

Progress reports

Report by the Secretariat

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Noncommunicable diseases

A. STRENGTHENING NONCOMMUNICABLE DISEASE POLICIES TO PROMOTE ACTIVE AGEING (resolution WHA65.3)

1. At its 132nd session in January 2013, the Executive Board noted an earlier version of this progress report.¹
2. Resolution WHA65.3 requests the Director-General, inter alia, to provide support to Member States in several areas, including placing emphasis on multisectoral approaches to healthy ageing, integrated care for older persons and support for providers of formal and informal welfare services.
3. The Secretariat has originated several initiatives to raise awareness of these issues. These projects include social media strategies linked to World Health Day 2012, such as the creation of a video “Good health adds life to years”, which has been viewed so far more than 50 000 times on the WHO web site. The global brief issued for World Health Day² is now available in all six official languages.
4. As information on noncommunicable disease and ageing in low-income and middle-income countries is limited, an important first step to providing evidence-based support is to fill these gaps in knowledge. WHO is therefore undertaking a major, longitudinal study of the health of more than 90 000 older people in 11 countries: Bangladesh, China, Ghana, India, Indonesia, Kenya, Mexico, Russian Federation, South Africa, United Republic of Tanzania and Viet Nam. Analysis of the first set of data from this study has now commenced, with earlier outputs helping to identify priority issues for future action. Similar studies have been completed in Finland, Poland and Spain in order to facilitate comparisons with high-income countries.
5. WHO is preparing technical advice on various aspects of the prevention and control of noncommunicable diseases in older age. In order to reduce their prevalence, the Secretariat has collaborated with academic partners on identifying evidence-based strategies for mainstreaming health-promoting actions for healthy ageing. It is also drafting technical guidance on the main issues for the integrated care of older people with noncommunicable disease as well as an intervention guide for the assessment, management and support of frail, dependent older people in non-specialized health settings in both low-income and middle-income countries.
6. With the aim of drafting a global agenda on long-term care in developed and less-developed settings, WHO plans to convene a meeting of experts in early 2013. A background paper on financing of long-term care is being written.
7. An important mechanism for encouraging multisectoral approaches is the WHO Global Network of Age-friendly Cities and Communities, which supports municipalities that want to foster active and healthy ageing. Nine programmes at national or regional level are now affiliated with the Network, and more than 105 individual cities and communities in 19 countries have joined. These include large cities such as Qiqihaer in China, Kolkata in India, and Washington DC, Chicago and New York in the United States of America, as well as La Plata in Argentina, Tampere in Finland, Haifa in Israel, Akita in Japan, Kumertau in the Russian Federation, and Ljubljana in Slovenia. An example of a rural community that participates is Portage la Prairie in Canada. Recent events held in association with the Network include a meeting on age-friendly rural and remote communities and a meeting of experts to define indicators for assessing and monitoring age-friendliness.

¹ See summary record of the fifteenth meeting of the Executive Board at its 132nd session, section 2.

² Document WHO/DCO/WHD/2012.2.

8. As *The world health report 2014* will cover other issues, the Secretariat intends to complete a separate world report on ageing and health by early 2015 as the basis for a plan for future action.

B. GLOBAL STRATEGY TO REDUCE THE HARMFUL USE OF ALCOHOL (resolution WHA63.13)

9. In resolution WHA63.13, the Health Assembly urged Member States to adopt and implement the global strategy to reduce the harmful use of alcohol, as appropriate. It also requested the Director-General, *inter alia*, to collaborate with and provide support to Member States in implementing the global strategy and strengthening the national responses to public health problems caused by the harmful use of alcohol, and to monitor progress in implementing the global strategy to reduce the harmful use of alcohol. At its 132nd session in January 2013 the Executive Board noted an earlier version of this progress report. At the request of a Member State, additional information on the work of the task forces has been added,¹ as well as an update on the number of countries that are working on national alcohol policies.

10. The Secretariat has issued and widely distributed the global strategy with the texts of the associated resolutions WHA63.13, WHA61.4 and WHA58.26 in WHO's six official languages. Endorsement of the global strategy prompted the development of strategies, action plans and programme activities in WHO's regions focusing on the recommended 10 target areas and the strategy's five objectives. A regional strategy on reduction of the harmful use of alcohol was endorsed by the Regional Committee for Africa in 2010.² The European action plan to reduce the harmful use of alcohol 2012–2020,³ aligned with the global strategy, was agreed upon by the Regional Committee for Europe in 2011.⁴ In the Region of the Americas, the plan of action⁵ for implementation of the global strategy was approved by PAHO's Directing Council (63rd session of the Regional Committee for the Americas).⁶

11. Following endorsement of the global strategy to reduce the harmful use of alcohol, an increasing number of countries are in the process of development or reformulation of national alcohol policies. Of the 178 Member States which provided information to the Secretariat by December 2012, 53 are currently in the process of developing a written national alcohol policy and 39 are in the process of reformulating existing policies for reducing the harmful use of alcohol. Of the 73 countries with a written national policy on alcohol, 37 have a national action plan for its implementation, and 22 countries have written reference in their national policy to the global strategy to reduce the harmful use of alcohol. The majority of Member States have established regulations on age limits for sales of alcoholic beverages: on-premise (160 Member States) and off-premise (158 Member States). The most frequently applied age limit is 18 years for all beverage types. A total of 154 Member States have some form of excise tax on beer, wine, or spirits. National systems for monitoring alcohol consumption and the health consequences of alcohol consumption exist in 54 and 53 Member States respectively.

¹ See the summary record of the fifteenth meeting of the Executive Board at its 132nd session, section 2.

² Resolution AFR/RC60/R2.

³ Document EUR/RC61/13.

⁴ Resolution EUR/RC61/R4.

⁵ Document CD51/8, Rev.1.

⁶ Resolution CD51.R14.

12. For strengthening collaboration with, and facilitating provision of support to, Member States the global network of WHO national counterparts for implementation of the global strategy has been established. At the inaugural meeting of the network, hosted by WHO in February 2011 and attended by national counterparts from 126 Member States, working mechanisms, plans and priority areas for implementation of the global strategy were established. The Secretariat facilitated international networking at the regional level by supporting the network of national counterparts in the European Region, and by establishing the Pan American Network on Alcohol and Public Health in the Region of the Americas and the network of national counterparts in the African Region.

13. The Secretariat has worked closely with Member States, intergovernmental organizations and major partners within the United Nations system on: promoting multisectoral action; building national capacity; identifying new partnership opportunities; promoting effective and cost-effective approaches to reducing the harmful use of alcohol for the prevention and control of noncommunicable diseases; and realizing the commitments included in the United Nations' Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.¹

14. WHO co-hosted the Global Alcohol Policy Conference "From the Global Alcohol Strategy to National and Local Action" (Nonthaburi, Thailand, 13–15 February 2012), which drew more than 1000 participants from some 50 countries. The Conference provided a global platform for information exchange, sharing experiences, building new partnerships to raise the awareness of public health problems attributable to alcohol, and advocating for implementation of the global strategy at all levels.

15. Technical tools and training programmes are being developed for supporting action at national level according to the 10 recommended target areas in the global strategy. The Secretariat has supported capacity-building workshops on alcohol policy development and implementation, also linked to the prevention and control of noncommunicable diseases, for selected countries in the African Region, the Region of the Americas, and the South-East Asia and Western Pacific regions. The development of Internet-based portals on alcohol and health, including web-based self-help interventions for hazardous and harmful drinking, has been supported in four countries. Technical guidance and supporting training materials have been developed for the identification and management of hazardous drinking and alcohol use disorders in health-care services. The guidance has also been included in the WHO's intervention guide for its mental health GAP Action Programme (mhGAP)² and in WHO's technical tools for screening and brief interventions for substance use and substance use disorders.³

16. Dialogue continues with nongovernmental organizations, professional associations and economic operators about ways in which they can contribute to reducing the harmful use of alcohol. The Secretariat has organized several consultations with nongovernmental organizations and professional associations to discuss their engagement in the implementation of the global strategy, and with economic operators on ways to reduce alcohol-related harm in their role as developers, producers, distributors, marketers and sellers of alcoholic beverages.

¹ United Nations General Assembly resolution 66/2, Annex.

² *mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings*. Geneva, World Health Organization, 2010.

³ *Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). Manual for use in primary care*. Geneva, World Health Organization, 2010; *Brief Intervention. The ASSIST-linked brief intervention for hazardous and harmful substance use. Manual for use in primary care*. Geneva, World Health Organization, 2010; *Self-help strategies for cutting down or stopping substance use: a guide*. Geneva, World Health Organization, 2010; and *Global status report on alcohol and health*. Geneva, World Health Organization, 2011, respectively.

17. Production and dissemination of knowledge on alcohol consumption, alcohol-attributable harm and policy responses in Member States has been improved by refining the data-collection mechanisms, data analysis and dissemination of the findings, and promoting international research on alcohol and health. WHO's Global Information System on Alcohol and Health has been further developed and integrated with regional information systems on alcohol and health. WHO's *Global status report on alcohol and health*, issued in 2011, presented comprehensive data on alcohol consumption, alcohol-related harm and policy responses at global, regional and country levels, including the country profiles of Member States. In 2012, the global survey on alcohol and health was implemented in collaboration with Member States and the data collected will be used for the next update of the global status report on alcohol and health. The Secretariat has begun a global research initiative on alcohol, health and development and supports international research activities focused on harm to people other than the drinkers themselves, fetal alcohol spectrum disorders and the relationship between the harmful use of alcohol and such communicable conditions as HIV infection and tuberculosis.

18. In order to ensure effective collaboration between Member States and the Secretariat in the implementation of the global strategy, a coordinating council and four task forces were established according to the following key components of the global action outlined in the strategy: public health advocacy and partnership; technical support and capacity building; production and dissemination of knowledge; and resource mobilization. In spite of the Secretariat's efforts to provide support to countries in resource mobilization and the pooling of available resources for implementation of the global strategy, the resources available at all levels continue to be inadequate in the face of the magnitude of alcohol-attributable disease and social burden.

C. SUSTAINING THE ELIMINATION OF IODINE DEFICIENCY DISORDERS (resolution WHA60.21)

19. At its 132nd session in January 2013, the Executive Board noted an earlier version of this progress report.¹

20. It is currently estimated that 29.8% (241 million) of school-age children globally have an insufficient intake of iodine, which is an improvement from 31.5% (266 million) in 2007 and 36.5% (285 million) in 2003.² About 76 million of these 241 million children live in the South-East Asia Region and 58 million in the African Region. It is estimated that 32 countries have inadequate iodine intakes (down from 47 in 2007); 69 countries have adequate intakes (up from 49 in 2007); 36 countries have intakes above the recommended level (up from 27 in 2007); and 11 countries have excessive iodine intakes (up from 7 in 2007). Adequate iodine nutrition status of school-age children or non-pregnant women may not indicate adequate iodine nutrition status among pregnant women but data on the prevalence of iodine deficiency in pregnancy from most countries are limited.³

Control strategy

21. The preferred strategy for the control of iodine deficiency disorders remains universal salt iodization. Data on household coverage with iodized salt are summarized each year by UNICEF in its

¹ See summary record of the fifteenth meeting of the Executive Board at its 132nd session, section 2.

² *Iodine status worldwide. WHO global database on iodine deficiency*. Geneva, World Health Organization, 2004.

³ Wong EM, Sullivan KM, Perrine CG, Rogers L, Peña-Rosas JP. Comparison of iodine status between pregnant women, school-age children, and non-pregnant women. *Food and Nutrition Bulletin*, 2011, **32**(3):206–212.

annual reports on the state of the world's children. According to the 2012 report,¹ primarily reflecting data from the period 2006–2010, the number of countries with at least 90% of households having access to adequately iodized salt had dropped to 23, from 33 in 2008² (data from 2000–2006) and 28 in 2004³ (data from 1997–2002). This fall may reflect the lower number of country surveys being conducted on the use of iodized salt (102 compared with 123 in 2008 and 117 in 2004). Despite this, 71% of households worldwide are estimated to have access to adequately iodized salt.

22. Countries should continue to recognize the importance of iodized salt as they work to reduce total salt intake. The currently recommended level of fortification of salt with iodine (20–40 ppm) needs to be adjusted by national authorities in light of their own data on dietary salt intake and the median urinary iodine concentration of the population. To support them in this work, WHO is conducting two systematic reviews on the use of iodized salt for preventing iodine deficiency disorders and the effect of reduced sodium intake on blood pressure, renal function and blood lipid concentrations.

23. Iodine supplementation is also an option for the control of iodine deficiency disorders, particularly for vulnerable groups such as pregnant women and young children living in high-risk communities who are unlikely to have access to iodized salt,⁴ or as a temporary strategy when salt iodization is not successfully implemented. WHO is systematically reviewing the effects of iodine supplementation on women during pregnancy and lactation.

24. Monitoring and evaluating the impact of programmes to control iodine deficiency disorders are crucial for ensuring that interventions are both effective and safe. Revised guidelines on indicators to assess and monitor these programmes were published in 2007.⁵ To enhance this process, WHO with the Centers for Disease Control and Prevention in the United States of America published in 2011 a logic model for micronutrient interventions in public health that can be used to depict the plausible relationships between iodine intake and the effects of such interventions on achievement of the Millennium Development Goals.⁶ It can be adapted by Member States as part of the continuous quality improvement cycle for planning, performance measurement or evaluation.

25. A development that will facilitate implementation of the resolution is the recent creation of the International Council for the Control of Iodine Deficiency Disorders (ICCIDD) Global Network through the consolidation of the Network for the Sustained Elimination of Iodine Deficiency and the International Council for the Control of Iodine Deficiency Disorders. The new body supports national efforts to accelerate the elimination of iodine deficiency disorders by promoting collaboration among public and private sectors and scientific and civic organizations.

¹ *The state of the world's children 2012: children in an urban world*. New York, United Nations Children's Fund, 2012 (<http://www.unicef.org/sowc2012/index.php>).

² *The state of the world's children 2008: women and children – child survival*. New York, United Nations Children's Fund, 2008.

³ *The state of the world's children 2004. Girls, education and development*. New York, United Nations Children's Fund, 2004.

⁴ World Health Organization, United Nations Children's Fund. Joint Statement: Reaching optimal iodine nutrition in pregnant and lactating women and young children. Geneva, World Health Organization, 2007.

⁵ *Assessment of iodine deficiency disorders and monitoring their elimination: a guide for programme managers*. 3rd edition. Geneva, World Health Organization, 2007.

⁶ Document WHO/NMH/NHD/MNM/11.5.

Preparedness, surveillance and response

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

26. At its 132nd session in January 2013 the Executive Board noted an earlier version of this progress report.¹

27. 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.

28. 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) were understood to have established the necessary core capacities.²

29. In 2012, health emergency and disaster risk management was on the agendas of the regional committees for Africa, the Americas, South-East Asia and the Eastern Mediterranean; notably, the Regional Committee for Africa adopted a resolution on the African Regional Strategy on Disaster Risk Management for the Health Sector.³ In addition, all WHO regions are implementing strategies for the development of national capacities to manage risks to health posed by emergencies. In 2014 WHO will publish a global report on the status of national health emergency and disaster risk-management capacities.

30. Although evidence in support of investing in prevention and preparedness continues to accumulate,⁴ preparedness continues to receive less than 5% of humanitarian funding.⁵ 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.

¹ See summary record of the fifteenth meeting of the Executive Board at its 132nd session, section 2.

² See document EB132/15.

³ See resolution AFR/RC62/R1 for the African Region, resolution CSP28.R19 for the Region of the Americas, resolution EM/RC59/R.4 for the Eastern Mediterranean Region and document SEA/RC65/9 for the South-East Asia Region.

⁴ *Natural hazards, unnatural disasters: the economics of effective prevention*. World Bank and United Nations, Washington, DC, 2010.

⁵ 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).

31. 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 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 strategies for Africa, the Arab States, Asia and the Americas within the International Strategy for Disaster Reduction system. 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.

32. 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.

33. 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 (resolution EB124.R5)

34. At its 132nd session in January 2013, the Executive Board noted an earlier version of this progress report.²

35. **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 entitled "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.

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.

² See summary record of the fifteenth meeting of the Executive Board at its 132nd session, section 2.

36. **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.

37. **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

38. **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

39. At a high-level side event at the 18th Conference of the Parties to the United Nations Framework Convention on Climate Change (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 were discussed.

40. 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 provide guidance on developing a workplan for the period 2014–2019.

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.

Communicable diseases

F. ERADICATION OF DRACUNCULIASIS (resolution WHA64.16)

41. In response to the request in resolution WHA64.16 to report progress annually, this report provides an update on the eradication of dracunculiasis. At its 132nd session in January 2013 the Executive Board noted an earlier version of this progress report.¹ During the discussions it was announced that more recent data would be included in the report to the Health Assembly, reflecting the number of cases for the entire calendar year.

42. After the eighth meeting of the International Commission for the Certification of Dracunculiasis Eradication (Geneva, 29 November–1 December 2011), 192 countries, territories and areas were certified free of dracunculiasis transmission. As at 1 January 2013, 14 Member States remain to be certified: four disease-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.

43. Progress towards eradication has continued: by the end of 2012, a total of 542 new cases had been reported in 272 villages, including three cases imported from Mali into Niger. This marked a fall of 49% against the number of new cases reported in 2011.

44. **Chad.** The outbreak continues into its third year, with 10 new indigenous cases reported in 2012 from nine villages. Only two of the villages concerned also reported cases in 2011; however, only four of the cases were contained. Measures to interrupt transmission are being implemented and in 2012, 710 villages were under active surveillance. Of the nine villages that reported cases in 2012, five do not have a single improved source of drinking-water.

45. **Ethiopia.** In 2011, six indigenous cases were reported from three villages; two imported cases from South Sudan were also recorded. Although the indigenous cases were reported to have been contained in 2011, it appears that transmission continued, resulting in four reported cases in 2012 involving four villages, two each in Gog and Abobo woredas. Transmission in three of these cases, involving three different villages, could be traced to Utuyu village in Gog Woreda. Of these, one indigenous case could be traced to Utuyu village and two imported cases were linked to Utuyu village and its surrounding forest. One additional case was reported in the village of Uma in Abobo Woreda. Of the four cases, two were reported to have been contained; of the four villages that reported cases in 2012, one does not have any improved drinking-water sources. 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.

46. **Mali** remains the only country in West Africa where dracunculiasis transmission is still continuing. During 2012, four cases were reported in three villages compared with 12 cases reported in six villages 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 sources. Because of security concerns, the national programme was not operating fully in two regions (Gao and Timbuktu) and was unable to carry out any interventions

¹ See summary record of the fifteenth meeting of the Executive Board at its 132nd session, section 2.

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.

47. **South Sudan** accounted for 96% of all the cases of dracunculiasis reported in 2012. In 2012, 255 villages – including 89 reporting indigenous cases – reported a total of 521 new cases. The number of new cases was 49% lower than in 2011. Of the cases concerned, 64% were contained. The new cases reported in 2012 included 420 (81% of the total) that were from Kapoeta East county in Eastern Equatoria State. During 2012, 55 of the 167 villages where dracunculiasis is endemic (representing 33% of the total) had one or more improved sources of drinking-water; in Kapoeta East county, however, only 20 of the 104 villages endemic for the disease (19% of the total) had access to improved drinking-water sources.

G. SMALLPOX ERADICATION: DESTRUCTION OF VARIOLA VIRUS STOCKS (RESOLUTION WHA60.1)

48. At its 132nd session in January 2013 the Executive Board noted an earlier version of this progress report.¹

49. 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.

50. 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.² The Advisory Committee was informed that the membership of its scientific subcommittee had been renewed.

51. 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).

52. The Advisory Committee also received updates from three pharmaceutical companies on advanced candidate vaccines and antiviral agents. Information presented included data on efficacy, safety, stability and large-scale manufacturing capacity. Work is continuing on the studies that are needed in order to satisfy the requirements for eventual regulatory approval.

53. 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.

¹ See summary record of the fifteenth meeting of the Executive Board at its 132nd session, section 2.

² Report of the fourteenth meeting of the WHO Advisory Committee on Variola Virus Research, in press.

54. Both authorized repositories of variola virus were 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 15793:2008 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.

55. 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.

56. 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.

Health systems

H. PATIENT SAFETY (resolution WHA55.18)

57. At its 132nd session in January 2013 the Executive Board noted an earlier version of this progress report.¹

58. In response to resolution WHA55.18 on quality of care and patient safety, the Secretariat established the World Alliance for Patient Safety in 2004, renaming it in 2009 as WHO's Patient Safety Programme. Since 2004, the Secretariat's work has had a major impact in addressing the challenges of unsafe care worldwide.

59. The **Global Patient Safety Challenges** galvanized international efforts to strengthen policy and health care delivery. The first Challenge, **Clean care is safer care**, aimed at engaging the world's health providers in reducing health care-associated infection primarily through improved hand hygiene. Since its launch in 2005, this global challenge has been taken up by 129 Member States and 15 000 hospitals are implementing WHO's guidelines and tools to improve hand hygiene.

60. For the second Challenge, **Safe surgery saves lives**, the Secretariat produced the WHO Surgical Safety Checklist in 2008. The Checklist has been endorsed by 700 organizations, and applied in nearly 2000 hospitals worldwide. Capitalizing on the success of the Surgical Safety Checklist, the Secretariat created the WHO Safe Childbirth Checklist to reduce risk related to childbirth.

61. In order to strengthen the science underlying the subject, the Secretariat has promoted **research in patient safety**. With experts' input, a set of priorities for research has been established, and research in 13 Member States has suggested that high risks to safe care exist in developing countries. The Secretariat has generated estimates for the global burden of unsafe care, set up a research funding scheme involving 24 teams in 22 countries, and provided an online training programme and tools in patient safety research.

¹ See summary record of the fifteenth meeting of the Executive Board at its 132nd session, section 2.

62. The Secretariat has developed global standards, protocols and guidelines for safe clinical practices aimed at reducing catheter-related bloodstream infections, incorrect site surgery, unsafe use of concentrated injectable materials, and poor communication between care providers. They have been disseminated worldwide and implemented in more than 400 hospitals in 10 countries.

63. In order to foster the engagement of patients and consumers, the Secretariat created the **Patients for Patient Safety** network, led by patients and their family members. Worldwide, the network has more than 250 active Patient Champions whose principle is that patient safety will not advance without the experience and wisdom of patients themselves. This programme is currently developing new applications for mobile communication devices (including messaging services) for patients.

64. The Secretariat has designed the conceptual framework for patient safety knowledge in order to improve the analysis of safety problems and facilitate learning. Coupled with WHO's guidelines on **reporting systems**, communities of practice in Member States can benefit from learning through experience in reducing patient harm.

65. In response to Member States' requests to build capacity in patient safety, the Secretariat has promoted **patient safety education**, and developed the multi-professional edition of the Patient Safety Curriculum Guide to enable health-care leaders, providers and students to learn about quality of care and patient safety. More than 300 universities have endorsed the curriculum and 30 universities are using it for teaching.

66. To broaden the spread of the Secretariat's action and integrate safety interventions, the **African Partnerships for Patient Safety** programme, set up in 2009 in response to a call for action considered by the Regional Committee for Africa at its fifty-eighth session,¹ has created a network of hospital-to-hospital partnerships that facilitates "bi-directional" patient safety learning involving 14 African and three European countries. Six partnership experiences have stimulated national patient safety change in six countries in the African Region.

67. During the Sixty-fifth World Health Assembly in May 2012, the Secretariat convened a technical briefing in order to hear about patient safety achievements from developed and developing Member States.

Renewed momentum for patient safety at WHO

68. In close collaboration with the WHO Envoy for Patient Safety, nominated by the Director-General in 2011, the Secretariat has launched a new five-year strategy on patient safety with the following strategic objectives:

- to provide global leadership for patient safety
- to harness knowledge, expertise and innovation to improve patient safety
- to engage health-care systems, nongovernmental organizations, civil society and the expert community in the global endeavour of making health care safer.

69. Building on the Secretariat's work to date, the renewed focus on patient safety will have the following priorities for the next five years: developing tools and best practices to improve safety in primary care; improving the provision of education and training on patient safety to the health-care

¹ Document AFR/RC58/8, adopted by the Regional Committee (see document AFR/RC58/20, paragraphs 111–118).

workforce in order to enhance the quality and safety of health services; expanding partnerships in Africa and beyond; and strengthening community and patient involvement.

70. Activities across the Organization, including work on safety of medications and medical devices, blood safety and human resources for health, are being coordinated, and the Secretariat is finalizing a major initiative on injection safety to be launched in 2013. Its work in patient safety also advances other priorities of the Organization, namely universal health coverage and the health and well-being of ageing populations.

I. DRINKING-WATER, SANITATION AND HEALTH (resolution WHA64.24)

Status

71. At its 132nd session in January 2013, the Executive Board noted an earlier version of this progress report.¹

72. The WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation reported in March 2012 that Target 7.C of Millennium Development Goal 7 (namely, to halve, by 2015, the proportion of the population without sustainable access to safe drinking-water and basic sanitation) had been met with respect to drinking-water in December 2010, as measured by the proportion of the population using improved drinking-water sources. Between 1990 and 2010 more than 2000 million people gained access to improved sources, with the proportion of the population without access falling over the same period from 24% to 11%.

73. The proportion of people without access to improved sanitation facilities fell from 51% in 1990 to 37% in 2010 – in absolute numbers, some 2500 million people remained without access in 2010. An estimated 1100 million people continued to defecate in the open.

74. The WHO report on cholera, issued in 2011,² shows that 58 countries from all regions reported a total of 589 854 cases of cholera including 7816 deaths, an increase of 85% in the number of cases compared with 2010.

75. The UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) 2012 called attention to the lack of national policies and programmes that emphasize a balanced approach towards managing human and financial resources, both to sustain existing infrastructure and to expand access to services – a major obstacle to progress in achieving the sanitation element of Target 7.C of Millennium Development Goal 7. The danger that the achievement of Target 7.C might not be sustained by 2015 is real. The dearth of reliable information at the country level about coverage in specific settings such as schools and health-care centres means that the relevant government authorities may be unaware of problems and therefore do not respond.

Strategies

76. In particular, the Health Assembly in resolution WHA64.24 requested the formulation of a new, integrated WHO strategy for water, sanitation and health including, inter alia, a specific focus on water quality issues. Three previously separate areas of work (drinking-water quality, safe use of wastewater, and safe management of recreational waters) are now covered under WHO's new unitary strategy on water quality and health, and are supported by a single expert group.

¹ See summary record of the fifteenth meeting of the Executive Board at its 132nd session, section 2.

² Cholera, 2011. *Weekly epidemiological record*, 2012, **87**(31–32):289–304.

77. The WHO/UNICEF Joint Monitoring Programme strategy for 2010–2015 aims at four main outcomes, including a focus on the needs of post-2015 monitoring. The four strategic objectives of the strategy for the UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water¹ include setting the gold standard in the collection of data on the drivers of and obstacles to progress in drinking-water and sanitation.

Promoting change

78. Major publications since the adoption of resolution WHA64.24 include the two reports mentioned in paragraphs 72 and 75 above, the fourth edition of WHO's *Guidelines for drinking-water quality*² and several technical documents in support of water safety planning. Strategies of both the WHO/UNICEF Joint Monitoring Programme³ and the UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water have been well received by bilateral and multilateral external support agencies, and WHO's unitary strategy is being widely disseminated following its launch in August 2012.

Normative role in target and indicator development

79. The WHO/UNICEF Joint Monitoring Programme has served as a platform for the development of targets and indicators for post-2015 global monitoring. Following the agreement on a road map at the first Consultation on Post-2015 Monitoring of Drinking-water and Sanitation, organized by WHO and UNICEF (Berlin, 3–5 May 2011), targets and indicators were set before being discussed at a second consultation held in The Hague in December 2012. The outcome of this technical effort will be mainstreamed into the political processes for post-2015 development goals.

Capacity building

80. Under the WHO/AusAID Water Quality Partnership for Health the second phase of the Water Safety Plan capacity development project was completed in six countries in the South-East Asia and Western Pacific regions in May 2012; an additional 12.5 million people were provided with safe drinking-water under 150 new water safety plans (for 60 urban and 90 rural areas). The third phase started in September 2012 in 12 countries and should result in sustainable national policy and institutional frameworks, the integration of the water safety plan approach with asset management, and the incorporation of water safety plans into regional investment planning.

J. WORKERS' HEALTH: GLOBAL PLAN OF ACTION (resolution WHA60.26)

81. At its 132nd session in January 2013, the Executive Board noted an earlier version of this progress report.⁴

82. This report describes progress towards implementing the five objectives of the global plan of action on workers' health 2008–2017.

¹ http://www.who.int/entity/water_sanitation_health/publications/glaas_strategy.pdf (accessed 25 October 2012).

² *Guidelines for drinking-water quality*, 4th ed. Geneva, World Health Organization, 2011.

³ See also the dedicated web site at www.wssinfo.org, which contains information on the extensive post-2015 water and sanitation work carried out during 2012.

⁴ See summary record of the fifteenth meeting of the Executive Board at its 132nd session, section 2.

Objective 1: to devise and implement policy instruments on workers' health

83. Workers constitute half the world's population and their health is a prerequisite for sustainable economic development. The Secretariat has provided technical support to 21 Member States in developing national policies and frameworks for workers' health, and for strengthening the relevant capacities of health ministries.

84. Action towards elimination of asbestos-related diseases has included raising awareness about the effects of asbestos on health, advocacy for primary prevention, and support for developing national profiles and programmes for elimination of those diseases in 45 Member States.

85. Support has been provided to 14 Member States in organizing campaigns for vaccinating health-care workers against hepatitis B.

Objective 2: to protect and promote health at the workplace

86. In order to improve the management of occupational risks the Secretariat has contributed to the development of International Chemical Safety Cards (there are currently 1700 in existence), toolkits for sound management of industrial chemicals, guides for management of psychosocial risks at work, and occupational exposure to ultraviolet and ionizing radiation.

87. Global guides on healthy workplaces and on diet and physical activity in the workplace have been published in order to facilitate integrated management of health determinants and major risks for noncommunicable diseases in the work setting.

88. Recommendations and policy options have been issued in order to broaden health-care workers' access to services for HIV infection and tuberculosis along with guidance on preventing needlestick injuries.

Objective 3: to improve the performance of and access to occupational health services

89. WHO jointly organized the global conference "Connecting Health and Labour" (The Hague, 29 November–1 December 2011), which provided strategic directions for expanding access of all workers to essential interventions for the prevention of occupational and work-related diseases and injuries. Particular emphasis was given to workers in informal and small-scale enterprises in the context of integrated and people-centred primary care.

90. Costing methods and practical tools for delivering essential occupational health interventions along with training materials and information resources for primary-care providers are being developed and distributed through the network of WHO collaborating centres for occupational health.

Objective 4: to provide and communicate evidence for action and practice

91. The Secretariat established a global working group on occupational diseases in order to provide input for the eleventh revision of the International Statistical Classification of Diseases and Related Health Problems. The working group has prepared content models for 120 diseases and external causes with occupational origin, which have been included in the beta version of the eleventh revision of the classification. The working group also contributed to the updating of the ILO List of Occupational Diseases¹ and to establishing diagnostic and exposure criteria for their recognition.

¹ *ILO List of Occupational Diseases (revised 2010)*. Geneva, International Labour Office, 2010.

Objective 5: to incorporate workers' health into other policies

92. The Secretariat has published a set of indicators for measuring the workers' health aspects of sustainable development policies and provided guidance on the role of workers' health in climate change adaptation and mitigation and in green economies. The Secretariat has also provided guidance for health impact assessment in extractive industries – mining, oil and gas.

93. Strong collaboration was established with the Strategic Approach for International Chemicals Management to support the sound management of priority industrial carcinogens and updating national chemicals profiles in several countries.

Implementation

94. The Secretariat's activities have been supported by the Network of WHO Collaborating Centres in Occupational Health (whose current membership is 50). Their effectiveness was maximized through concerted action in a few priority areas: prevention of occupational cancer and chronic respiratory diseases, safety of health-care workers, tools and standards for healthy workplaces, occupational health services and capacities, occupational diseases, green economies and climate adaptation, vulnerable populations and high risk employment. Additionally, close collaboration with ILO and other international partners has resulted in synergies.

K. STRATEGY FOR INTEGRATING GENDER ANALYSIS AND ACTIONS INTO THE WORK OF WHO (resolution WHA60.25)

95. At its 132nd session in January 2013, the Executive Board noted an earlier version of this progress report.¹

96. This report presents information about work under the four strategic directions: building WHO's capacity for gender analysis and planning; bringing gender into the mainstream of WHO's management; promoting the use of sex-disaggregated data and gender analysis; and establishing accountability.

97. Progress in building WHO's capacity for gender analysis and planning includes the publication of a manual for gender mainstreaming for health managers,² and the systematic training of WHO staff members and government staff (mostly in health ministries) in all WHO's regions. The manual provides guidance on capacity building and has been institutionalized in several countries. For example, the health ministries of Afghanistan and Oman have adopted the guidelines and organized many national training courses on gender and health for the health sector. The Regional Office for the Western Pacific has held training sessions on gender mainstreaming in health for both national counterparts and WHO staff members in many countries in the Region.

98. The Gender, Women and Health Network, currently comprising 112 gender focal points in all six WHO regions, is being expanded into a network that also includes focal points for gender, equity and human rights. When fully operational the Network should increase capacity to some 200 focal points.

¹ See summary record of the fifteenth meeting of the Executive Board at its 132nd session, section 2.

² *Gender mainstreaming for health managers: a practical approach*. Geneva, World Health Organization, 2011.

99. The current good level of gender integration in the operational planning process at regional and country levels can be attributed to continuous provision of support to Member States in the form of policy guidance, operational research and capacity building. For example, the Secretariat provided support to the Ministry of Public Health in Afghanistan in developing the National Gender Strategy 2012–2016. It also supported a gender assessment during a mid-term review in 2011 of Cambodia's Health Sector Strategic Plan 2008–2015, the first example in the Western Pacific Region of gender being mainstreamed into national health plans and policies. The case study has been documented and published. The Lao People's Democratic Republic has asked for similar support.

100. In order to strengthen approaches to institutional mainstreaming of gender, equity and human rights across the Organization and recognizing the interrelation of these core values, in 2012 the Director-General established the Gender, Equity and Human Rights mainstreaming team at headquarters. Its task is to support an Organization-wide mainstreaming of these core values, engaging staff members at all levels and in all offices as well as national counterparts. An Organization-wide gender, equity and human rights strategy on how to mainstream these issues at each level of the Organization is needed for directing the future work of WHO and to replace the existing gender strategy.

101. A good regional example of integrating gender, equity and human rights into policy can be found in Health 2020: a European policy framework supporting action across government and society for health and well-being.¹ Health 2020 was adopted by the Regional Committee for Europe in resolution EUR/RC62/R4 in September 2012. The policy's main strategic objectives are reducing health inequalities in Europe and improving governance for health, recognizing the importance of gender, social determinants and human rights approaches in advancing these objectives.

102. WHO is increasingly using sex-disaggregated data. For example, in 73% of the publications issued by the Regional Office for the Americas data are disaggregated by sex. Another important development is the preparation for the launch of an equity monitor by the Global Health Observatory, which will include sex-disaggregated childhood malnutrition indicators and data on child mortality and vaccination coverage.

103. WHO is committed to the implementation of the United Nations system-wide action plan on gender equality and women's empowerment² adopted by the Chief Executives Board for Coordination in April 2012. The Secretariat will consequently prepare a corresponding action plan that will provide a coherent approach to mainstreaming gender, equity and human rights across the Organization with appropriate arrangements for reporting progress on the 15 indicators specifically relating to WHO's performance in the implementation of the United Nations system-wide action plan to both the Chief Executives Board and WHO's governing bodies.

104. Gender considerations have been integrated into WHO's technical programmes, such as those on HIV, and violence and injury prevention. Thus WHO's global health sector strategy on HIV/AIDS, 2011–2015, includes a strategic direction that specifically highlights the need to promote gender equality through, for instance, monitoring HIV-related gender-based inequities and introducing services related to gender-based violence. WHO's forthcoming guidelines on prevention and management of sexually transmitted infections, including HIV, among sex workers also include explicit recommendations on addressing violence against sex workers as a risk factor for those infections. The Secretariat has also strengthened capacity for prevention of intimate partner violence in countries through regional

¹ Document EUR/RC62/9.

² *System-wide action plan for implementation of the United Nations CEB policy on gender equality and the empowerment of women*. New York, United Nations Women, April 2012.

workshops in the Region of the Americas and the African and Western Pacific regions. In the Region of the Americas, action plans for gender mainstreaming have been prepared in 13 countries. A mid-term monitoring report on the implementation of PAHO's Plan of Action for implementing the Gender Equality Policy 2009–2014,¹ considered by the 28th Pan American Sanitary Conference in September 2012, indicated that the greatest challenge to gender integration in health is political support.

L. PROGRESS IN THE RATIONAL USE OF MEDICINES (resolution WHA60.16)

105. At its 132nd session in January 2013, the Executive Board noted an earlier version of this progress report.²

106. In response to resolution WHA60.16, the Secretariat is working with Member States, in collaboration with international, regional and national partners, to promote the rational use of medicines. The aim of the activities concerned is to minimize overuse, underuse or misuse of medicines, all of which result in wastage of scarce resources and poor health outcomes.

107. WHO was a partner in the Third International Conference on Improving Use of Medicines (Antalya, Turkey, 14–18 November 2011). The Conference, which brings the global medicines community together every 7 years, welcomed 594 participants from 86 countries, who gathered in order to review previous work performed on promoting rational use and to discuss future directions. The general view of participants was that the useful pilot research projects already undertaken on rational use now needed to be translated into policies and programmes in health-care systems.

108. The Secretariat provided one of the two technical papers considered at the Ministerial Summit of Health Ministers on the theme “The benefits of responsible use of medicines: setting policies for better and cost-effective healthcare”.³ The Summit, organized by the Ministry of Health, Welfare and Sports of the Netherlands was held in Amsterdam, Netherlands on 3 October 2012. It provided an opportunity for countries to share experiences and learn from one another. At both the Third International Conference and the Ministerial Summit it was emphasized that there was a need to improve the access to and use of medicines for achieving universal health coverage.

109. Rational use of medicines has also been discussed at key regional meetings. WHO was a collaborating partner for the Asia Pacific Conference on National Medicines Policies (Sydney, Australia, 26–29 May 2012). The Secretariat also organized a regional workshop on ensuring access to priority medicines for mothers and children (Manila, 15–17 August 2011), followed by an intercountry consultation on improving access to essential medicines, diagnostics and medical devices for the management of noncommunicable diseases (Manila, 18–20 August 2011).

110. The regional strategy to promote rational use was updated in the Region of the Americas in 2012; and in the South-East Asia Region, resolution SEA/RC64/R5 on national essential drug policy, adopted by the Regional Committee at its sixty-fourth session in September 2011, included rational use of medicines as a major component.

¹ Document CSP28/INF/3.

² See summary record of the fifteenth meeting of the Executive Board at its 132nd session, section 2.

³ Available at http://www.who.int/medicines/publications/responsible_use/en/index.html (accessed 2 November 2012).

111. World Health Day 2011 had as its theme “Antimicrobial resistance: no action today, no cure tomorrow”. The six accompanying policy briefs included one on regulating and promoting rational use of medicines, including in animal husbandry, and ensuring proper patient care. In the wake of World Health Day 2011, the Antimicrobial Resistance Task Force was established. The promotion of rational use of medicines is an important part of its activities.

112. Under the auspices of the ASEAN Working Group on Pharmaceutical Development, and with facilitators from the WHO Secretariat, the Ministry of Health of Brunei Darussalam organized a five-day training workshop on the rational use of antimicrobial agents. Participants included delegates from Indonesia, Lao People’s Democratic Republic, Malaysia and Philippines. The extensive discussions covered the rational use of medicines, infection control, and the surveillance and control of antimicrobial resistance. In the European Region, in collaboration with the University of Antwerp, Belgium, and with institutions in the Netherlands, a subregional workshop was held for measuring consumption of antibiotics in southern and eastern European countries (Utrecht, Netherlands, 3–6 September 2012). This work is intended to help in establishing a database of antibiotic consumption compatible with that in the European Centre for Disease Prevention and Control, and thus to support implementation of the European strategies for containment of antimicrobial resistance.

113. The WHO Model List of Essential Medicines has been revised as a part of the two-yearly cycle, with the 17th Model List published in May 2011.¹ The next revision is scheduled for April 2013. National essential medicines lists continued to be updated widely throughout the regions; a number of countries updated their lists along with standard treatment guidelines. India developed its National Formulary (based on the WHO Model Formulary) and made it available to prescribers. The formulary has also been made universally available as a mobile phone application that has been downloaded in over 50 countries.

114. In the area of patient safety, WHO has produced a publication on antimicrobial resistance that targets policy-makers. The book, which sets out potential interventions, contains chapters on measures to ensure better use of antibiotics and on reducing antimicrobial use in animal husbandry.

115. Measuring medicines use is an important part of evaluating rational use. Analysis of data collected at headquarters on medicines use and medicines policy revealed that medicines use is more rational in countries with policies than in those without policies. Information from France, Germany, Netherlands, Slovenia and the United Kingdom of Great Britain and Northern Ireland is being collected so that medicines use indicators can be compiled.

116. Training in medicines selection, pharmacotherapy and rational use is essential for improving medicines use. The PAHO/WHO Virtual Campus for Public Health, coordinated by the WHO Collaborating Centre for Problem-Based Pharmacotherapy Teaching (La Plata, Argentina), has trained more than 200 health-care professionals in these areas, and in the European Region training on these issues was provided for European Union Member States, together with the acceding countries, in Denmark and the Netherlands in November 2012.

117. Despite the examples of sector-wide coordination in rational use described above, including the work undertaken on combating antimicrobial resistance, the national efforts that Member States were urged to make in resolution WHA60.16 remain limited.

¹ <http://www.who.int/medicines/publications/essentialmedicines/en/index.html> (accessed 2 November 2012).

M. HEALTH POLICY AND SYSTEMS RESEARCH STRATEGY

118. At its 132nd session in January 2013, the Executive Board noted an earlier version of this progress report.¹

119. A number of WHO reports on health research, backed up by international declarations,² have highlighted the need for continued commitment to research-driven knowledge generation and increased investment in scientific enterprise. Although the publications concerned have succeeded in raising the profile of health research among policy-makers, only a few focused on research related to health policy and systems. In order to support a strengthened evidence base for accelerating universal health coverage, additional emphasis was therefore required on the role of all stakeholders and, in particular, health system decision-makers in setting the agenda for health policy and systems research.

120. In response, WHO and partners organized the First Global Symposium on Health Systems Research (Montreux, Switzerland, 16–19 November 2010). The Symposium offered a first opportunity for more than 1200 stakeholders from diverse backgrounds – including health research, policy, funding, implementation and civil society – to debate the important role and contribution of health policy and systems research in decision-making. During the Symposium there was general agreement among delegates on the need for a strategy on health policy and systems research, in support of the greater generation and use of research evidence in health policy and in order to build the case for further investment in this critical area of research.

121. The Secretariat has taken the lead in developing this strategy, grounding its work in science and drawing on the experience of multiple stakeholders in a transparent, inclusive and participatory manner. For this purpose, a 29-member advisory group was established, composed of men and women from all over the world, and including research leaders and policy-makers.

122. The strategy on health policy and systems research, entitled “changing mindsets”,³ was launched on 1 November 2012 during the Second Global Symposium on Health Systems Research (Beijing, 31 October–3 November 2012). The Symposium, organized by WHO and partners and hosted by the Government of China, was aimed at evaluating progress and readjusting research priorities in order to accelerate universal health coverage.

123. The strategy is intended to augment and amplify WHO’s previous mandates for work on health research.⁴ The new strategy explains how the evolving field of health policy and systems research is sensitive and responsive to the knowledge needs of decision-makers, health practitioners, citizens and civil society, all of whom are involved in the planning and performance of national health systems.

124. The strategy aims to change the way health policy and systems research is managed as a research endeavour, embedding it more effectively in the domains of policy-making and implementation. It sets out to encourage active engagement between researchers on the one hand and

¹ See summary record of the fifteenth meeting of the Executive Board at its 132nd session, section 2.

² Including the Bamako Call to Action on Research for Health (2008), which is available at http://www.who.int/rpc/news/bamako_call_to_action/en/index.html (accessed 6 November 2012).

³ *Strategy on health policy and systems research: changing mindsets*. Geneva, World Health Organization, 2012. Available at <http://www.who.int/alliance-hpsr/whostrategyhpsr/en/index.html> (accessed 6 November 2012).

⁴ Particularly the WHO strategy on research for health, which was endorsed by the Health Assembly in resolution WHA63.21.

policy- and decision-makers on the other, and calls for both sides to recognize the need to build capacity in health policy and systems research. A further, but equally important, aim of the strategy is to unify the diverse disciplines of research and combine the several platforms of knowledge generation, which are at present loosely connected, into an integrated instrument of change that can provide impetus to health system strengthening and health transformation globally.

125. Outlined in the last chapter of the strategy are a number of options for action by stakeholders to facilitate evidence-informed decision-making and the strengthening of health systems. These mutually complementary options are intended to support the embedding of research within decision-making processes and promote a steady programme of national and global investment in health policy and systems research. Member States will be able to pursue some or all of these actions, based on their individual context and available resources.

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