

Progress reports on technical and health matters

Report by the Secretariat

CONTENTS

	Page
A. Improving the containment of antimicrobial resistance (resolution WHA58.27).....	2
B. Implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (resolution WHA59.12)	3
C. <i>World report on violence and health</i> : implementation of recommendations	5
D. Promotion of road safety and traffic-injury prevention (resolution WHA57.10)	7
E. Disability, including prevention, management and rehabilitation (resolution WHA58.23) ..	8
F. Cancer prevention and control (resolution WHA58.22): cervical cancer.	9
G. Sustaining the elimination of iodine deficiency disorders (resolution WHA58.24)	11
H. Strengthening active and healthy ageing (resolution WHA58.16)	12
I. Emergency preparedness and response (resolution WHA59.22).....	13
J. Reducing global measles mortality	15
K. Health Metrics Network.....	18
Action by the Health Assembly	19

A. IMPROVING THE CONTAINMENT OF ANTIMICROBIAL RESISTANCE (Resolution WHA58.27)

1. In resolution WHA.58.27, the Health Assembly requested the Director-General to expand and strengthen the provision of technical support to Member States in order to accelerate the implementation of resolutions WHA51.17 and WHA54.14 concerning containment of antimicrobial resistance. It also noted that the strategy for containment of antimicrobial resistance¹ had not been widely implemented and re-emphasized the need for a comprehensive, integrated, national approach to promoting the containment of that resistance.

Implementation of the strategy for containment of antimicrobial resistance

2. Overlap of issues and recommendations has resulted in the subject of containment of antimicrobial resistance being subsumed into the rational use of medicines. The Executive Board considered the matter at its session in January 2007² and adopted resolution EB120.R12 on rational use of medicines. The resolution that it recommend to the Health Assembly for adoption requested the Director-General, *inter alia*, to strengthen WHO's technical support to Member States in their efforts to establish or strengthen, where appropriate, multidisciplinary national bodies for monitoring medicine use, and implementing national programmes for the rational use of medicines. This request embodies the main component of WHO's strategy, namely for countries to establish intersectoral national task forces in order to coordinate containment strategies and a previous proposal to establish an independent fully-resourced intersectoral task force on antimicrobial resistance at headquarters and regional level in order to formulate a plan of action.³ The financial implications of that resolution⁴ envisage sufficient resources for setting up a global team in order to provide necessary additional technical support to countries. A proposed implementation plan will be discussed at the 15th meeting of the Expert Committee on Selection and Use of Essential Medicines (due to be held in Geneva, 19–23 March 2007).

3. Progress has been made in building a stronger evidence base, with the thrust of the Secretariat's work being on collecting and analysing data on antibiotic use in primary health care in low- and middle-income countries and on pharmaceutical policies relating to antimicrobial resistance. With 792 surveys now analysed, the evidence underlines the continuing overuse and inappropriate use of antibiotics worldwide⁵. The data on policies show that few countries have a national task force or strategy for containment of resistance, a reference laboratory for surveillance, or enforcement of policies such as limiting the availability of antibiotics to prescription only.⁶

¹ Document WHO/CDS/CSR/DRS/2001.2.

² See document EB119/2006–EB120/2007/REC/2, summary record of the sixth, eighth and twelfth meetings.

³ Document WHO/CDS/CSR/RMD/2003.7.

⁴ Document EB120/7 Add.1.

⁵ See document EB120/7 for more details.

⁶ Document WHO/TCM/2006.2.

Advocacy and research

4. WHO has continued its multidisciplinary work, concentrating on the following approaches to containment of antimicrobial resistance:

- research on surveillance of use of antimicrobial agents and drug resistance in resource-poor communities;
- dissemination of guidelines to improve management of common childhood infections, including evidence-based strategies for reducing the inappropriate use of antibiotics (e.g. the efficacy of a three-day course of antibiotics for treatment of pneumonia and the use of zinc in treatment of diarrhoea);
- provision of guidance, through the World Alliance for Patient Safety, on the prevention of health-care-associated infections and antibiotic prophylaxis in surgery;
- implementation of the Stop TB strategy, launched in 2006, in order to improve control of tuberculosis through promoting a patient-centred approach, use of quality-assured medicines in fixed-dose combinations, regular surveillance of resistance, and creation of the Green Light Committee, which facilitates access to quality assured second-line medicines against tuberculosis while ensuring their rational use by a stringent review and monitoring process;
- advocating the use of artemisinin-based combination therapy as treatment for uncomplicated falciparum malaria and banning the marketing and use of oral artemisinin monotherapies.

The future

5. The limited progress so far in implementing resolution WHA58.27 reflects the low investment in developing coherent, comprehensive programmes across health systems for promoting rational use of antimicrobial medicines and containing resistance. However, the subject is recognized in the Eleventh General Programme of Work and forms part of strategic objective 11 in the draft Medium-term strategic plan 2008–2013 and the draft Proposed programme budget 2008-2009.

B. IMPLEMENTATION BY WHO OF THE RECOMMENDATIONS OF THE GLOBAL TASK TEAM ON IMPROVING AIDS COORDINATION AMONG MULTILATERAL INSTITUTIONS AND INTERNATIONAL DONORS (Resolution WHA59.12)

6. Resolution WHA59.12 endorsed the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors and requested the Director-General to implement those recommendations, in collaboration with UNAIDS and its other cosponsors, and to report on progress to the Executive Board and to the Sixtieth World Health Assembly.

7. The Global Task Team's recommendations included the need for donors and multilateral institutions (e.g. WHO, UNAIDS, the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria and others) to work together more effectively in order to ensure that financial and technical support to national AIDS responses is harmonized and aligned in accordance with the

“Three Ones” principle and with the Rome Declaration on Harmonization (2003) and the Paris Declaration on Aid Effectiveness (2005).

8. By the end of October 2006, UNAIDS had supported the establishment of joint United Nations teams on AIDS in 44 countries. WHO has played an active role in these teams, including participation in joint programming with other United Nations agencies and partners.

9. WHO’s contribution to the implementation of the Global Task Team’s recommendations has focused on improving coordination between multilateral agencies, especially for the provision of technical support at country level. As chair of the Global Joint Problem-Solving and Implementation Support Team, WHO leads work to overcome obstacles in the implementation of major grants for national HIV/AIDS programmes. Core members of the Support Team include WHO, UNDP, UNICEF, UNFPA, UNAIDS, the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Team facilitates in-country analysis of the obstacles and the design of technical support plans to overcome them. Monthly telephone and videoconferences are held with countries to review their technical support requests. Decisions about responsibilities for providing technical support are made within the agreed framework for the division of labour.¹

10. The Support Team has coordinated and provided policy, technical and management support, with the close involvement of United Nations theme groups, joint United Nations country teams and other national and international partners. By March 2007, the Support Team had made rapid analyses of the obstacles to programme implementation in 32 countries and facilitated action in 15. Support was provided in areas of procurement and supply management, ability to oversee and manage grants, monitoring and evaluation, and dealing with systemic challenges in relation to the policies, procedures and practices of multilateral institutions and their partners. In November 2006, membership of the Support Team was expanded to include bilateral donors and civil society partners, who are fully engaged in working with core members to overcome obstacles in grant implementation by national HIV/AIDS programme.

11. The Support Team’s work complements the technical support provided to UNAIDS and its cosponsors at regional and country levels, for instance, through the knowledge hubs established by WHO and its partners, and UNAIDS’ technical support facilities. WHO is also working with the Emergency Plan for AIDS Relief, launched by the United States of America, and with the GTZ BACKUP Initiative to ensure that the technical assistance provided by bilateral agencies is consistent with United Nations system’s work. WHO, UNICEF, the World Bank, UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Emergency Plan for AIDS Relief are cosponsoring the next HIV/AIDS Implementers’ Meeting (Kigali, 16–19 June 2007), whose aim is the sharing of lessons learnt in the extension of HIV/AIDS programmes.

12. As countries’ demand for technical support grows, efforts are continuing to ensure that adequate financing is available. Of the funds available for WHO’s HIV/AIDS work in the current biennium, 79% has been distributed to regional and country offices. WHO is also working with UNAIDS and its other cosponsors to raise more resources for technical support, exploring, for example, the possibility of making additional funds available at country level from the UNAIDS Unified Budget and Workplan.

¹ *UNAIDS Technical Support Division of Labour: summary and rationale*, UNAIDS, August 2005.

13. While contributing to broader coordination efforts, WHO's specific support for national AIDS responses remains focused on expanding key health-sector interventions in order to come as close as possible to the goal of universal access to prevention, treatment, care and support by 2010. By the end of 2006, 90 countries had provided national targets based on outcome indicators proposed by UNAIDS, and, of these, 81 had set treatment targets and 84 had set outcome targets for at least one prevention intervention. WHO is working on technical guidance for setting targets specifically for antiretroviral therapy, prevention of mother-to-child transmission of HIV, HIV testing and counselling, and HIV prevention, treatment and care for injecting drug users. This guidance will be of use to countries that have not yet set targets in these areas or that want to adopt a systematic approach to setting, reviewing or adjusting targets across interventions.

14. The Executive Board considered the progress report at its 120th session, in January 2007.¹

C. WORLD REPORT ON VIOLENCE AND HEALTH: IMPLEMENTATION OF RECOMMENDATIONS²

15. Resolution WHA56.24 urged Member States to promote the *World report on violence and health*, and encouraged Member States to prepare a report on violence and health and all those that had not already done so to appoint a violence-prevention focal point in the health ministry. The resolution requested the Director-General to cooperate with Member States in establishing policies and programmes for the implementation of measures to prevent violence.

16. Since 2005, the number of countries in which the report has been launched has increased from 40 to 52; the number producing national violence and health reports has risen from four to 15; and the number of focal points has doubled to 100. Countries that initiated new violence-prevention activities in collaboration with WHO – such as data collection, research on the costs of violence, evaluation of prevention programmes, the establishment of national prevention institutes or task forces, and the improvement of victim services – include: Angola, Argentina, Colombia, Belgium, Brazil, Canada, Congo, El Salvador, Finland, France, Germany, Guatemala, Honduras, India, Jamaica, Jordan, Kenya, Latvia, Malaysia, Mongolia, Mozambique, Nepal, Nicaragua, Philippines, Peru, Russian Federation, South Africa, Thailand, The former Yugoslav Republic of Macedonia, Uganda, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America, and Yemen.

17. Some of these achievements were reviewed at a 2nd meeting on Milestones of a Global Campaign for Violence Prevention (San Francisco, United States of America, 19 October 2005),³ and advances made by the Violence Prevention Alliance were assessed. Following this assessment, the Belgian Ministry of Health and WHO convened a meeting of experts from 14 countries (Brussels, 19–20 June 2006) to discuss the strategic direction of the Alliance. It was agreed to establish a high-level working group on advocacy for the inclusion of violence prevention in the global development agenda.

¹ Document EB119/2006–EB120/2007/REC/2, summary record of the thirteenth meeting of the 120th session, section 2.

² *World report on violence and health*. Geneva, World Health Organization, 2002.

³ *Milestones of a global campaign for violence prevention 2005: changing the face of violence prevention*. Geneva, World Health Organization, 2005.

18. In 2005, the Regional Committee for Europe adopted resolution EUR/RC55/R9 urging Member States to prioritize prevention of violence and injury. Meetings of focal points from 34 Member States in the Region were subsequently held with the aim of agreeing a shared goal and devising a joint programme of activities. Earlier this year, 100 focal points from 67 countries, participating in the First Global Meeting of Health Focal Persons for Injury and Violence Prevention (Durban, South Africa, 31 March – 1 April 2006) agreed to create a network for exchanging information and strengthening national violence-prevention policies. In a subsequent consultation, some 30 African health ministers or their delegates made commitments to give violence prevention a higher priority in national health programmes and policies, and, by way of follow up, WHO has begun to prepare a report on violence and health in Africa.

19. Publications in 2005 and 2006 include the *WHO Multi-country study on women's health and domestic violence against women*,¹ *Injuries in Europe: why they matter and what can be done*,² a series of fact sheets on interpersonal violence and alcohol,³ a package for teaching prevention of violence and injuries,⁴ *Developing policies to prevent injuries and violence*,⁵ and *Prehospital trauma care systems*.⁶

20. With the Office of the High Commissioner for Human Rights and UNICEF, WHO provided data and technical input to the United Nations Secretary-General's Study on Violence Against Children. The report was presented to the General Assembly on 11 October 2006. WHO's follow-up will focus on supporting countries in their implementation of *Preventing child maltreatment: a guide to taking action and generating evidence*.⁷

21. In 2006 the Secretariat established a task force on the prevention of sexual and intimate partner violence, which will draw up a draft global plan of action for the prevention of intimate partner and sexual violence. An expert consultation to be held on 2 and 3 May 2007 will provide input for the plan.

22. Progress in violence prevention has led to increased country-level uptake of WHO's recommendations on violence prevention. Further progress requires intensifying support for country-level implementation of WHO guidelines, including investment in evaluation of outcomes. This process is stimulated by biennial review meetings of the Global Campaign for Violence Prevention, the next of which takes place in the United Kingdom of Great Britain and Northern Ireland in July 2007.

¹ Garcia-Moreno C, Jansen HAFM, Ellsberg M, Helse L, Watts C. *WHO multi-country study on women's health and domestic violence: initial results on prevalence, health outcomes and women's responses*. Geneva, World Health Organization, 2005.

² Sethi D, Racioppi F, Baumgarten I, Vida P. *Injuries in Europe: why they matter and what can be done*. Copenhagen, WHO Regional Office for Europe, 2006.

³ Accessible at http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/en/index.html

⁴ Accessible at http://www.who.int/violence_injury_prevention/capacitybuilding/teach_vip/en/index.html

⁵ Schopper D, Lormand JD, Waxweiler R (Eds). *Developing policies to prevent injuries and violence: guidelines for policy-makers and planners*. Geneva, World Health Organization, 2006.

⁶ Sasser S, Varghese M, Kellermann A, Lormand JD. *Prehospital trauma care systems*. Geneva, World Health Organization, 2005.

⁷ World Health Organization, International Society for Prevention of Child Abuse and Neglect. *Preventing child maltreatment: a guide to taking action and generating evidence*. Geneva, World Health Organization, 2006.

23. The Executive Board noted the above progress report at its 120th session.¹

D. PROMOTION OF ROAD SAFETY AND TRAFFIC-INJURY PREVENTION (Resolution WHA57.10)

24. Resolution WHA57.10 urged Member States to mobilize their public-health sector by appointing focal points for prevention and mitigation of the adverse consequences of road crashes, who would coordinate the public-health response in terms of epidemiology, prevention and advocacy, and liaise with other sectors. The Health Assembly accepted the invitation of the United Nations General Assembly for WHO to act as a coordinator on road safety issues within the United Nations system, working in close cooperation with the United Nations regional commissions. It also requested the Director-General to collaborate with Member States in establishing science-based public health policies and programmes for implementation of measures to prevent road traffic injuries.

25. In accordance with the mandate conferred upon it by the General Assembly, WHO coordinates the United Nations Road Safety Collaboration, a group of more than 40 governmental and nongovernmental organizations, donors, research agencies, and private companies, which meets biannually. Its members focus their efforts on the implementation of the recommendations of the *World report on road traffic injury prevention*.² Activities include convening regional road safety conferences; advocacy and the creation of the Global Road Safety Facility, managed by the World Bank. A consortium of members is producing a series of good-practice manuals on prevention.

26. A manual to increase motor-cycle helmet use³ was published in 2006 in several languages and launched initially in Lao People's Democratic Republic, Malaysia, Thailand and Viet Nam. More country workshops are planned for 2007. A second manual, on drink-driving, is due to be launched in April 2007. Further manuals are being developed on data collection, speed, seat-belts and the establishment of a lead agency for road safety.

27. Three major regional road safety meeting's,⁴ held with WHO support, have raised the profile of road safety and called for action. In addition, WHO convened the first global and several regional meetings of health ministry focal points for prevention of injury and violence in 2006.

28. WHO continues to provide technical support to low- and middle-income countries for strengthening of collection systems for integrated data on road traffic injuries, primary prevention programmes and emergency trauma care.

29. WHO has supported capacity building. In 2006 it produced a training manual on prevention of road traffic injuries,⁵ which is being used in several countries, and it continues to support the use in more than 60 countries of an injury-prevention training programme that includes core units on road

¹ See document EB119/2006–EB120/2007/REC/2, summary record of the thirteenth meeting of the 120th session of the Board, section 2.

² *World report on road traffic injury prevention*. Geneva, World Health Organization, 2004.

³ *Helmets: a road safety manual for decision-makers and practitioners*. Geneva, World Health Organization, 2006.

⁴ In the African and Eastern Mediterranean regions and the Region of the Americas.

⁵ *Road traffic injury prevention: training manual*. Geneva, World Health Organization, 2006.

safety. It also supports research through the development of methods for assessing prevalence rates of wearing helmets and seat-belts in low- and middle-income countries and by providing technical and financial support to the Road Traffic Injuries Research Network, a global partnership for road traffic injury research in low- and middle-income countries.

30. Recognizing that improved trauma and emergency care is an essential part of comprehensive prevention of road traffic injuries, WHO has collaborated with a group of specialists in order to draw up guidelines in this area and promote their implementation.

31. For advocacy, WHO is collaborating with the United Nations regional commissions to organize the First United Nations Global Road Safety Week (23–29 April 2007), in accordance with General Assembly resolution 60/5.

32. Awareness raising, preparation of guidelines and integration of the recommendations on traffic-injury prevention into policy processes have resulted in considerable achievements, but these activities need to be strengthened. Member States are encouraged to continue investing in improved multisectoral data collection and the prevention efforts, as outlined in the *World report on road traffic injury prevention*.

E. DISABILITY, INCLUDING PREVENTION, MANAGEMENT AND REHABILITATION (Resolution WHA58.23)

33. In response to resolution WHA58.23, a plan of action on disability and rehabilitation was drawn up for the period 2006–2011,¹ which includes nine key activities that contribute to implementing the resolution.

34. Work has begun on a world report on disability and rehabilitation through the recruitment of staff and establishment of editorial and advisory committees. The editorial committee, which includes nine experts from different regions has determined the objectives, target audience, drafting process, draft structure and main contents of the report. The draft report will be reviewed at regional consultations in 2008; it is planned to launch the report in 2009. The distribution and rehabilitation data and terminology that should be included in the report have been defined.

35. In order to help to strengthen national rehabilitation programmes drafts of two guidelines have been prepared on provision of manual wheelchairs in resource-poor settings and on community-based rehabilitation. The first, intended to promote production, distribution and maintenance of wheelchairs, was reviewed at a meeting of experts (Bangalore, India, 6 to 11 November 2006) and will be issued in 2007. The second will be field tested and peer reviewed in 2007, and issued in 2008. Organizations of the United Nations system, nongovernmental organizations and disabled people's organizations are involved in the drafting of these guidelines.

36. An intercountry meeting (Cairo, 2 to 4 May 2006) reviewed implementation of the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities related to health in the Eastern Mediterranean Region.

¹ Document NMH/VIP/DAR/2005.1.

37. At the first Continental Congress on Community-based Rehabilitation (Santiago, 22 to 24 November 2006) participants from 15 Latin-American countries exchanged experiences and lessons learnt regarding actions that contribute to ensuring the equality of persons with disabilities and their full participation in the community. A Latin-American network to improve coordination of community-based rehabilitation is being established as a result.

38. WHO provided technical support to strengthen national rehabilitation services in countries of the African and Eastern Mediterranean regions. It also initiated two multicountry research projects in collaboration with diverse academic and institutional partners: one on the cost-effectiveness of medical rehabilitation interventions and their impact on poverty reduction and the other on the impact of assistive technology in reducing poverty.

39. A module on disability and rehabilitation has been added to TEACH-VIP, a comprehensive electronic curriculum on prevention and control of injury for a diverse range of training audiences engaged in this field. A training-of-trainers programme for community-based rehabilitation managers will be conducted in the Islamic Republic of Iran in June 2007.

40. WHO actively participated in the meetings of the Ad Hoc Committee responsible for drafting the Convention on the Rights of Persons with Disabilities that was adopted by the United Nations General Assembly on 13 December 2006. WHO will continue to provide Member States with appropriate information and guidance with respect to implementation of the Convention.

41. The Executive Board reviewed an earlier version of the above progress report at its 118th session in May 2006.¹

F. CANCER PREVENTION AND CONTROL (Resolution WHA58.22): CERVICAL CANCER

42. Cervical cancer, a preventable but common cancer in women, was responsible in 2005 for up to 500 000 new cases and up to 257 000 deaths, more than 90% in low- and middle-income countries where access to cervical cancer screening and treatment and palliative-care services is often non-existent or insufficient. According to WHO's projections, deaths from cervical cancer will rise to 320 000 in 2015 and to 435 000 in 2030. Cervical cancer is caused by a common sexually transmitted infection with oncogenic types of human papillomavirus (HPV). The pathogenesis can evolve over a period of 10 to 20 years through precancerous lesions to invasive cancer and death.

43. Following resolution WHA57.12 on reproductive health and resolution WHA58.22, on cancer prevention and control, the Secretariat has drawn up an action plan against cervical cancer. That plan is based on a comprehensive approach that encompasses primary prevention, early detection and screening, treatment, and palliative care under the umbrella of national cancer control programmes,² to promote which WHO is working in partnership with major stakeholders including UNFPA and IAEA.

¹ See document EBSS-EB118/2006/REC/1, summary record of the fourth meeting of the 118th session, section 5.

² *Cancer control knowledge into action. WHO guide for effective programmes: Module 1 – Planning*. Geneva, World Health Organization, 2006.

44. Also in response to resolution WHA58.22, prevention and control of cervical cancer are being recommended,¹ through the promotion of condom use and the implementation of systematic screening for detecting precancerous lesions and invasive cancer and determining appropriate management. Screening for cervical cancer by cytology has been shown to be effective in reducing incidence and mortality but this technique requires appropriate health-service infrastructure, technical resources and a well-defined system of referral to treatment services. Alternative screening techniques more suitable for low-resource countries, such as visual inspection with acetic acid, followed by cryotherapy, are currently under investigation,² and, in further response to the resolution WHA58.22, an operational research programme is introducing these techniques in various African countries.

45. As also requested in resolution WHA58.22, applied research on vaccines against cervical cancer has been promoted. The newly available HPV vaccine and another one in advanced clinical testing have proven to be effective in preventing 65% to 76% of infections and lesions due to the viruses, depending on the local prevalence of oncogenic types of human papillomavirus.³ Several challenges to implementation and research gaps have been identified.^{3,4} New delivery strategies need to be developed, including those that integrate HPV vaccines into existing programmes supporting cancer prevention, reproductive, sexual, and adolescent health, and immunization. For example, WHO's current routine immunization programmes mainly target infants less than one year of age whereas the HPV vaccine is aimed at pre-adolescent girls and immunization coverage may be expanded in the future to boys. Delivery costs, therefore, are likely to be higher, adding to the already high costs of the vaccine itself, although it is expected that the vaccine producers will practice differential pricing, and processes should be put in place to accelerate affordability. Use of this vaccine, moreover, raises culturally sensitive issues, such as sexual behaviour, sexually transmitted infection and genital cancer, adding to implementation. Lastly, sustainable financing of future HPV vaccine programmes needs to be considered in the context of financing of screening programmes as a reduction in cancer incidence and mortality might not be measurable before 10 to 30 years after the vaccine is introduced.

46. The decision on whether and when to introduce HPV vaccines will depend on national policies based on the burden of cervical cancer, the level of risk for exposure to human papillomaviruses, the cost-effectiveness of interventions, and strategies for implementation. Introducing HPV vaccines also presents opportunities to strengthen immunization beyond infancy, including delivering booster doses and new vaccines to children and adolescents, and to provide other health interventions to this age group. An essential element of any cervical cancer control plan is monitoring and evaluation through cancer registries. Striving for universal and equitable access to cervical cancer prevention, screening, treatment and palliative-care services will be the key to reducing the burden of cervical cancer worldwide.

47. The Executive Board at its 120th session noted the above report.⁵

¹ *Comprehensive cervical cancer control. A guide to essential practice*. Geneva, World Health Organization, 2006.

² *Cervix cancer screening*. IARC Handbooks of cancer prevention Vol. 10. Lyon, IARC Press, 2005.

³ WHO, UNFPA. *Preparing for the introduction of HPV vaccines: policy and programme guidance for countries*. Geneva, World Health Organization, 2006.

⁴ *Human papillomavirus and HPV vaccine: key technical information*. Geneva, World Health Organization, in press.

⁵ See document EB119/2006–EB120/2007/REC/2, summary record of the thirteenth meeting of the 120th session of the Board, section 2, and summary record of the eighth meeting, section 2.

G. SUSTAINING THE ELIMINATION OF IODINE DEFICIENCY DISORDERS (Resolution WHA58.24)

48. During the past two years, some progress has been made towards elimination of iodine deficiency disorders and the number of Member States in which they are a public health problem continues to decrease. Within this period, 41 countries reported new national data. Since 1993 the number of countries with national estimates has increased from less than 10 to 75 in 2004 and 94 in 2006, and survey data on iodine deficiency now cover 91.1%¹ of the world population. Data are lacking for 63 countries, representing 8.9% of the world population. In 47 of the 130 countries with estimates at national or subnational level, iodine deficiency disorders are still a public health problem compared to 54 in 2004 and 126 in 1993. Iodine intake is “adequate” or “above recommended nutrient intake” in 76 countries and “excessive”, thereby placing susceptible groups at risk of hyperthyroidism, in seven countries.² Compared to 2004, the affected population, expressed as a percentage of the general population, decreased by 4.6% in 2006, but the number of people with insufficient iodine intake remained stable at about 2000 million, the most affected regions still being South-East Asia and Europe.

49. The preferred strategy for control of iodine deficiency disorders is universal salt iodization. In high-risk communities that are unlikely to have access to iodized salt, iodized oil is recommended, especially for susceptible groups such as pregnant women and young children. An estimated 70% of households worldwide have access to iodized salt; this proportion is higher than 90% in 33 countries³ compared to 28 in 2004. In most countries the use of iodized salt in processed foods is neither mandatory nor regulated.

50. Sustainability of control programmes is crucial, with monitoring and impact evaluation an essential part in order to ensure that interventions are both effective and safe. New tools for monitoring programmes, include the use of new reference data for determining goitre size by ultrasonography and field tests to measure serum thyroglobulin concentration. Moreover, an expert group convened by WHO, UNICEF and the Centers for Disease Control and Prevention (United States of America) made recommendations for improving the reliability of test kits used to monitor iodized salt. The guidelines on indicators for assessing and monitoring control programmes have recently been revised. Since 2001, 17 national programmes have been reviewed by WHO and UNICEF with the technical support of the International Council for Control of Iodine Deficiency Disorders in order to assess achievements towards the goal of iodine deficiency disorders.⁴

51. Experience from countries shows that enforcement of legislation on iodized salt and collaboration among sectors are also important to ensure sustainability of control programmes. Of the

¹ Survey coverage relates to school-aged children, an age group used as a proxy indicator for the general population in assessing iodine deficiency disorders.

² Countries are divided into three groups: “adequate iodine intake” (median urinary iodine concentration (UI), an indicator of iodine intake between 100 and 199 µg/l, “above recommended nutrient intake” (UI 200-299 µg/l) and “excessive iodine intake” (UI >300 µg/l), i.e. in excess of the amount required to prevent and control iodine deficiency disorders.

³ Argentina, Armenia, Belize, Bhutan, Bolivia, Bulgaria, Burundi, Chile, China, Colombia, Costa Rica, Croatia, Ecuador, Iran (Islamic Republic of), Jamaica, Kenya, Lebanon, Lesotho, Libyan Arab Jamahiriya, Mexico, Nicaragua, Nigeria, Panama, Peru, Rwanda, Saint Kitts and Nevis, Sri Lanka, The former Yugoslav Republic of Macedonia, Tunisia, Turkmenistan, Uganda, Venezuela (Bolivarian Republic of), Zimbabwe.

⁴ Armenia, Bhutan, Bulgaria, Cambodia, China, Haiti, Indonesia, Lao People's Democratic Republic, Malaysia, Mongolia, Nigeria, Panama, Peru, Thailand, Turkmenistan, The former Yugoslav Republic of Macedonia, Viet Nam.

countries in which iodine deficiency disorders are a public health problem most (81%) have established a national intersectoral body. The Network for Sustained Elimination of Iodine Deficiency, created in order to support national efforts by promoting collaboration among public and private sectors and scientific and civic organizations, has convened regional conferences¹ in order to mobilize and strengthen collaboration with stakeholders. The Network has also contributed to reviews of national programmes, and is currently formulating a communication plan in order to mobilize decision makers and public health authorities on the importance of iodine deficiency.

52. Over the past two years, activities to fight iodine deficiency have continued, with the aim of sustaining control programmes in the 76 countries where iodine intake is sufficient, improving monitoring in the seven countries where it is excessive and reinforcing programmes in the remaining 47 countries still affected. The main constraints are inadequate monitoring of programmes, inadequate concentrations of iodine in salt, difficulties in delivering iodized salt to the most vulnerable populations, lack of commitment of the salt industry, and poor enforcement of relevant legislation.

53. A list of countries with adequate or above recommended intake of iodine for the period 1993-2006 is available on request.

H. STRENGTHENING ACTIVE AND HEALTHY AGEING (Resolution WHA58.16)

54. In resolution WHA58.16, the Health Assembly requested the Director-General to initiate and provide support to a number of activities in order to strengthen the Organization's work on active, healthy ageing and to report to the Sixtieth World Health Assembly, through the Executive Board, on progress made.

55. The Secretariat developed initiatives involving Member States, and professional, academic and nongovernmental organizations in order to raise awareness worldwide of the public-health challenges of ageing. For example, the intersectoral project "age-friendly cities", in which 27 cities in 18 countries are participating,² uses a common qualitative research protocol within which older people define priority interventions that could make their urban environment more age friendly.

56. WHO contributes to implementation of the Madrid International Plan of Action on Ageing, 2002, by using the active ageing policy framework which defines active ageing as "the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age".³ The principles and recommendations for action contained in this document have been adopted globally by Member States and leading academic, professional and nongovernmental organizations. The framework rests on a life-course approach, focusing on ageing at all stages of life, rather than compartmentalizing older people. The inclusion of ageing throughout WHO's activities and programmes has been strengthened accordingly.

¹ In Senegal (Dakar, 2004), Peru (Lima, 2003) and China (Beijing, 2003), with WHO and UNICEF among the sponsors.

² Argentina, Australia, Brazil, Canada, China, Costa Rica, Germany, India, Ireland, Jamaica, Japan, Mexico, Pakistan, Russian Federation, Spain, Switzerland, Turkey and United Kingdom of Great Britain and Northern Ireland.

³ Document WHO/NMH/NPH/02.8.

57. WHO is collaborating with academic institutions and government agencies from Australia, Brazil, Canada, Costa Rica, Jamaica, Singapore, Spain and Turkey adapting primary health care capacity to meet the needs of older people. Results include widely circulated documents enunciating principles and calling for action in the areas of core competencies, physical environment and administrative procedures. A tool kit on ways to make primary health care centres more age friendly is being piloted in five of the above-mentioned countries.

58. WHO conducted a multistage, qualitative and quantitative research project entitled “Integrated Health Systems’ Response to Rapid Population Ageing in Developing Countries” in 18 countries, with a focus on capacity building, south–south exchange of models and experiences, adoption of “bottom-up” approaches and policy development and implementation.

59. The WHO Study on Global Ageing and Adult Health was designed in order to develop valid, reliable and comparable survey methods to examine patterns of health and well-being among older persons in six countries.¹ The study was the first multidimensional and community-based international survey on ageing and it is expected that its instruments will be used for other studies worldwide.

60. In order to make optimal use of scarce resources, the Secretariat, including staff in regional and country offices, has focused on a few projects in priority, yet neglected, areas. Work is carried out in collaboration with other specialized agencies of the United Nations system and international nongovernmental organizations, thus ensuring intersectoral action. Areas include older people in emergency situations; prevention of falls in older age; women, ageing and health from a gender perspective; minimum curriculum content on ageing for health professionals; and older persons as carers in the context of the AIDS epidemic in Africa.

61. The Executive Board reviewed the above report at its 120th session, reaffirmed their support for the resolution, and expressed satisfaction at its implementation.²

I. EMERGENCY PREPAREDNESS AND RESPONSE (Resolution WHA59.22)

62. In resolution WHA59.22 the Health Assembly requested the Director-General to support Member States in building their health-sector emergency preparedness and response programmes at national and local levels, working in collaboration with relevant organizations of the United Nations system and other partners, and to inform the Sixtieth World Health Assembly, through the Executive Board, of progress made.

63. A WHO five-year emergency preparedness and risk reduction strategy, focusing on the health sector and on community capacity building, has been finalized. Four priority areas have been identified; (1) institutionalization of emergency preparedness programmes within health ministries; (2) human resource development; (3) national capacity building for immediate medical and health care following major emergencies and sudden onset disasters; and (4) support to community-based initiatives.

¹ China, Ghana, India, Mexico, Russian Federation and South Africa.

² See document EB119/2006–EB120/2007/REC/2, summary record of the thirteenth meeting of the 120th session of the board, section 2.

64. In order to enable Member States to deal with existing emergency response gaps, WHO has prepared managerial and technical guidelines on mass casualty management, following input from an expert consultation in September 2006. Other initiatives include the preparation of guidance on chronic disease management and maternal and newborn health in emergencies.

65. A global assessment of the level of emergency preparedness in Member States has been launched. Phase I, involving 60 countries, has been completed; phase II was initiated in November 2006. The report will be available in March 2007.

66. The Safe Hospitals Initiative is being developed jointly with the United Nations International Strategy for Disaster Reduction and the World Bank as part of the Hyogo Framework¹ in preparation for the 2008–2009 Campaign for Safe Hospitals.

67. WHO is an active member of the United Nations Inter-Agency Standing Committee and the Executive Committee on Humanitarian Affairs, an active partner of the United Nations Office for the Coordination of Humanitarian Affairs and participates in the humanitarian reform process. It is the lead agency for the Inter-Agency Standing Committee Health Cluster, co-chairs its Task Force on Gender and Humanitarian Assistance, its Task Force on Mental Health and Psychosocial Support, and participates in its Ad Hoc Working Group on Strengthening the Humanitarian Coordinator System. An action plan for the global health cluster is being implemented in coordination with other health partners. The plan covers training, common health needs assessments, a coordinated response and health management tool kit, and the health and nutrition tracking service.

68. The health and nutrition tracking service has been the subject of a detailed consultation with the main stakeholders. The final project proposal has been endorsed by the Inter-Agency Standing Committee's Health and Nutrition clusters and welcomed officially by its Working Group. Extensive discussions have since been held with other potential partners. The first meeting of the Steering Committee of the tracking service has been proposed for March 2007. Implementation will start during the first half of 2007.

69. The health cluster approach has been implemented in Lebanon, Mozambique and the Philippines and is currently being introduced in Democratic Republic of Congo, Liberia, Somalia and Uganda.

70. WHO collaborated with the International Federation of Red Cross and Red Crescent Societies in establishing a Tsunami Recovery Impact Assessment and Monitoring System in south-east Asia.

71. In the Horn of Africa, WHO was instrumental in making the health sector a major beneficiary of the new Central Emergency Response Fund in order to meet the humanitarian needs of the most vulnerable communities in Djibouti, Eritrea, Ethiopia, Kenya and Somalia. The successful implementation of grants in those situations enabled the Fund to provide aid to a total of 20 countries worldwide, including 13 in the African Region, through its rapid response and under-funded emergency grants.

72. WHO is participating in United Nations system-wide mechanisms for logistics and supplies. Work in this area is carried out through the Organization's involvement in the Inter-Agency Standing

¹ Hyogo Framework for Action 2005–2015: Building the Resilience of Nations and Communities to Disasters, adopted by the World Conference on Disaster Reduction (Kobe, Japan, 18–22 January 2005).

Committee's Logistics Cluster, the United Nations Joint Logistics Centre and in the development of the Logistical Supply System. In 2006, focused negotiations with WFP resulted in bilateral agreements on privileged access to WFP's logistic capacities for WHO's surge response in emergencies, and on the common use of the five regional logistics hubs for health purposes, and in a joint project proposal for the mobilization of external resources. The relevant Technical Agreements were signed in November 2006.

73. The Executive Board at its 120th session in January 2007 took note of the progress report.¹

J. REDUCING GLOBAL MEASLES MORTALITY

74. In resolution WHA56.20, the Health Assembly stressed the importance of achieving the goal to reduce deaths due to measles by half by 2005, compared with the 1999 level. Activities aimed at reducing measles mortality are concentrated in 47 priority countries that account for about 98% of measles deaths globally.

75. Global mortality from measles fell from an estimated 873 000 deaths in 1999 to 345 000 in 2005 – a 60% reduction (see Figure 1). Thus, the goal of halving deaths due to measles has been not only achieved but exceeded, and the figures show that 2.3 million deaths have been prevented through accelerated disease-control efforts. In Africa, the region with the highest burden of the disease, deaths due to measles fell by 75% from an estimated 506 000 in 1999 to 126 000 in 2005.

76. Over the same period 1999–2005, routine measles immunization coverage globally increased from 71% to 77%, although coverage rates varied significantly across geographical regions. Moreover, there was a marked increase in the proportion of countries providing children nationwide with a second opportunity for measles immunization: as of September 2006, 175 (91%) Member States have offered children a second opportunity, compared to 125 (65%) in 1999. Among the 47 priority countries, 37 (79%) had completed nationwide catch-up campaigns by this date.

77. This outstanding public health success is the direct result of:

- strong political commitment at country level and hard work by governments and their partners to provide better access to routine childhood immunization
- nationwide measles vaccination campaigns conducted by countries with a heavy burden of disease due to measles, in which more than 360 million children were vaccinated against measles over the period 2000–2005
- provision of technical and financial support by the Measles Initiative partnership²
- intensified surveillance, with laboratory confirmation, of suspected measles cases.

¹ See document EB119/2006–EB120/2007/REC/2, summary record of the thirteenth meeting of the 120th session, section 2.

² Lead partners in the Measles Initiative are WHO, UNICEF, the American Red Cross, Centers for Disease Control and Prevention (Atlanta, Georgia, United States of America) and the United Nations Foundation.

78. The goal now is to build on this achievement and reduce global measles mortality by 90% by 2010 as compared to the baseline of 2000.¹ In order to achieve this new goal, several challenges have to be overcome through the following measures:

- efforts need to be intensified in order to ensure that at least 90% of each birth cohort are vaccinated against measles according to national immunization schedule; based on WHO/UNICEF estimates, more than 29 million one-year-old children had not received a dose of measles vaccine through routine immunization services in 2005 (see Figure 2)
- populous countries that continue to have large numbers of deaths due to measles should implement nationwide catch-up campaigns to reduce measles mortality
- high-priority countries must continue to conduct follow-up vaccination campaigns every three to four years until their routine immunization systems are able to provide all children with two opportunities for measles vaccination
- field surveillance with laboratory confirmation of suspected cases of measles will need to be extended to all prioritized countries in order to allow effective monitoring.

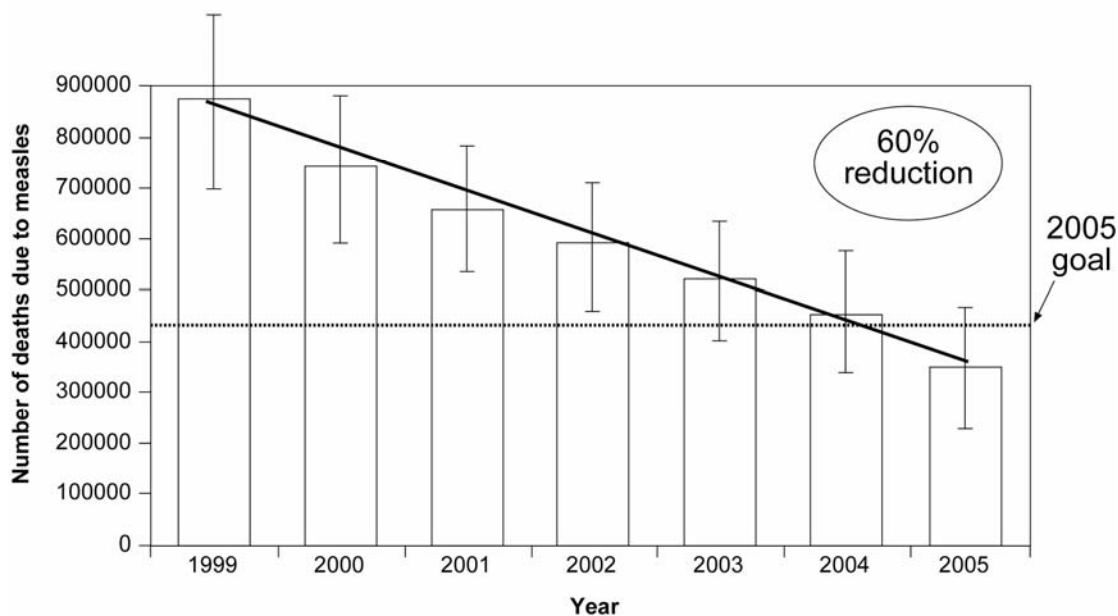
79. The successful reduction in global measles mortality by 90% by 2010 will depend on developing and maintaining strong political commitment in the countries with high disease burdens and continuing support from international partners. In addition to country contributions, US\$ 479 million is required for attainment of the 2010 goal; of this sum, US\$ 147 million has been raised through the International Finance Facility for Immunisation Company and an additional US\$ 80 million have been pledged by partners in the Measles Initiative.

80. The above progress report was noted by the Executive Board at its 120th session.²

¹ The goal of reducing globally mortality due to measles by 90% by 2010 or earlier forms part of the Global Immunization Vision and Strategy 2006–2015, which was welcomed by the Health Assembly in resolution WHA58.15.

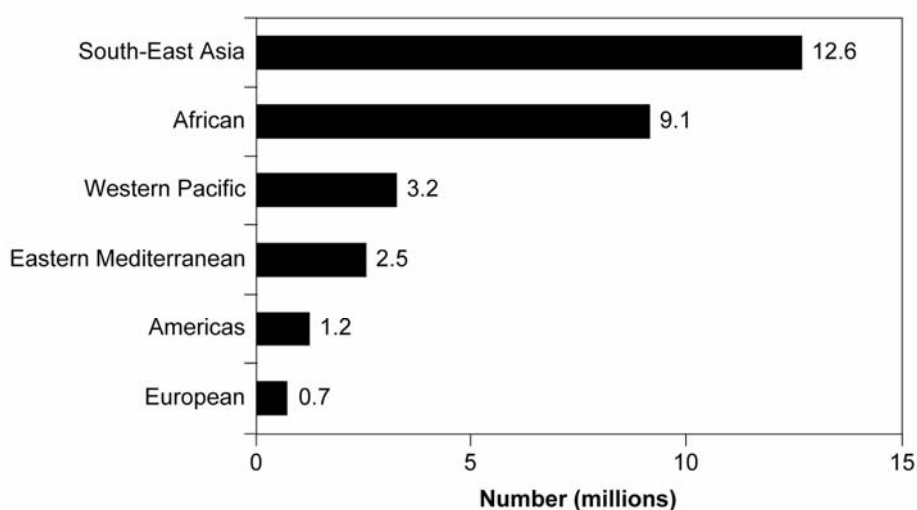
² See document EB119/2006-EB120/2007/REC/2, summary record of the thirteenth meeting of the 120th session of the Board, section 2.

Figure 1. Estimated reduction in global mortality due to measles, all ages, 1999–2005



WHO 06.157

Figure 2. Number of one-year-old children not vaccinated against measles in 2005, by WHO Region



Source: WHO/UNICEF estimates 2005.

WHO 06.158

K. HEALTH METRICS NETWORK

81. The Health Metrics Network, an innovative network of producers and users of health information, launched during the Fifty-eighth World Health Assembly in May 2005, aims to increase the availability, quality and use of timely and accurate health information at subnational, national and global levels. Partners include health ministries, national statistics offices, organizations of the United Nations system, development banks, global health partnerships, donors and technical experts.

82. The key objectives of the Network are:

- to define a framework, i.e. core set of standards for health-information systems, and data generation, analytical capacities, and guidelines to develop national health-information systems;
- to apply the framework at country level, mobilizing technical and financial support to catalyse development and improvement of health-information systems;
- to frame policies and create incentives to improve access to, and use of, information at local, regional and global levels.

83. A first version of the framework was drawn up during 2005 in collaboration with countries, technical partners and development agencies. It is a dynamic reflection of the best practice in health information to which partners are committed and are already aligning their health and statistical development assistance. Experience gained through such collaboration will help to stimulate further evolution of the framework.

84. After the Network was launched, requests from Member States for support to develop health-information systems surged. Forty countries received grants from the Network as a result of the first call for proposals and a further 25 after the second round. Most of the proposals are from low- and lower-middle income countries which are in greatest need of sound information to guide decision-making and which have little technical and financial capacity. Grants are used to mobilize political, technical and financial support and to develop comprehensive, prioritized, costed and funded plans for development of health-information systems.

85. The Network is expected to define and implement strategies to overcome lack of resources for some components of the health-information system. Guidelines on demographic surveillance and sample registration, and harmonized verbal autopsy tools will enable countries to move towards the universal goal of comprehensive vital statistics. Methods for generating sound population-based data at subnational level will empower district managers and enhance equity. Tools to measure the functioning of health systems (such as availability and distribution of human, physical and financial resources for health) will permit better planning to meet health needs.

86. Use of the framework has revealed the need to elaborate further the architecture of a sound health-information system. It will therefore be expanded to address the relationship between demand and supply of health information, links between indicators and data sources, frequency of data collection and disaggregations, and ways of facilitating data flows across indicators and data sources. The policy frameworks, institutional mechanisms and leadership skills needed to ensure that data are converted into information and that knowledge is used to inform decision-making will also be examined.

87. By 2011, the framework should be the universally accepted standard for collection, reporting on, and use of, health information. Its adoption as the global standard will require strong political endorsement and consensus-building. Considerable progress has been made already. Partners such as the World Bank, regional development banks, and Partnership in Statistics for Development in the 21st Century (PARIS 21) have adopted the framework as the sectoral component of broader statistical strategies. At country level, health ministries, statistics offices and development partners are working to ensure that their plans for health-information systems are integrated into national strategies for compilation of statistics.

88. WHO provides the Network's secretariat, and is fostering collaboration among those involved in strengthening health systems and in the production and use of health information. For example, the WHO Regional Committee for South-East Asia urged Member States "to consider using the Health Metrics Framework as a tool for health-information systems assessment and in enhancing harmonization of country efforts related to the strengthening of health-information systems ...".¹ Regional strategic frameworks have been developed in order to strengthen health-information systems, to seize the new technical and financial opportunities opened up by the Network, and to contribute to better global reporting of health information.

89. The Executive Board noted the above report at its 120th session.²

ACTION BY THE HEALTH ASSEMBLY

90. The Health Assembly is invited to note the progress reports.

= = =

¹ Resolution SEA/RC59/R10.

² See document EB119/2006–EB120/2007/REC/2, summary record of the thirteenth meeting of the 120th session of the Board, section 2.