerability and consequent adaptation needs in more than 30 countries, across all regions. It has completed the second year of a seven-country global pilot project on health adaptation to climate change (in Barbados, Bhutan, China, Fiji, Jordan, Kenya and Uzbekistan), the third and final year of regional projects in Central Asia and eastern Europe (covering Albania, Kazakhstan, Kyrgyzstan, the Russian Federation, Tajikistan, the former Yugoslav Republic of Macedonia, and Uzbekistan), and United Nations country team projects in China, Jordan and the Philippines. Projects on climate change and infectious disease are entering their second year in Cambodia, Mongolia and Papua New Guinea. The Secretariat supports these activities through a capacity-building programme including training materials, a database of national expertise, guidance on access to funding sources, and a clearinghouse of existing public health systems' adaptation projects.

Continuing progress

12. At a high-level side event planned for the 18th Conference of the Parties to the United Nations Framework Convention on Climate Change (due to be held in Doha, 26 November–7 December 2012) potential institutional arrangements to further broaden and deepen the engagement of actors on climate change and health will be discussed.

13. As WHO's current workplan on climate change and health was to be implemented within the time frame of the Medium-term strategic plan 2008–2013, Member States may wish to consider extending the time frame of the workplan and reporting requirements.

Communicable diseases

F. MALARIA (resolution WHA64.17)

14. The Organization has closely monitored progress in relation to Health Assembly and Regional Committee resolutions, including implementation of existing regional strategies, achievement of targets for malaria and work to halt the use of oral artemisinin-based monotherapies.

15. **Global progress in reducing the disease burden.** Owing to an unprecedented international effort to combat malaria, mortality rates decreased by more than 25% worldwide between 2000 and 2010. The decline was 33% during the same period in the African Region, where the disease burden is

¹ Janssen NAH, Gerlofs-Nijland ME, Lanki T et al. *Health effects of carbon black*. Copenhagen, WHO Regional Office for Europe, 2012.

² http://www.wmo.int/pages/gfcs/index_en.php.

the greatest. Between 2004 and 2010, the annual number of global malaria deaths dropped from an estimated 810 000 to 655 000. Malaria transmission continues, however, in 99 countries and territories, and further progress is imperilled by a substantial funding gap for prevention, control and elimination, and by emerging drug and insecticide resistance. In 2010, about 3300 million people were at risk of malaria, and 91% of all deaths occurred in sub-Saharan Africa, mainly among children under five years of age.

16. Strengthening the policy-setting process. In 2011, the Director-General established the Malaria Policy Advisory Committee, an independent advisory group, which met for the first time in January 2012. Its creation has allowed the Secretariat to strengthen its policy-setting process for malaria control and elimination, and to make it more transparent and responsive to the needs of Member States. At its September 2012 meeting, the Committee asked the Global Malaria Programme to prepare a global technical strategy for malaria control and elimination for the period 2016–2025.

17. Development of evidence-based technical guidance. WHO issued several new strategies and policies, including: the Global plan for insecticide resistance management in malaria vectors; a recommendation on seasonal malaria chemoprevention for *Plasmodium falciparum* malaria control in highly seasonal transmission areas of the Sahel subregion of Africa; and a position statement on the role of larviciding for malaria control in sub-Saharan Africa, all in 2012. In April 2012, the Director-General launched new surveillance manuals for malaria control and elimination, together with the *T3: Test. Treat. Track* initiative, urging a scale-up in diagnostic testing, treatment and surveillance of malaria. At the regional and country levels, the Secretariat has provided support to Member States in implementing malaria control and elimination programmes – including the conduct of national programme reviews and updating of national malaria policies and strategies – and assisted with resource mobilization and coordination of partners. During 2011 and 2012, WHO facilitated malaria programme reviews in 27 countries. It has also issued region-specific technical guidance, including a new manual in the African Region for the development of national malaria strategic plans.

18. Monitoring trends in malaria control and elimination. WHO's *World malaria report 2011*, published in December 2011, contained the latest available data from WHO regions, with profiles for all countries and territories where malaria transmission continues. In November 2011, WHO revised its malaria burden estimates for the period 2000–2010 (see paragraph 15 above), following a revision within the United Nations interagency system of estimates of child mortality and cause-of-death ranking.

19. Strengthening human-resource capacities and promoting technology transfers. The Secretariat has run several international and regional malaria training courses, ranging from programme planning and management to monitoring drug resistance, and produced a series of new training materials and manuals. It has issued guidelines on transfer of technology in pharmaceutical manufacturing,¹ and held technical seminars in several WHO regions for interested manufacturers of medicines against HIV/AIDS, tuberculosis and malaria. Through the Prequalification of Medicines Programme the Secretariat has continued to provide technical support to manufacturers, which are making significant progress in meeting prequalification requirements. In June 2012, the Secretariat launched a pilot project to test a new collaborative procedure for sharing with interested national medicine regulatory authorities the outcomes of assessments and inspections organized by WHO and to accelerate national registrations of antimalarials and other prequalified medicines.

¹ WHO Technical Report Series, No. 961, 2011 (Annex 7).

20. **Combating insecticide resistance.** Given that mosquito resistance to insecticides had been detected in 64 countries and in response to the request in resolution WHA 64.17, the Secretariat held a broad-based consultation with more than 130 stakeholders in the global malaria community as the basis for the development of the Global plan for insecticide resistance management in malaria vectors, which was issued in May 2012. The Global plan calls on governments, donor organizations, bodies in the United Nations system, as well as research and industry partners to implement a five-pillar strategy to tackle this growing threat, including the development of innovative vector-control tools and the planning and implementation of strategies for managing insecticide resistance.

21. **Containing artemisinin resistance.** WHO advocates implementation of the Global plan for artemisinin resistance containment, launched by the Director-General in 2011, and issues regular updates on the status of artemisinin resistance in the Greater Mekong subregion. The Secretariat has supported containment efforts in the four countries that are now affected (Cambodia, Myanmar, Thailand and Viet Nam) and called for a coordinated regional response to increase efforts to tackle resistance to antimalarial medicines. It has also increased its technical assistance to countries endemic for malaria in the African and other regions for improving the monitoring of the efficacy of antimalarial medicines.

22. **Mitigating shortages in the supply of artemisinin-based combination therapy at country level.** In September 2011, WHO established an interagency taskforce to identify potential causes of artemisinin-based combination therapy being out of stock in the public sector and to promote mitigating actions. The taskforce monitored central-level stocks of artemisinin-based combination therapy quarterly in order to predict supplies over subsequent six-month periods, considering expected levels of consumption and orders. In February 2012, the taskforce began monitoring stocks of rapid diagnostic tests as well. By triangulating data from countries, procurers and manufacturers, the taskforce confirmed supply risks and helped health ministries to avert the therapy being out of stock on several occasions. The number of rapid diagnostic tests meeting WHO's performance requirements that are procured for the public sector continues to increase, in line with WHO's recommendation for universal access to diagnostic testing for patients with suspected malaria.

G. ERADICATION OF DRACUNCULIASIS (resolution WHA64.16)

23. In response to the request in resolution WHA64.16 to report progress annually, this report provides an update on the eradication of dracunculiasis.

24. After the eighth meeting of the International Commission for the Certification of Dracunculiasis Eradication (Geneva, 29 November to 1 December 2011), 192 countries, territories and areas were certified free of dracunculiasis transmission. As of 1 January 2012, 14 Member States remain to be certified: four endemic countries (Chad, Ethiopia, Mali and South Sudan), six countries in the pre-certification phase (Côte d'Ivoire, Ghana, Kenya, Niger, Nigeria and Sudan) and four which have not reported any recent history of the disease (Angola, Democratic Republic of the Congo, Somalia and South Africa). The challenge for dracunculiasis eradication remains the interruption of transmission in the four countries in which the disease remains endemic.

25. Member States endemic for dracunculiasis have continued to progress towards eradication. In the first eight months of 2012, 499 new cases were reported from four countries (Chad, Ethiopia, Mali and South Sudan), 49% fewer than during the same period in 2011.

26. **Chad.** The outbreak continues into its third year, with seven new indigenous cases reported during January–August 2012 from seven villages; only two of these cases were contained. Measures to interrupt transmission are being implemented. By the end of August 2012, 755 villages were under

active surveillance; four of the seven villages that reported cases in 2012 do not have a single improved source of drinking-water.

27. **Ethiopia.** In 2011, six indigenous cases were reported from three villages and two imported cases from South Sudan were recorded. Although the indigenous cases were reported to have been contained, it appears that transmission continued in a forest focus, resulting in three cases in 2012 (as of August) from three villages; two cases were reported to have been contained. Of the three villages that reported cases in 2012, one does not have any improved drinking-water source. The recent insecurity in Pibor county, South Sudan, has caused people to move across the border into camps in Ethiopia. Currently, the Ethiopian Dracunculiasis Eradication Programme is reinforcing surveillance in areas bordering South Sudan.

28. **Mali** remains the only country in West Africa where dracunculiasis transmission is still continuing. From January to August 2012, four cases were reported in three villages compared with nine reported in four villages during the same period in 2011: one case each from the Segou and Mopti regions and two cases from Kidal. Only one case was reportedly contained. One of the three villages that reported cases in 2012 does not have any improved drinking-water source. Because of security concerns, the national programme is not operating fully in two regions (Gao and Timbuktu) and has been unable to carry out any interventions in the region of Kidal or even verify the two reported cases. Surveillance has been intensified in Malian refugee camps in Burkina Faso, Mauritania and Niger in an effort to prevent further spread of the disease. Members of the humanitarian missions to the north of the country organized by the Ministry of Health and its partners have been oriented on surveillance of the disease. In September 2012, three cases were reported in Niger, allegedly imported from Mali.

29. **South Sudan** accounted for 97% of all the cases reported in 2012. In 2012, 250 villages including 175 villages where dracunculiasis is endemic reported a total of 485 new cases, 49% fewer than in 2011; 66% of these cases were contained. Of the total number of new cases reported in 2012, 393 (81%) were from Kapoeta East county in Eastern Equatoria State. During January–August 2012, 49 (28%) of the 175 villages had one or more improved sources of drinking-water, whereas only 12 (13%) of the 95 villages endemic for the disease in Kapoeta East county had access to improved drinking-water sources.

H. SMALLPOX ERADICATION: DESTRUCTION OF VARIOLA VIRUS STOCKS (resolution WHA60.1)

30. This report summarizes the outcome of the fourteenth meeting of the WHO Advisory Committee on Variola Virus Research (Geneva, 16 and 17 October 2012) and describes relevant work undertaken by the Secretariat.

31. The Advisory Committee noted that the work under the authorized programme of research with variola virus had been done under its supervision. In 2012, so far, nine projects had been approved by its scientific subcommittee.¹ The Advisory Committee was informed that the membership of its scientific subcommittee had been renewed.

¹ Report of the fourteenth meeting of the WHO Advisory Committee on Variola Virus Research, in press.

32. The Advisory Committee received reports on the virus collection held at the two WHO Collaborating Centres, authorized as repositories of variola virus: the State Research Centre for Virology and Biotechnology (Koltsovo, Russian Federation) and the Centers for Disease Control and Prevention (Atlanta, Georgia, United States of America).

33. The Advisory Committee also received updates from three pharmaceutical companies on candidate vaccines and antiviral agents that are closest to licensure. Information presented included data on efficacy, safety, stability and large-scale manufacturing capacity. The companies estimated that they will be able to license their products, two antiviral agents and one candidate vaccine, within one year.

34. As part of the process of establishing the laboratory network for diagnosis of smallpox and other orthopoxvirus infections, headquarters and regional offices will be identifying existing diagnostic laboratories with the appropriate capacities. Currently, and based on existing diagnostic tests, a variola virus-specific diagnostic test that will distinguish variola virus from other poxviruses is being refined.

35. Both authorized repositories of variola virus have been inspected during 2012 and the final reports of these biosafety inspections will be posted on the WHO web site. The protocol that was used followed the European Committee for Standardization's Laboratory Biorisk Management Standard CWA 15793:2011 and addresses 16 elements of laboratory biorisk management. The biosafety inspection visits of 2012 confirmed that this approach allows effective inspections of the repositories, helping to assure the wider community that this vital work is being done safely and securely, in line with the highest standards of biosafety and biosecurity.

36. Work continues on an operational framework for access to WHO's smallpox vaccine emergency stockpile in response to a smallpox event. The framework includes legal considerations for donating smallpox vaccines, standard operating procedures for donating as well as for recipient countries, logistic requirements and a vaccine request form with terms and conditions for the donation and reception of smallpox vaccines. The Secretariat has initiated discussions with the national regulatory agencies of donating countries in order to create a regulatory framework for smallpox vaccines.

37. The Secretariat aims to hold a meeting in 2013 of the Ad Hoc Committee on Orthopoxvirus Infections in order to re-evaluate the composition and size of the smallpox vaccine stockpile needed to support WHO's emergency response to a possible future outbreak of smallpox.

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