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Implementation of resolutions (progress reports)

Report by the Secretariat

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A. GLOBAL STRATEGY ON DIET, PHYSICAL ACTIVITY AND HEALTH (RESOLUTION WHA57.17)

1. Implementing the Global Strategy on Diet, Physical Activity and Health will lead to a significant reduction in the occurrence of chronic diseases and their common risk factors, primarily unhealthy diets and physical inactivity. It calls upon all stakeholders to take action at global, regional and local levels.

Country and regional activities

2. WHO's global survey on assessing progress in national prevention and control of chronic noncommunicable diseases currently under way has shown that progress on implementation of the strategy varies widely across the regions. Of the 85 Member States which have responded, 25 have implemented it. Of the remaining 60 countries, 17 are planning implementation. The survey does not yet include the South-East Asia and Western Pacific regions, where good progress is being made.

Global activities

3. The Secretariat is producing and disseminating a range of tools to provide support to Member States and stakeholders in implementing the Strategy. These include guidance for Member States on effective relations with the private sector, marketing food and non-alcoholic beverages to children, and promotion of physical activity in developing countries, and a framework and indicators for monitoring progress in implementation of the Strategy. The publication, *Preventing chronic diseases: a vital investment* is an important advocacy tool that incorporates many of the Strategy's objectives.¹

4. **Private sector.** Some food and non-alcoholic beverage manufacturers, food-service providers, and retailers are making changes to their products and services in keeping with the Strategy's recommendations. Even though these initiatives are commendable, they remain isolated and their impact on public health remains limited. Small and medium-sized enterprises, in general, have failed to be engaged in the global effort. Therefore, much additional work is needed to secure industry-wide actions to improve the quality of their food and drink products, the information available to consumers, and the way in which products are marketed.

5. **Civil society and global nongovernmental organizations.** Informal agreements have been reached with a limited number of nongovernmental organizations with a global mandate and influence to contribute to the implementation of the Strategy. For example, WHO is cooperating with the International Olympic Committee to increase people's physical activity in the context of the biannual World Sport for All congresses. The newly established Global Prevention Alliance provides a promising avenue through its networks for coordinated action by nongovernmental organizations.

6. **International partners.** WHO is collaborating with other organizations of the United Nations system to promote the Strategy's objectives. For example, FAO and WHO jointly developed a framework for promoting fruit and vegetable consumption for health. WHO has also promoted the principles of the Strategy through active participation in several events linked to the United Nations International Year of Sport and Physical Education (2005) and Sport for Development and Peace.

¹ *Preventing chronic diseases: a vital investment: WHO global report.* Geneva, World Health Organization, 2005.

7. **Codex Alimentarius Commission.** WHO is working closely with FAO and the Codex Alimentarius Commission to explore ways in which the Commission can contribute to implementation of the Strategy, which presents new challenges for Codex.

Conclusions

8. Some progress has been made with implementation of the Strategy's recommendations, but results are limited. Some Member States have responded positively but more countries need to do the same. Similarly, selected actions have been taken by other stakeholders, but much more needs to be done – and urgently.

9. Implementation of the Strategy has been limited by resource constraints, both human and financial, and reflects continuing low investment in prevention and control of chronic, noncommunicable diseases at local and global levels.

10. Continued monitoring will include an analysis of the health, socioeconomic and gender impact of implementation as requested in resolution WHA57.17.

11. A more detailed report is available.¹

B. HEALTH ACTION IN RELATION TO CRISES AND DISASTERS

12. In resolution WHA58.1, the Health Assembly requested the Director-General to undertake several activities in order to strengthen the Organization's work on health action in crises and disasters, and to inform the Fifty-ninth World Health Assembly, through the Executive Board, of progress made.

Earthquakes and tsunamis of 26 December 2004: relief and recovery

13. The Secretariat has developed and implemented a relief and recovery strategy based on the Organization's four priority functions in crises, namely assessing the health situation; supporting coordination of health-related action; filling, or ensuring that others fill, critical gaps; and building capacity within national authorities and civil society. The focus is now on strengthening the capacity of communities in the following priority areas: assessment of health needs; health promotion and disease prevention; health policy formulation and coordination; health information management; and health-services delivery.

14. WHO continues to monitor relief and rehabilitation activities in India, Indonesia, Maldives, Sri Lanka, and Thailand. The information-gathering phase has now been completed and the data thus generated are being analysed by the Karolinska Institute (Sweden) and Geneva University (Switzerland). The results will be presented at a meeting in Bangkok, which is being organized in collaboration with the Office of the United Nations Special Envoy for Tsunami Recovery and the International Federation of Red Cross and Red Crescent Societies, from 3 to 5 May 2006. At the same meeting, it is expected that participants will agree on common indicators for monitoring the impact of the tsunami and on a system to monitor progress of recovery and relief efforts.

¹ Document NMH/CHP/SPP/2006.1.

Enhanced cooperation with other international organizations

15. Within the United Nations, WHO has been designated as the lead agency for the Inter-Agency Standing Committee's Humanitarian Health Cluster, which aims to provide capacity, predictability, effectiveness and accountability in the health sector. WHO and the International Federation of Red Cross and Red Crescent Societies have signed a joint letter on cooperation and strengthened collaboration, with a particular focus on emergencies. WHO and InterAction, an alliance of nongovernmental organizations, are co-chairing the Taskforce on Mental Health and Psychosocial Support in Emergency Settings recently established by the Standing Committee. More recently, WHO and WFP initiated discussions on the possibility of forming partnerships in areas of mutual interest, such as logistic support in emergency settings, analysis and mapping of vulnerability in crisis-prone countries, joint training and capacity-building programmes and nutrition in emergencies. It is expected these discussions will be finalized and a joint agreement signed within the next few months.

Enhanced logistics and crisis-response mechanisms

16. A working group on emergency response has been established to review the Organization's administrative policies and processes and to recommend ways of adapting them for emergencies. The expected outcome is a set of standard operating procedures for emergencies to be used at all levels of the Organization.

17. Joint negotiations with partner agencies and programmes, in particular WFP, concerning the possible use of common assets for logistic support in emergency and crisis situations are well advanced.

Mobilization of health expertise

18. WHO has been asked to establish a health emergency expert network as one component of the Joint Initiative to Improve Health Outcomes. In November 2005, WHO conducted a pilot training course for emergency personnel, which was completed by 32 public health and other professionals. WHO's presence in countries is being consolidated by the recruitment of some 60 additional field staff for emergency work, using funds donated to WHO's three-year programme for enhancing the Organization's performance in crises. The training project will be further adapted to the needs of crisis-prone countries, enabling them to develop their own network of experts who can be called upon in the immediate aftermath of emergencies.

Risk monitoring and health assessments

19. The Secretariat is working with Member States and other health partners to use reliable information on health threats, vulnerability factors and performance of local health systems for mitigation, preparedness, response and recovery. An overview of health risks, humanitarian needs and response worldwide is kept up to date. Weekly updates on areas prone to, affected by, or recovering from crises are supplied directly to the United Nations humanitarian early warning system.

20. Risk-mapping, when properly done, can ensure that national emergency-preparedness plans pay due attention to public health. In 2005, staff conducted risk assessments in Nepal, rapid needs assessments in Niger, health-sector analyses in Burundi and the Democratic Republic of the Congo, and crude and under-five mortality surveys in the Darfur region of Sudan and in northern Uganda. WHO is participating in joint needs assessment for recovery in Somalia. The Organization has also been monitoring the health aspects of the deteriorating food situation in the Horn of Africa and has

carried out an in-depth risk assessment in Eritrea. WHO is now launching an intercountry needs assessment, in collaboration with other United Nations agencies.

21. In order to build on successful projects implemented by other United Nations entities, WHO has initiated partnership discussions with WFP concerning the latter's project on vulnerability analysis and mapping. The intention is to adapt the existing platform by adding reliable health indicators and determinants for use in emergency situations in crisis-prone countries.

South Asia earthquake¹

22. Applying the lessons learnt during the earthquake emergency, the Government of Pakistan requested WHO's technical support for the development of a regional centre for emergency preparedness and disaster management. In that connection, a WHO mission visited Pakistan in March 2006 and provided support to national authorities in developing a proposal for the establishment of an institution to focus on applied research, planning, capacity development and emergency coordination tools in crisis settings.

C. CONTROL OF HUMAN AFRICAN TRYPANOSOMIASIS

23. The last meeting of the WHO Expert Committee on Control and Surveillance of African Trypanosomiasis (November 1995) emphasized not only the recrudescence of the disease, with major outbreaks in many countries where it is endemic, but also the dramatic lack of awareness about the situation. The ensuing undersurveillance resulted in approximately 25 000 new cases reported each year, and estimates of the infection level rising to some 300 000 new cases.

24. Since that meeting, however, a number of developments have had an impact on the control of human African trypanosomiasis. For example, the interruption of social upheavals and civil strife in most endemic areas has improved access to people at risk, making it possible to increase control activities. The shortage of financial support for control activities, lack of coordination and standardization of control methods, and the threat of interruption of disease-specific drug production has been partially resolved through an extensive programme financed by a WHO-private sector partnership. Sanofi-aventis provided a long-term supply of pentamidine, melarsoprol and eflornithine, an efficient drug delivery system, and the financial support to build capacity in national programmes and implement active case-finding using appropriate diagnostic tools. Bayer AG donated suramin. Investments have been made in the fight against the disease through bilateral cooperation projects with the Belgian, French and Spanish governments. Several nongovernmental organizations committed themselves to combating the disease through major dedicated projects. WHO's strong advocacy of control of human African trypanosomiasis has substantially increased awareness of the disease within the international community and among national decision-makers in many endemic countries. The Organization has played a significant role in combating the disease, through leadership and implementation of a reinforced network. As a consequence, surveillance activities have increased during the past years, raising the total number of people screened through surveys of active

¹ Details of WHO's response in the immediate aftermath of the earthquake are provided in document EB117/30.

case-finding to about 3 300 000, which in turn has led to a substantial and regular decline in the number of new cases to fewer than 17 000 per year.¹

25. In view of improvements in control, particularly during the past two years, which have led to a substantial reduction in the number of new cases reported each year and a new estimated cumulative rate of some 50 000 to 70 000 cases, the elimination of human African trypanosomiasis as a public health problem could be envisaged. The main challenges currently facing WHO are to maintain awareness, strengthen surveillance and sustain efforts to achieve elimination. Key undertakings for sustaining elimination are WHO initiatives in developing more specific and sensitive tools for diagnosis, such as those carried out in collaboration with the Foundation for Innovative New Diagnostics, and new oral drugs that are safe and simple to administer at different stages of the disease, such as those being funded by the Bill and Melinda Gates Foundation.

26. In accordance with resolution WHA56.7, close collaboration will continue with the Pan African Tsetse and Trypanosomiasis Eradication Campaign, and the joint WHO/FAO/IAEA/African Union Programme Against African Trypanosomiasis.

D. FAMILY AND HEALTH IN THE CONTEXT OF THE TENTH ANNIVERSARY OF THE INTERNATIONAL YEAR OF THE FAMILY

27. As part of WHO's commitment to attaining the United Nations Millennium Development Goals to reduce child mortality and improve maternal health, *The world health report 2005*² and World Health Day this year were dedicated to the health of mothers, neonates and children. The report identifies exclusion as a key feature of inequity and a major constraint on progress towards universal access to care for women and children. It presents new data on causes of neonatal deaths, argues strongly for care continuing both along the life course from mother to newborn to child and across all levels of the health-delivery system from community to referral, and shows that Integrated Management of Childhood Illness is one of the most successful and cost-effective delivery strategies for newborn and child health.

28. To accompany that report, a set of policy briefs has been issued on the most pertinent and potentially difficult aspects.³ These briefs, which had been finalized and highly commended at a high-level policy meeting of representatives of Member States and partners (Geneva, 7-8 March 2005), are being used as a basis for policy discussions at national level.

29. The Partnership for Maternal, Newborn and Child Health, launched in September 2005, brings together existing alliances, thereby uniting developing and developed countries, United Nations agencies, professional associations, academic and research institutions, foundations and nongovernmental organizations. Stakeholders in this unprecedented collaboration will promote universal coverage of the interventions that enable mothers and children to survive. Global partners are working with Member States to set up national-level partnerships to update national policies and

¹ For full details, including a country-by-country review, see *Weekly epidemiological record*, No. 8, 2006, 81: 71-80.

² *The world health report 2005: Make every mother and child count*. Geneva, World Health Organization, 2005.

³ *WHO policy briefs*. 1. *Integrating maternal, newborn and child health programmes*. 2. *Rehabilitating the workforce: the key to scaling up MNCH*. 3. *Access to care and financial protection for all*. 4. *Working with civil society organizations*. Geneva, World Health Organization, 2005.

strategies, assure complementarity and consistency among approaches, and ensure the most effective use of resources.

30. The Secretariat continues to provide guidance on application of the Convention on the Rights of the Child as a legal and normative framework for reducing inequities in child and adolescent health. Guidance is similarly provided on the application of the Convention on the Elimination of All Forms of Discrimination against women and human rights-based approaches for addressing women's health concerns including maternal mortality. WHO staff participate in key health and human rights conferences and workshops, and support is provided to countries for preparing and implementing rights-based assessments and analyses of child health, in particular at district level, and of women's health.

31. Indicators of parental regulation of adolescent behaviour and the strength of the parent-adolescent connection (the emotional bond between the adolescent and a key carer) are being defined for parenting programmes. With the reduction of the incidence of HIV infection in young people being taken as an entry point to the larger field of adolescent health and development, adolescent-specific indicators have also been formulated for HIV prevention programmes, and their use in Member States has been supported.

32. The WHO Multi-Country Study on Women's Health and Domestic Violence against Women is the first research of its kind to gather internationally comparable data on the prevalence of such violence and its effect on women's health. The study also provides information on children witnessing abuse and the impact of this violence on behaviours and school performance. The findings will be used to generate policies and strategies that respond to this global problem. WHO also works with partners to assess and address the impact of gender inequality (including violence) on the HIV epidemic, and to improve the health-sector response to sexual violence, including in the context of crises.

33. Vaccination has a significant role to play in meeting the Millennium Development Goals to reduce child mortality and improve maternal health. Between 1999 and 2004, measles deaths dropped worldwide by almost 50%. Substantial progress has been made in eliminating maternal and neonatal tetanus. Partnerships such as GAVI, the Global Polio Eradication Initiative and the Measles Partnership have enabled immunization services to be brought to even the most hard-to-reach communities. Links between immunization and other health interventions, for example provision of vitamin A supplements and insecticide-treated nets for malaria prevention at immunization points, are increasing. The Global Immunization Vision and Strategy, adopted by resolution WHA58.15, provides the framework for the work of WHO and UNICEF in the area of immunization for the next 10 years.

34. With four million child deaths each year attributable to causes and conditions related to the environment, reducing environmental risks to children's health is one of the most important contributions to attaining the relevant Millennium Development Goals. WHO's programmes on water and sanitation, vector-borne diseases, indoor air pollution, chemical safety, radiation, occupational health, food safety and injury prevention are complemented by its leadership of innovative multi-stakeholder partnerships such as the Healthy Environments for Children Alliance, the Global Initiative on Children's Environmental Health Indicators and the International Network to Promote Household Water Treatment and Safe Storage.

35. The Executive Board at its 117th session reviewed the subject of family and health in the context of the tenth anniversary of the International Year of the Family.¹

E. REPRODUCTIVE HEALTH: STRATEGY TO ACCELERATE PROGRESS TOWARDS THE ATTAINMENT OF INTERNATIONAL DEVELOPMENT GOALS AND TARGETS²

36. Following its endorsement in resolution WHA57.12, WHO's strategy to accelerate progress in reproductive health has been widely disseminated, and both Member States and the Secretariat have implemented a wide range of activities.

37. To monitor implementation of the strategy, the Secretariat sent an assessment tool to all Member States. Responses to date show that the strategy is being used as a comprehensive framework by many Member States in order further to integrate reproductive and sexual health into national development policies by strengthening existing policies and strategies or elaborating new ones. Member States are also using the strategy to identify problems, set priorities, monitor progress towards reproductive health goals, and refine survey instruments for monitoring and evaluation of national programmes. Quality of care in services has been assessed and the strategy has been used in introducing new standards for clinical practice. Some Member States have used it as the basis for measures to provide supplies for reproductive and sexual health care free and ensure security in those reproductive and sexual health commodities.³ Some have also applied the strategy to increase awareness among specific groups and communities, using the mass media for advocacy and health information. Finally, the strategy has facilitated increased collaboration among partners involved in service delivery.

38. Initial conclusions from the assessment highlight three areas of concern: limited access to services by poor people; insufficient action to meet the needs of adolescents; and inadequate working conditions for health-care providers.

39. In order to respond to these concerns, four policy briefs are being finalized, on: financing of services, with emphasis on ensuring universal coverage; meeting the particular needs of adolescents; supportive legislation and removal of regulatory barriers; and integration of the five core components of reproductive and sexual health into health services.

40. Progress in ensuring reproductive health commodity security has been made through the Reproductive Health Supplies Coalition, of which WHO is a member. A draft comprehensive list of essential reproductive health commodities including medicines and devices was drawn up in collaboration with UNFPA. Work has also been undertaken to ensure the inclusion of reproductive

¹ See document EB117/2006/REC/2, summary record of the tenth meeting, section 8.

² Document WHA57/2004/REC/1, Annex 2; the strategy recognizes the crucial role of reproductive and sexual health to social and economic development and targets five priority areas: improving antenatal, perinatal, postpartum and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections, including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promoting sexual health.

³ The term reproductive health commodities refers to all medicines and devices essential for the provision of high-quality reproductive health services.

health medicines on the WHO Model List of Essential Medicines. A process of prequalification of reproductive health commodities is currently being elaborated.

41. *The world health report 2005*,¹ which like World Health Day 2005 was devoted to maternal, neonatal and child health, included the most recent mortality and morbidity estimates, an expert analysis of the obstacles to progress, and comprehensive recommendations for overcoming them. It contributed substantially to the United Nations 2005 World Summit.² Five policy briefs have also been issued. The goal of achieving universal access to reproductive health by 2015 as set out at the International Conference on Population and Development (Cairo, 1994) was included in the outcome document of the Summit.³ In addition, a WHO Goodwill Ambassador for Maternal, Newborn and Child Health has been appointed. Finally, WHO headquarters is hosting the Partnership for Maternal, Newborn and Child Health, launched in September 2005.

42. The benefits of the strategy for national economic development cannot yet be assessed. Based on past experience, however, increased use of family planning, for instance, could be expected to yield positive returns: gains in maternal health and expansion of employment opportunities for women with the potential for the contribution of both parents to the family and national income.

43. Continued progress towards implementation of the strategy will require sustained efforts in high priority areas of work, such as tackling HIV/AIDS prevention and care as a reproductive and sexual health issue, and assessment of the economic impact of the strategy.

44. At its 117th session the Executive Board considered progress towards attainment of international development goals and targets related to reproductive health.⁴ Since then, a framework for use by Member States to implement the strategy has been finalized, in consultation with the regional offices.⁵

F. SUSTAINABLE HEALTH FINANCING, UNIVERSAL COVERAGE AND SOCIAL HEALTH INSURANCE

45. Resolution WHA58.33 urged Member States to develop sustainable health-financing systems that can ensure that all people have access to needed services without the risk of financial catastrophe. It recognized that options to achieve the goal of universal coverage needed to be designed within the macroeconomic, sociocultural and political context of countries and that a variety of options were possible.

46. In response to the resolution, the Secretariat has strengthened and re-focused its work in health-system financing, concentrating on three key questions: how to raise additional funds where they are needed; how to use them effectively, efficiently and equitably; and how to ensure that disadvantaged groups have access to needed services without the risk of financial catastrophe or

¹ *The world health report 2005: Make every mother and child count*. Geneva, World Health Organization, 2005.

² High-level Plenary Meeting of the sixtieth session of the United Nations General Assembly, 14-16 September 2005.

³ Document A/60/L.1.

⁴ See document EB117/2006/REC/2, summary record of the tenth meeting, section 8.

⁵ Document WHO/RHR/06.3.

impoverishment. Information has been disseminated on health-financing policy, tools have been developed to help frame policy and technical support provided to countries.¹

47. Efforts will now be geared to strengthening technical support to countries, building capacity, and collating and disseminating policy-relevant information and tools. Areas covered will include tracking the amounts spent on health, by whom, and for what service; determining the cost of scaling up interventions and programmes and its impact on health status; coordinating financing arrangements (including donor flows) aimed at specific diseases or interventions with the overall health financing system; identifying the economic consequences of disease, and the extent and nature of catastrophic payments for health services; and drawing policies and strategies for contracting in the health sector and for the appropriate design of health financing systems to achieve universal coverage. Discussions are under way with external partners on the best way to meet the increasing demand for technical support at country level.

48. A number of outstanding issues discussed at the Fifty-eighth World Health Assembly will also be tackled during 2006. These include gathering and disseminating evidence on the role of safety nets for the poor (such as exemption and waiver mechanism for fees) and analysing how particular methods for revenue collection, pooling of funds, and purchasing of services (e.g. payroll taxes earmarked for social health insurance, general tax revenues, mixed public/private management of insurance and provision) can be coordinated within a comprehensive health financing policy and strategic plan.

49. The Executive Board noted this progress report at its 117th session in January 2006.²

G. THE ROLE OF CONTRACTUAL ARRANGEMENTS IN IMPROVING HEALTH SYSTEMS' PERFORMANCE

50. Resolution WHA56.25 invited Member States to ensure that contracting in the health sector followed rules and principles that were coherent with national health policy; and to design contractual policies that maximized impact on the performance of health systems and harmonized the practices of all those concerned. Since its adoption, the use of contracting in health systems has increased significantly in developed and developing countries alike. Contracting takes different forms depending on the national context, from the delegation of responsibility (concession, lease contract, better association between private and public sectors, performance contracts between different levels of the system) to the purchase of health services, or contractual relations based on cooperation (franchising, networking, partnerships). Contracts may involve the public sector and both for-profit and not-for-profit entities, or different actors in the public sector. Quite complex arrangements have evolved to organize the relationships among multiple actors in the health sector especially in developed countries.

51. The Secretariat has continued its efforts to define and analyse various approaches to contracting, keeping in mind the practical needs of Member States. Several documents have been prepared, notably on the role of contracting in improving the performance of health systems.³ The regional offices for Europe and for the Western Pacific have also prepared several documents related to contracting,

¹ See document EIP/HSF/HFP/2005.1 for further details.

² See document EB117/2006/REC/2, summary record of the tenth meeting, section 8.

³ Document EIP/FER/DP.E.04.1.

especially with regard to the purchase of health services. These different documents were presented in several international workshops and seminars, then disseminated widely.

52. Support has been provided to several countries for national workshops, where information on the different forms of contracting was presented to a variety of stakeholders (government, nongovernmental organizations, private sector, etc.), and has been continued as countries develop their own strategies to incorporate contracting in their health systems where appropriate. The Regional Office for the Eastern Mediterranean undertook studies on contractual arrangements in 10 countries, and organized a workshop in April 2005 to draw up an inventory of progress and a regional strategy for the use of contracting arrangements. Special attention has been given to providing support to countries that have decided to frame national policies on contracting, including Burkina Faso, Chad, Madagascar, Mali, Morocco and Senegal.

53. In collaboration with ILO and the World Bank Institute, WHO organized several intercountry workshops in the African Region, to which African training institutions contributed their teaching skills. They aimed at reinforcing the technical capabilities of those using contracting instruments, to date, mostly responsible staff in ministries of health, nongovernmental organizations and micro-insurance schemes. One of these workshops was particularly designed to transfer knowledge and exchange experience of the design of national contracting policies.

54. An internet site focusing on contracting in health systems is now in operation, which allows users to access several documents on contracting, to find information on forthcoming events and training workshops and, importantly, to share their field experiences.¹

55. In order to continue sharing information on experiences related to contracting, a special issue of the *Bulletin of the World Health Organization* is scheduled to appear towards the end of 2006.

56. In the period 2006-2007 particular emphasis will be laid on assessment of innovative experiences in terms of access, efficiency, quality and equity. In addition, sufficient time has now elapsed since the first policies were introduced to warrant an evaluation of some of them in order to determine whether the strategies adopted have improved the efficiency of health systems, and allowed for their more balanced development.

57. The Executive Board noted this progress report at its 117th session in January 2006.²

H. STRENGTHENING NURSING AND MIDWIFERY

58. The health workforce was the focus of World Health Day 2006 and of *The world health report 2006*.³ All future activities to strengthen nursing and midwifery will be implemented in the broad context of WHO strategies for the health workforce. This report highlights some of the accomplishments in response to resolution WHA54.12.⁴

¹ www.who.int/contracting (in English and French).

² See document EB117/2006/REC/2, summary record of the tenth meeting, section 8.

³ *The world health report. Working together for health*. Geneva, World Health Organization, 2006.

⁴ See document WHO/EIP/HRH/2006 for details.

Global shortage of nursing and midwifery personnel

59. Support was provided for multidisciplinary meetings by the regional offices for Africa, the Americas, South-East Asia and the Western Pacific to discuss the worldwide health-workforce shortage and to recommend regional strategies to mitigate it. Studies were conducted in the African Region, the Americas and the Western Pacific Region to identify ways to reduce outflows related to health-workforce migration.

Contribution of nurses and midwives to improved health services

60. In the African Region, representatives of 11 English-speaking countries with high maternal-mortality rates drew up strategies to strengthen the education, regulation and practice of midwifery. The Regional Office for Europe has developed curricula for continuing education in nine areas of work.¹ The Regional Office for the Eastern Mediterranean is working to strengthen nursing, midwifery and allied health institutions in order to improve response to complex emergencies and post-conflict situations.

61. The introduction of district-level family health nurses in the European Region has resulted in better health-service provision,² and nurse-driven approaches to HIV care in the African Region has increased access to HIV antiretroviral therapy.

62. WHO continued to provide support for the network of 40 collaborating centres on nursing and midwifery development. An additional 33 institutions, mostly in developing countries, have been identified for designation.

Integrated programming and support for skilled birth attendants

63. In 2004 WHO convened a forum of government chief nursing and midwifery officers, attended by representatives of 40 countries, that proposed mechanisms to enhance implementation of national and regional health priorities through use of leadership skills.

64. Support was provided for regional consultations on human resources for health, with significant involvement of nursing and midwifery leaders, in the Western Pacific (2004) and South-East Asia (2005). Those organized in Africa and the Americas (2005) had inadequate representation of nursing or midwifery leaders, prompting some Member States to call for a global consultation on nursing and midwifery.

65. Globally, 45 countries have benefited from leadership projects implemented by the International Council of Nurses with technical support from WHO. A similar project targeting young midwives is being implemented by the International Confederation of Midwives.

66. The joint statement, *Making pregnancy safer: the critical role of the skilled birth attendant*, issued by WHO, the International Confederation of Midwives and the International Federation of

¹ *Nurses and midwives: a force for health. WHO European strategy for continuing education for nurses and midwives, 2003.* Copenhagen, WHO Regional Office for Europe, 2003.

² See *Fourth Workshop on WHO Family Health Nurse Multinational Study: Intercountry Evaluation. Report on a WHO workshop, Glasgow, Scotland, 20-21 January 2005.* Copenhagen, WHO Regional Office for Europe, 2005.

Gynaecologists and Obstetricians, highlights the importance of a skilled birth attendant in reducing maternal and infant morbidity and mortality rates.¹

Plan of action and coordination between all agencies and organizations

67. WHO's *Strategic directions for strengthening nursing and midwifery services* forms the basis for operationalizing activities on strengthening nursing and midwifery services in countries.² The Regional Office for Africa has drawn up guidelines to support countries on implementing the strategic directions.

The Global Advisory Group on Nursing and Midwifery

68. WHO has continued to provide support to the Global Advisory Group on Nursing and Midwifery through meetings and regular teleconferences. The Group has provided policy advice and support for the establishment of a task force to work more closely with the Secretariat in integrating nursing and midwifery in health policies and services.

Systems of uniform performance indicators

69. A global survey is currently being conducted that will establish baseline information in the key result areas of the *Strategic directions* by WHO and its partners. A follow-up study will be conducted in 2008. Global mapping of mental health and midwifery services is under way for use by Member States in planning and implementing targeted programmes.

ACTION BY THE HEALTH ASSEMBLY

70. The Health Assembly is invited to take note of this report.

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¹ *Making pregnancy safer: the critical role of the skilled attendant. A joint statement by WHO, ICM and FIGO.* Geneva, 2004.

² *Nursing and midwifery services: strategic directions 2002-2008.* Geneva, World Health Organization, 2002.