

Progress reports on technical and health matters

Report by the Secretariat

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A. POLIOMYELITIS: MECHANISM FOR MANAGEMENT OF POTENTIAL RISKS TO ERADICATION (resolution WHA61.1)

1. At an urgent stakeholders consultation of the Global Polio Eradication Initiative in February 2007 participants agreed on a 24-month intensified eradication effort with specific indicators to monitor progress. In May 2008, the Health Assembly in resolution WHA61.1 urged all remaining poliomyelitis-affected Member States to engage all levels of political and civil society to ensure that every child is consistently reached and vaccinated during every supplementary immunization activity against poliomyelitis. It also urged Nigeria to undertake intensified activities to stop rapidly the outbreak of poliomyelitis in the north of the country, and Afghanistan, India and Pakistan to implement large-scale mopping-up activities to interrupt their final chains of poliovirus transmission. The Health Assembly requested the Director-General to assist in mobilizing the financial resources necessary for full implementation of the intensified eradication effort, to undertake the necessary research for managing the long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis and to develop a new strategy to reinvigorate the fight to eradicate poliomyelitis from the remaining affected countries.

2. In June 2008, the Minister of Health in Nigeria established a high-level task force in order to improve the quality of supplementary immunization activities. Two such activities were urgently undertaken across the northern states in July and August 2008. Although the large outbreak of the disease experienced in 2008 has subsided, monitoring indicates that significant gaps in coverage of these immunization activities persist, with more than 60% of children remaining not fully vaccinated (having received three or fewer doses of oral poliovirus vaccine). Because of a continuing outbreak caused by a type 2 vaccine-derived poliovirus, northern Nigeria is the only area in the world where all three poliovirus serotypes are circulating. Since June 2008, polioviruses originating in northern Nigeria have spread to Benin, Burkina Faso, Chad, Côte d'Ivoire, Ghana, Mali, Niger and Togo.

3. In October 2008, India confirmed that indigenous type 1 poliovirus had not been detected in Uttar Pradesh state for 12 consecutive months, affirming the technical feasibility of poliomyelitis eradication. However, a new outbreak due to type 1 poliovirus in western Uttar Pradesh, following importation of the virus from Bihar state in mid-2008, has highlighted the fragility of progress because of the suboptimal efficacy of oral poliovirus vaccine in this area. Mopping-up activities with monovalent oral poliovirus vaccines continue on average every six weeks in western Uttar Pradesh and central Bihar. New approaches to enhancing vaccine efficacy are being assessed in order to accelerate eradication in northern India. In December 2008, type 1 poliovirus originating in western Uttar Pradesh, was detected in a sewage sample in Cairo.

4. In Pakistan, and to a lesser extent Afghanistan, the number of poliomyelitis cases surged in the second half of 2008 as a deterioration in security resulted in large-scale population movements and outbreaks in poliomyelitis-free areas, particularly in the Punjab province of Pakistan. In late 2008 and early 2009 Pakistan increased the number of nationwide supplementary immunization activities to supplement mopping-up activities in known reservoir areas, such as Sindh province where coverage during supplementary immunization activities was suboptimal. By early 2009 poliomyelitis was largely restricted to areas where insecurity hampers supplementary immunization activities, notably North-West Frontier Province in Pakistan and three of Afghanistan's 34 provinces (all three are in that country's Southern Region). This reality was underscored by the deaths in 2008 of two doctors and their driver on WHO duty for poliomyelitis eradication, in Kandahar province, Afghanistan.

5. Responses to outbreaks are continuing in 16 countries where there are cases associated with the importation of poliovirus in 2008 and early 2009. It is a matter of concern that 12 of these countries have become reinfected since mid-2008, demonstrating that international spread of poliovirus is continuing. Three of the outbreaks have continued for more than 12 months because response activities have been suboptimal:¹ Angola, Chad and Ethiopia and border areas in southern Sudan. Although the risk of poliovirus importation remains high globally, 90 Member States have not maintained certification-standard surveillance for acute flaccid paralysis, as requested for global certification, and 39 have not maintained routine immunization coverage with oral poliovirus vaccine at more than 80%, as recommended in resolution WHA61.1.

6. In order to reduce the risk of international spread of poliovirus, in November 2008 the Advisory Committee on Poliomyelitis Eradication urged WHO to amend its recommendations on immunization against poliomyelitis in *International Travel and Health*,² to ensure that all travellers to and from countries affected by poliomyelitis are fully immunized. Travellers who are resident in an area affected by the disease are recommended to receive an additional dose of oral poliovirus vaccine between one and 12 months prior to each international journey.

7. Resource mobilization activities have been enhanced in order to sustain the intensified eradication effort in 2009–2010. In 2008, countries where poliomyelitis was endemic and a range of new and existing donors provided additional funding for eradication activities, with important new multi-year commitments by Rotary International, the Bill & Melinda Gates Foundation and several G8 countries, the latter following a renewed commitment to poliomyelitis eradication by G8 leaders at the 2008 Summit (Hokkaido, Toyako, Japan, 7–9 July 2008). Rigorous resource mobilization activities will continue in order to ensure full funding of the intensified eradication effort. As at 27 February 2009, the Global Polio Eradication Initiative had a global funding gap for the period 2009–2010 of US\$ 340 million, against a budget of US\$ 1340 million.

8. New research on the management of the long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis includes: the development, field-testing and introduction of a real-time polymerase chain reaction test for more rapid detection of circulating vaccine-derived polioviruses; eight studies to characterize better the risks of chronic immunodeficiency-associated excretion of vaccine-derived polioviruses in low- and middle-income countries; investigation of the use of adjuvants and strategies to decrease doses and compress vaccination schedules in order to reduce the cost associated with existing inactivated poliovirus vaccines; and, a clinical development project for the production of an inactivated poliovirus vaccine using Sabin-strain polioviruses.

9. As a basis for a renewed fight to eradicate poliomyelitis, the Global Polio Eradication Initiative has developed a new strategic plan for 2009–2013. The plan consolidates the proven eradication strategies and recently-developed tools and tactics (i.e. monovalent oral poliovirus vaccines and their use), with new and country-specific initiatives to respond to the primary challenges in each remaining area affected by poliomyelitis.² These new initiatives include the following: development of new vaccines (e.g. bivalent oral poliovirus vaccine); novel use of existing vaccines in areas where the efficacy of oral poliovirus vaccines is compromised (i.e. higher-titre monovalent oral poliovirus vaccine type 1 and inactivated poliovirus vaccines); targeted use of seroprevalence surveys to assess vaccine efficacy and programme effectiveness more accurately; short interval additional dose strategies

¹ With respect to the activities Member States were urged to undertake in resolution WHA59.1.

² Conclusions and recommendations of the Advisory Committee on Poliomyelitis Eradication, November 2008. *Weekly Epidemiological Record*, 2009, **84**(3): 17–28.

to deliver extra vaccine doses to communities living in security-compromised areas; ensuring the continuation of annual oral poliovirus vaccine campaigns in areas subject to recurrent importations; and full implementation of the commitments of state governors in northern Nigeria outlined in their communiqué of 2 February 2009 entitled the “Abuja Commitments to Polio Eradication in Nigeria”.¹

10. In October 2008, the Director-General announced the commissioning of an independent evaluation of the intensified eradication effort at its 24-month mark in March 2009. After consultation with stakeholders in the Global Polio Eradication Initiative, the evaluation will focus on the principal affected areas, giving particular attention to the primary challenges identified in each,² and will establish a common roadmap for the actions needed in order to achieve the 2009 and 2010 milestones of the Global Polio Eradication Initiative Strategic Plan 2009–2013.

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

11. The present document reports on the tenth meeting of the WHO Advisory Committee on Variola Virus Research (Geneva, 19 and 20 November 2008) and on the work of the Secretariat. In resolution WHA60.1, the Health Assembly requested the Director-General to undertake a major review in 2010 of the results of the research undertaken in accordance with the terms of resolution WHA55.15, so that the Sixty-fourth World Health Assembly may reach global consensus on the timing of the destruction of existing variola virus stocks.

12. **Update on research proposals submitted to WHO.** The Advisory Committee received a list of research proposals currently approved by its scientific subcommittee. Overall, 18 work programmes have been approved. For the major review of variola virus research in 2010, research projects that are in progress should be concluded, with an extension being considered only after the review has been finalized; that does not preclude submission of research proposals but it does mean that clear research goals are vital for enabling assessment of such proposals.

13. **Virus strains in the two repositories.**³ The Committee reviewed data on the variola virus strains and primary isolates held in the two collections. The planned introduction of a new biosafety level 4 laboratory at the Centers for Disease Control and Prevention in the United States of America in 2009 will increase capacity for research. Since the previous report to the Committee,⁴ there have been no additions to or withdrawals from the long-term repository, but material was withdrawn from the laboratory stocks for work on agreed research protocols. At the VECTOR centre in the Russian Federation a new repository with high physical security has been created. During the past year, 200 working stocks of non-viable or duplicate material have been destroyed, bringing the total number of vials in the Russian repository to 691.

¹ Accessible online at www.polioeradication.org.

² Conclusions and recommendations of the Advisory Committee on Poliomyelitis Eradication, November 2008. *Weekly Epidemiological Record*, 2009, **84**(3): 17–28.

³ Russian State Centre on Virology and Biotechnology (VECTOR), Koltsovo, Novosibirsk Region, Russian Federation and the Centers for Disease Control and Prevention, Atlanta, Georgia, United States of America.

⁴ Document EB122/29 Add.1, section E.

14. **Update on prophylaxis and therapeutics.** The Committee was informed of progress in research into chimeric chimpanzee/human monoclonal antibodies. Combinations of antibodies fully protected mice challenged with vaccinia virus and were also active therapeutically. Recent advances in the development of antiviral agents against orthopoxviruses include the synthesis and testing of a series of compounds for antiviral activity in cell culture against various orthopoxviruses; 74 compounds from three groups proved to be active, and it is planned to extend this research to cowpox virus and ectromelia virus in mice. The orally-administered prodrug of cidofovir, CMX001, and a series of other compounds are currently being investigated. Further pharmacokinetic studies of oral administration of ST-246 have been conducted in order to establish appropriate doses, which have been shown to be effective in the monkeypox primate model. ST-246 was made available for emergency (compassionate) use in 2007 for the treatment of a clinical case of eczema vaccinatum and the manufacturer would consider direct requests in the case of a further requirement for such use.

15. **Update on diagnostic assays.** The Committee was informed of recent developments in diagnostic assays. Two assays, both based on real-time polymerase chain reaction, were designed for field use; one differentiated variola virus from other orthopoxviruses and the other distinguished between variola major and minor. Information on both the assays is in the public domain. Another avenue of research has been the development of protein-based “point-of-care” diagnostic assays for antigen and antibody detection. Pilot studies of a serological assay conducted in field conditions in the Democratic Republic of the Congo confirmed the robustness of the assay. The Committee noted the potential application of these diagnostic systems in the field, as long as they were affordable and available.

16. **Update on animal models.** The Committee was informed of the results of five years of primate model development authorized by WHO to facilitate the evaluation and licensing of antiviral drugs and vaccines using the Animal Efficacy Rule of the Food and Drug Administration in the United States of America. These models simulated human smallpox but could be improved by mimicking more natural routes of exposure. Additional enhancements were described but, although parallels between monkeypox and smallpox exist, the Committee heard conflicting views on the utility of monkeypox as an adequate surrogate for variola. Significant progress has been made, but further refinement of the animal models is desirable.

17. **Update on vaccines and vaccination.** The Committee was told about the results of experiments using live variola virus as the target of plaque-reduction neutralization tests in the evaluation of different vaccination regimens. The data suggest that such tests may be important for evaluating smallpox vaccines. The Committee was also updated about the attenuated vaccinia vaccine LC16m8, which is being stockpiled in Japan and may confer long-lasting protective immunity in humans. The Committee noted several advantages of LC16m8, and it was argued that LC16m8 had not received sufficient attention as a less reactogenic smallpox vaccine.

18. **Regulatory issues.** An overview was given of current strategies to improve the safety of the smallpox vaccine while maintaining its efficacy. In the United States of America, the Food and Drug Administration’s Center for Biologics and Research requires that any new candidate vaccine demonstrate efficacy in multiple animal models of smallpox but not necessarily in a model infection with variola virus. Use of live variola virus would, however, be desirable, in terms of expediting the review process, and would be needed for the evaluation of new antiviral agents. It was argued that the usefulness of non-variola animal models should not be underestimated and that they should be fully exploited. Other members stressed that a better understanding of the correlates of immunity or pathogenesis may be required for the evaluation of new candidate vaccines and therapeutics.

19. **Is there a need to stockpile ST-246?** The Secretariat informed the Committee that its previous report had generated interest among Member States, in particular regarding access to antiviral agents. The Committee considered that it would be premature to establish a WHO stockpile of any drug that had so far shown promising activity in animal models of variola but did not yet have approval for use by drug regulatory authorities. An in-depth evaluation of potential epidemiological scenarios would be required to estimate the need for drugs when they were approved. The Secretariat would act as a facilitator between potential users and the company in the case of a requirement for emergency compassionate use of ST-246.

20. **Synthesis of variola virus.** The Committee was given a brief review of the literature which suggested that currently available technology could allow the recreation of a full-length variola virus genome solely by chemical synthesis, as has been done for other larger microorganisms. The Secretariat reminded the Committee that WHO had published guidelines¹ on the use of fragments of variola virus DNA that strictly excluded the synthesis of the virus. Members of the Committee were strongly encouraged to promulgate these guidelines widely, not just in the orthopoxvirus research community but also among policy-makers and other researchers.

21. **Review of research proposals.** The Committee accepted the suggestion that the Scientific Subcommittee should be expanded to seven members, approved its new membership, and agreed to mechanisms for increasing its efficiency.

22. **Review in 2010 and process.** The Committee reviewed the timetable necessary to undertake the major review in 2010 and decided to consider the following steps: (1) a comprehensive review of the literature and of unpublished data concerning live variola virus research to be undertaken by a group of scientists endorsed by the Committee and representing all areas of research and development on orthopoxviruses; (2) the consideration by the Advisory Committee of the above-mentioned reviews; (3) an external review of the above-mentioned reviews to be undertaken by independent experts from outside the field of variola virus research; and (4) the preparation of a report on the major reviews for the final consideration by the Advisory Committee. A report from the Secretariat would be submitted to the Executive Board for consideration at its session in January 2011 and that report and the Board's comments would be further considered by the Sixty-fourth World Health Assembly. The Committee agreed that the state-of-art review should target a broad range of readers and cover the following subjects: the current state of the variola virus stocks and repositories, diagnostics, genomics, vaccines, therapeutic agents, animal models and pathogenesis, and benefits. The final review by the Advisory Committee should also feature policy issues, such as how to respond to and manage outbreaks and the regulation of relevant biologics and drugs, with final conclusions and recommendations about the way forward.

23. **Variola virus diagnostic network.** The Committee discussed the possible need for a WHO informal network of laboratories for smallpox confirmatory diagnostics and considered that such a network would be important; additional details were needed on criteria for membership, quality management, and diagnostic testing. A specific concern was to limit the culturing of potentially infectious material. The Committee also considered how to formalize such a network, in particular verification of smallpox diagnostic capabilities with the involvement of the two WHO Collaborating Centres for smallpox, but no criteria were determined.

¹ *Weekly Epidemiological Record*, 2008, **83**(44): 393.

24. The Executive Board noted the progress report at its 124th session in January 2009.¹

25. In March 2009 a WHO biosafety team undertook an inspection of the authorized repository in the Centers for Disease Control and Prevention (Atlanta, Georgia, United States of America). The team was impressed with the security and safety arrangements, and made some recommendations, which were to be seen as contributing to a process of continuous improvement. The report of the mission is being finalized and will, as requested in resolution WHA60.1, be made available for public information.

C. MALARIA, INCLUDING PROPOSAL FOR ESTABLISHMENT OF WORLD MALARIA DAY (resolution WHA60.18)

26. WHO convened a panel in January 2008 to examine the technical issues underpinning malaria control and to review the feasibility of eradicating the disease. The achievements of the past few years demonstrate that, with a rapid expansion of effective antimalarial interventions, malaria-related morbidity and mortality can be significantly reduced within a relatively short period of time in all epidemiological situations. However, malaria cannot be eradicated with existing tools. The Secretariat is proposing that a meeting of the WHO Expert Committee on Malaria be convened in 2010 in order to make technical recommendations on malaria control and elimination.

27. WHO has worked at all levels with partners such as UNICEF, the World Bank Global Strategy and Booster Program, the Malaria Initiative of the President of the United States of America, and the Roll Back Malaria Harmonization Working Group in order to support countries prepare applications to Rounds 7 and 8 of the Global Fund to Fight AIDS, Tuberculosis and Malaria. This support had an unprecedented result: some 70% of country applications for funding on malaria control and elimination were successful.

28. The United Nations Secretary-General announced the appointment of Mr Raymond G. Chambers of the United States of America as his Special Envoy for Malaria and issued a call to action on the goal of providing universal coverage of key malaria interventions to Africa by the end of 2010, and to reduce preventable malaria deaths to near zero by 2015.

29. Events took place worldwide to celebrate the first global World Malaria Day on the theme of *Malaria – a disease without borders*, with the support of all WHO regional offices. World Malaria Day was an ideal platform for countries and regions to encourage greater awareness and to ensure that advocacy is sustained in all regions.

30. On 18 September 2008, the Director-General launched the *World malaria report*,² which noted an estimated 247 million cases of malaria and 881 000 deaths from the disease in 2006, mostly among children in Africa. A total of 91% of deaths were in Africa and 85% of deaths were in children under five. Yet the report provided strong evidence that a renewed global assault on malaria, under way since the turn of the millennium, has been accelerating in the past few years. Further integration of existing strategies will help to achieve the goals.

¹ See document EB124/2009/REC/2, summary record of the twelfth meeting, section 4.

² *World malaria report 2008*. Geneva, World Health Organization, 2008.

31. The Roll Back Malaria Partnership launched the Global Malaria Action Plan at the 2008 United Nations Millennium Development Goals Malaria Summit.

32. International funding commitments to the Global Malaria Action Plan in 2008 included US\$ 1620 million over two years from the Global Fund with a plan to distribute 100 million additional bednets; US\$ 1100 million from the World Bank; US\$ 168.7 million from the Bill & Melinda Gates Foundation for vaccine research; and £40 million from the United Kingdom of Great Britain and Northern Ireland, which includes support for artemisinin combination therapy.

33. The following major constraints on resources and capacity continue to require attention.

- Inadequate funding for malaria control remains an issue in some countries where there is a lack of domestic funds or a failure to appropriately manage the available funds.
- In countries where malaria is endemic, more human resources are required to ensure that national malaria control programmes have the necessary managerial and technical capacities to deliver interventions.
- Requests for technical support are increasing but are not matched by sufficient funding. As a result, WHO and its partners are facing the crucial challenge of maintaining adequate human resources to respond to countries' needs.
- A major effort to increase the capacity of health systems should be extended beyond the health facility level in order to empower communities to achieve treatment and prevention goals.
- With malaria incidence and deaths decreasing in many places, there is an additional demand on surveillance systems to monitor progress.
- Resources are required to support research into improved formulations of artemisinin-based combination treatments, particularly those for children, and into new combination medicines.

34. The Executive Board at its 124th session noted the progress report.

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

35. The 20th UNAIDS Programme Coordinating Board (Geneva, 25–27 June 2007) called for the establishment of a reference group for oversight and implementation of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors. WHO was appointed to the Global Task Team Oversight Reference Group to represent the 10 UNAIDS cosponsors.

36. The Secretariat has continued to work with countries to improve planning for national HIV/AIDS responses, including the development of national health-sector plans on HIV/AIDS that are aligned with the UNAIDS AIDS Strategy and Action Plan, the International Health Partnership and related processes, including International Health Partnership Plus (IHP+). The process has provided support to more than 40 countries in developing costed, multisectoral national HIV plans.

37. WHO has participated in the latter process in order to assist in development of the model of the Global Fund to Fight AIDS, Tuberculosis and Malaria for programmatic funding for countries through national strategy applications.

38. WHO has reviewed its work on HIV to bring it in line with the UNAIDS Division of Labour matrix. To better define its scope of work, WHO has developed a guide on priority health sector interventions for HIV/AIDS prevention, treatment and care. The guide summarizes WHO's policy and technical recommendations for each intervention, and provides references to the Organization's resources and other materials in order to support decision-making and implementation.

39. WHO has been working with UNICEF and UNAIDS to harmonize indicators and monitoring and evaluation systems in order to measure progress in scaling up of health sector interventions in countries, and reports annually on the global situation. Member States have been supported in implementation of their national monitoring frameworks and WHO has participated in the joint evaluation of national HIV responses and programmes in a range of countries.

40. The UNAIDS Division of Labour matrix has been revised to clarify the roles of different cosponsors in the following areas: gender; sexual minorities, including men who have sex with men; and HIV in humanitarian emergency and security settings. WHO, in collaboration with UNDP and UNAIDS has intensified its work on matters concerning men who have sex with men. In September 2008 WHO's Secretariat held a consultation in Geneva on prevention, treatment and care of HIV/AIDS and sexually transmitted infections among men who have sex with men.

41. By the end of October 2008, Joint United Nations Teams on AIDS had been established in 89 countries. WHO has contributed to the development of an annual review process for monitoring the performance of the Teams.

42. The Global Joint Problem Solving and Implementation Support Team reformulated its Terms of Reference in 2007 to focus on global-level issues that affect the implementation of programmes at country level. It has developed a set of principles for technical support. A global-level, web-enabled database, known as Coordinating AIDS Technical Support, has been established; it is designed to improve planning and coordination of technical support to countries, including implementation of grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

43. WHO's Secretariat has strengthened its technical support to countries in order "to make the money work". A working group has been established to coordinate WHO's technical support in order to allow countries to access and implement grants from the Global Fund. For example, WHO country offices provided support to all 72 countries that submitted HIV/AIDS proposals to the Global Fund for the Round 8 call for proposals. In addition, WHO participated in technical support missions to 52 countries for the development of proposals, including joint missions with ILO, UNICEF, UNFPA and UNAIDS.

44. WHO is establishing networks of technical partners, including WHO collaborating centres, WHO knowledge hubs and others, to provide coordinated technical assistance for priority health sector interventions. As a first step, the Regional Office for the Western Pacific hosted a regional meeting of collaborating centres and technical partners in December 2008 in order to plan for the establishment of a WHO technical network on HIV and health for the Western Pacific Region. A global meeting of collaborating centres, knowledge hubs and other technical partners is planned for the first half of 2009.

45. Funding for technical support has not kept pace with the demand from countries and partners. Planning for the UNAIDS' 2010–2011 Unified Budget and Workplan will need to refocus resources in order to provide adequate funding for technical support to countries and ensure full alignment with the UNAIDS Division of Labour.

46. The Executive Board noted an earlier version of this report at its 124th session in January 2009.

E. PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED INFECTIONS (resolution WHA59.19)

47. From 2006 to date, the Global strategy for the prevention and control of sexually transmitted infections 2006–2015 has been presented at international, regional and national conferences, and an action plan to guide its implementation has been produced in consultation with countries and stakeholders.

48. Globally, 28 countries have reported that they had strengthened diagnosis and treatment of sexually transmitted infections and had updated national treatment guidelines. Thirty trainers from 10 Pacific island Member States were trained in management of sexually transmitted infections at a training of trainers course, held in Suva in October 2008.

49. Screening for syphilis during pregnancy has been scaled up in Brazil, China, Haiti, Indonesia, Myanmar, Madagascar, Mozambique, Papua New Guinea, Peru and Sri Lanka. The Caribbean initiative for elimination of vertical transmission of HIV and syphilis was agreed upon and will be launched in 2009. Some countries in Latin America have designated a national day for elimination of congenital syphilis. In support of these two initiatives, WHO has disseminated the rationale and strategy for elimination of congenital syphilis.

50. A post at WHO headquarters intended to guide surveillance activities at the global level has received the required funding. The process to fill the post has begun. An updated WHO guide for surveillance is expected to be published in early 2009.

51. Monitoring of antimicrobial resistance in *Neisseria gonorrhoeae* was improved in countries of the Western Pacific and South-East Asia Regions; plans are complete for monitoring in Africa, the Caribbean and South America.

52. The Western Pacific Region standardized definitions and the minimum data set for case reporting of sexually transmitted infections. In the European Region, management training in surveillance of sexually transmitted infections was added to the tasks of the Surveillance Knowledge Hub for HIV at the WHO Collaborating Centre in Croatia. A situation analysis of sexually transmitted infections was conducted in nine countries of the Eastern Mediterranean Region. In Latin America, 20 countries reported that they had undertaken analysis of national policies on prevention and control of sexually transmitted infections. A report on the results of the analysis, in English and Spanish, will be posted on the WHO web site. Participating countries have committed to implement action on sexually transmitted infection control and congenital syphilis elimination.

53. Based on the 100% condom use programmes in Asian and Pacific countries, initiatives have been launched in Africa to improve control of sexually transmitted infections and increase use of condoms by sex workers. Viet Nam initiated periodic presumptive treatment to control sexually transmitted infections in two sites with a target population of 33 000 sex workers and men who have sex with men.

54. WHO, with UNDP and UNAIDS as cosponsors, convened a consultation on men who have sex with men and the prevention and treatment of HIV and other sexually transmitted infections (Geneva, September 2008). WHO and the cosponsors highlighted the urgency of scaling up interventions and strengthening surveillance within this population group.

55. The online Human Papillomavirus Vaccine Global Community¹ was launched in 2008 as a forum to exchange knowledge of and resources for vaccines. Cervical cancer screening using visual inspection with acetic acid and cryotherapy are being scaled up in Madagascar, Malawi, Nigeria, Uganda, United Republic of Tanzania and Zambia. WHO has published four guides for prevention of cervical cancer and information on human papillomavirus vaccines. These can be found on the WHO web site.

56. At the regional level, the Regional Strategy for the Prevention and Control of Sexually Transmitted Infections 2007–2015 for the South-East Asia Region and the Regional Strategic Plan for the Prevention and Control of Sexually Transmitted Infections 2008–2012 for the Western Pacific Region were published. The Asia-Pacific Operational Framework for Linking HIV/STI Services with Reproductive, Adolescent, Maternal, Newborn and Child Health Services was published in 2008. These publications can be found on the respective WHO regional web sites. The Regional Strategy for the Prevention and Control of Sexually Transmitted Infections 2009–2015 was endorsed by the Regional Committee for the Eastern Mediterranean in October 2008. The PAHO Regional Strategy and Plan of Action for Cervical Cancer Prevention and Control was presented to the Regional Committee for the Americas in September 2008. Regional action plans for prevention and control of sexually transmitted infections for the European and African Regions are in preparation.

57. The Executive Board at its 124th session in January 2009 reviewed and noted the Secretariat's report on the subject; reference was made to the importance of controlling sexually transmitted infections for improved sexual and reproductive health and the prevention of HIV infection.

¹ <http://hvpv-vaccines.net>.

F. STRENGTHENING OF HEALTH INFORMATION SYSTEMS (resolution WHA60.27)

58. WHO and the Health Metrics Network have continued to support the strengthening of health information systems with a range of activities, reviews and consultations involving all levels of the Organization. WHO is a major partner in the international statistical system and in all its work promotes adherence to the principles governing international statistical activities.¹ WHO has continued to contribute to the strengthening of health information systems through the following: the development of an integrated system for information flow, based on common standards for data and indicators; advocacy for and commitment to the principles of sharing data and statistics and of access thereto; collaboration with country and global partners to enhance the efficiency and effectiveness of international investments; and the provision of technical support for improved performance monitoring and evaluation practices, in accordance with the common evaluation framework principles of the International Health Partnership Plus.²

59. In support of the International Health Partnership Plus, WHO has developed an evaluation framework to help improve monitoring and evaluation across the different activities to tackle specific diseases and strengthen health systems, and to provide the basis for international reporting. The framework aims to ensure that the demands for accountability and results from single-donor and joint initiatives are translated into well-coordinated monitoring and evaluation efforts. The framework also encourages importance to be given to working in ways that contribute to the strengthening of organizational capacity and health information systems within countries, thus enabling evidence-informed decision-making and improved country performance.

60. In its support to the strengthening of national health information systems, the Secretariat's priorities include the following: the strengthening of health surveys (with a particular focus on adult health); the improvement of birth and death registration through high-level political advocacy; the elaboration of tools and methods for improving death registration and cause of death attribution; the improvement of surveillance and service statistics; the development and implementation of standards and guidelines for disease surveillance (in line with obligations under the International Health Regulations (2005)); the monitoring of health systems strengthening, and the strengthening of national capacity for analysis and use of information.

61. WHO and the Health Metrics Network have provided continuing support for the updating of the *Framework and standards for country health information systems*. The Framework continues to evolve in the light of countries' and partners' experiences, including the Health Metrics Network's work on implementation in six Wave One Countries (Belize, Cambodia, Ethiopia, Sierra Leone, Syrian Arab Republic and Zambia).³

¹ The principles are accessible online at http://unstats.un.org/unsd/methods/statorg/Principles_stat_activities/principles_stat_activities.pdf.

² *Framework and standards for country health information systems*, 2nd ed. Geneva, World Health Organization, 2008.

³ Wave One Countries are priority countries for funding and technical support from the Health Metrics Network.

62. The Health Metrics Network has provided support to 64 countries in undertaking assessments to identify gaps in their health information systems, with 37 countries now at advanced stages of preparing costed, long-range plans to close the gaps. In addition, more than US\$ 158 million in new funding have been mobilized for strengthening country information systems.
63. A review of 65 countries in July 2008 found in-country coordination of health information systems had improved. In particular, countries have reported improved collaboration between national statistical offices and health ministries. Better coordination will reduce fragmentation and help to foster a “one-country” health information system. Countries also reported an increase in the allocation of domestic resources for health information system strengthening between 2006 and 2008.
64. WHO regional and country offices and the Health Metrics Network have jointly supported 12 countries in preparing applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria to finance health information system interventions in Round 8. Similar support to countries is planned for the Global Fund’s call for proposals for Round 9.
65. An earlier version of this progress report was noted by the Executive Board at its 124th session in January 2009.

G. WORKING TOWARDS UNIVERSAL COVERAGE OF MATERNAL, NEWBORN AND CHILD HEALTH INTERVENTIONS (resolution WHA58.31)

66. Maternal, newborn and child health interventions have helped to decrease under-five deaths from 10.3 million in 2004 to 9.5 million in 2006. Measles deaths alone fell from 757 000 in 2000 to 242 000 in 2006. Maternal mortality remained stable between 1990 and 2005, although no Region achieved the necessary 5.5% annual decline to meet United Nations Millennium Development Goal 5. In sub-Saharan Africa annual rates of decline in maternal and under-five mortality are especially low, at 0.1% and 1%, respectively.

Current levels of coverage

67. Coverage with effective interventions remains limited and large inequities in access have been noted within and between countries. The proportion of women wishing to delay or stop childbearing but who do not have access to contraception varied between 10% and 24% across regions, according to data reported in 2007. The consequence is high fertility rates, with adolescents particularly vulnerable to unwanted pregnancy. Although 75% of pregnant women in low-income countries received one antenatal visit, only around 50% received four or more. The proportion of births attended by a skilled health worker in low-income countries showed an 8% increase between 2006 and 2008. The greatest increases in coverage with child health interventions over a three-year period since 2000 (for countries with two data points), were observed for distribution of insecticide-treated nets in selected countries (7%) and for neonatal tetanus protection (5%). Interventions requiring 24-hour services, such as managing childhood illnesses, increased by 1% between 2006 and 2008. Immunization coverage with three doses of diphtheria-tetanus-pertussis vaccine increased from 73% in 2000 to 81% in 2007, and measles vaccination coverage increased from 72% to 82%. Table 1 illustrates coverage levels in 68 high-burden countries between 2000 and 2006.

68. Low intervention coverage is naturally associated with health-system deficiencies. Workforce density in 54 of the 68 countries fell below the threshold required to deliver primary health care interventions. In 60 countries, the proportion of payments made by households to point-of-use health services was more than 15%, a level that can lead to hardship and impoverishment.

Action to improve coverage

69. WHO monitors progress in nutrition and in reproductive, maternal, newborn and child health with partners – including through participation in the Countdown to 2015 initiative to track progress towards achievement of the United Nations Millennium Development Goals. Immunization coverage is reported annually by 95% of countries. WHO also has produced country profiles for maternal health and supported countries in adoption of indicators to assess reproductive health. An assessment of key national policies for maternal, newborn and child health was completed in 2008 and showed that the domain required further strengthening.

70. WHO, UNICEF, UNFPA and the World Bank agreed in July 2008 on a framework for coordinated country action to reduce maternal and newborn deaths. WHO also worked through the International Health Partnership, the Global Campaign for Health, and the Partnership for Maternal, Newborn and Child Health to improve standardization. WHO played a leading role in organizing the Women Deliver Initiative and the Women Deliver Conference for global advocacy (London, 18–20 October 2007).

71. The Secretariat has worked with Member States to formulate strategies and action plans for reproductive, maternal, newborn and child health, and to introduce updated guidelines. It also has promoted policies that increase coverage and quality of care, including authorizing midwives to perform life-saving tasks and community health workers to manage common childhood illnesses.

72. Organizationally, the Secretariat is working on guidelines for integrated services, including integrated management of childhood illness and integrated management of pregnancy and childbirth. For instance, immunization contacts are used to distribute vitamin A capsules, insecticide-treated nets, and medicines for deworming. Prevention of mother-to-child transmission of HIV is included in antenatal and postnatal care. Linkages are promoted between services for sexual and reproductive health and HIV/AIDS. WHO created three regional networks of experts on malaria in pregnancy in 2004. A fourth network is being set up in Asia.

73. WHO is evaluating the effectiveness of approaches to increasing access to services, such as abolishing user fees for maternal and child health services, contracting out of reproductive health services and performance-based payment schemes, including collaboration with the private sector and civil society.

74. The need to increase investment in maternal, newborn and child health was stressed in the Toyako Framework for Action, drawn up at the G8 Summit in 2008 (Toyako, Japan, 7–9 July 2008), and in multiple forums, such as Countdown to 2015 and Women Deliver conferences, and in the Director-General's roundtable with women leaders at the United Nations General High Level Event on the Millennium Development Goals (25 September 2008). WHO supports the GAVI Alliance in its allocation of funds for health-system strengthening, and builds capacity in countries in order to maximize use of the Global Fund to Fight AIDS, Tuberculosis and Malaria and strengthen reproductive, maternal and child health services.

Table 1. Key indicators of intervention coverage for reproductive, maternal, newborn and child health¹

		RANGE		
Number of countries		Median (%)	Low (%)	High (%)
Nutritional intervention coverage				
63	Proportion of infants less than six months old who were exclusively breastfed	28	1	88
63	Proportion of infants 6–9 months old who received complementary foods and continued breastfeeding	62	10	91
55	Proportion of children less than five years old who received two doses of vitamin A supplementation in the last 12 months	78	0	99
		RANGE		
Number of countries		Median (%)	Low (%)	High (%)
Intervention coverage for child health				
68	Proportion of infants who were vaccinated against measles	80	23	99
68	Proportion of infants less than one year old who had received the third dose of diphtheria-tetanus-pertussis vaccine	81	20	99
57	Proportion of children less than five years old with diarrhoea who received oral rehydration therapy or increased fluid with continued feeding	38	7	76
35	Proportion of children less than five years old who slept under an insecticide-treated net in the last 24 hours*	7	0	49
34	Proportion of children less than five years old with fever in the last two weeks who received antimalarial treatment*	40	0	63
60	Proportion of children less than five years old with suspected pneumonia for whom care was sought from a qualified health provider	48	12	93
19	Proportion of children less than five years old with pneumonia who received treatment with an antibiotic	32	3	82
Intervention coverage for reproductive, maternal and newborn health				
64	Proportion of women of reproductive age (15–49 years) who are using (or whose partner is using) a contraceptive method, at a particular point in time	29	3	87
40	Unmet need for family planning	23	9	41

¹ The data were compiled for 68 countries that account for 97% of maternal and child deaths. “Number of countries” indicates the countries for which comparable data were available in the period 2000–2006. The latest data point was included in the analysis. “Median” lists the median coverage level among the countries with relevant data, but masks the inequities between and within countries. “Range” reflects the lowest and highest coverage levels. Indicators marked * reflect interventions applicable to the 45 (out of 68) countries where malaria is endemic. Sources of data: Multiple Indicator Cluster Surveys, Demographic and Health Surveys, interagency global monitoring of immunization coverage and of vitamin A coverage. More details can be found in the Countdown Report 2008 at www.countdown2015mnch.org.

39	Proportion of women who had four or more antenatal care contacts during their last pregnancy in the five years before the most recent survey	49	12	87
64	Proportion of pregnant women who received two doses of tetanus vaccine	81	31	94
22	Proportion of pregnant women who received at least one dose of intermittent preventive treatment for malaria*	7	0	61
66	Proportion of births attended by a skilled health worker	53	6	100
47	Proportion of infants who initiated breastfeeding within one hour of birth	43	23	78

75. The Executive Board at its 124th session noted the progress report.

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

76. Significant progress has been made in implementing the four strategic directions contained in the WHO gender strategy. On the first strategic direction – Building WHO capacity for gender analysis and planning – activities were implemented to strengthen capacity on gender, women and health, including providing gender-sensitive health care. More than 215 health managers from more than 30 countries have been trained in gender analysis and in developing responsive actions; 59 people were trained using the draft gender and HIV tool, designed to help managers of HIV/AIDS programmes in the health sector to integrate gender into programmes. The training activities enabled sustainable networks to be established to support national efforts. Work is under way to finalize a computer-based course for all WHO staff on integrating gender, another on addressing gender-based violence in emergencies and a module on providing gender-sensitive health care.

77. Progress in the second strategic direction – Bringing gender into the mainstream of WHO's management – includes integrating gender dimensions into the operational planning and systematic support and/or ongoing collaboration of 17 selected programmes and departments encompassing all the Organization's strategic objectives. In order to support countries, in addition to training, the electronic guide for developing country cooperative strategies was updated to reflect the need to integrate gender analysis and actions. New tools for assessing human rights and gender equality dimensions in national health-sector plans are being developed and have been pilot tested in two regions.

78. Some progress has been made in the third strategic direction (Promoting use of sex-disaggregated data and gender analysis), including initialization of gender analysis of the World Health Survey, the WHO STEPS¹ approach to the surveillance of risk factors for chronic disease, the global school-based student health survey, and access to and use of health services. Some regions have included sex disaggregation in their health statistics review; others are building capacity within countries to collect and analyse health data that are disaggregated by sex, age and other relevant variables, such as ethnicity.

¹ The WHO STEPwise approach to Surveillance (STEPS) is a simple, standardized method for collecting, analysing and disseminating data in Member States.

79. Implementation of the final strategic direction – Establishing accountability – began by developing a monitoring and evaluation framework and a baseline assessment involving more than 2000 WHO staff members from all regions and headquarters. Preliminary findings suggest that professional staff have fair knowledge of gender equality. Areas for improvement include: applying gender analysis; enhancing institutional support; systematically promoting and using sex-disaggregated data and gender analysis in key WHO publications; and ensuring that major speeches by senior management reflect the commitment to gender equality. Performance management of some senior managers incorporates objectives that reflect accountability for gender mainstreaming. Further work is required to ensure that the Organization applies this practice universally.

80. The Secretariat's gender, women and health network has facilitated the implementation of resolution WHA60.25 in the African Region, where a workshop involved 11 countries in central Africa in accelerating the implementation of the Regional Strategy for Women's Health, underpinning gender mainstreaming as an important strategy for achieving better health for women. In the Region of the Americas, the resolution is being implemented in accordance with the PAHO gender-equality policy. A regional action plan and preliminary national action plans for gender mainstreaming in 13 countries were also developed.

81. The Eastern Mediterranean Region integrated gender equality dimensions into the results-based management framework and trained health managers from nine countries in gender analysis and developing responsive actions. The European Region is focusing on ensuring that gender equality is institutionalized and addressed as an important social determinant of health. The South-East Asia Region developed regional strategic directions and trained WHO staff and key partners from eight countries in gender analysis and developing responsive actions. The Western Pacific Region focused on reproductive health, especially as it related to youth, and on training participants from 10 countries in gender and rights.

82. The Executive Board at its 124th session noted the progress report.¹

I. RATIONAL USE OF MEDICINES (resolution WHA60.16)

83. In resolution WHA60.16, the Health Assembly requested the Director-General to strengthen WHO's leadership in promoting rational use of medicines by undertaking evidence-based advocacy; supporting countries to implement national programmes; strengthening coordination of international support; promoting research on sustainable interventions; and promoting discussion among health authorities, professionals and patients.

84. The Secretariat has designed a strategy for supporting implementation of national programmes, in which a multi-stakeholder process in pilot countries facilitates coordination of national policies. A quality improvement cycle will be created to identify and set up and apply priorities for problems relating to medicines use, and to deal with those problems. An evaluation will also be carried out. A global steering committee will guide the process. The strategy has been approved by all six WHO regions in meetings with Medicines and Health Systems staff, but implementation has not yet begun and resources are being sought.

¹ See document EB124/2009/REC/2, summary record of the twelfth meeting.

85. A technical document to be published soon provides evidence-based information on patterns of medicines use and on the impact of interventions on medicines use in developing and transitional countries.¹

86. Technical support to countries on various aspects of promoting rational use of medicines has continued as before, on request. The support includes:

- review of essential medicines lists, development and implementation of clinical guidelines, monitoring of medicines use practices, interventions to correct drug-use problems, and training of health professionals and consumers
- publication of new WHO recommendations for the management of infections in childhood – administration of oral rehydration solution and zinc for diarrhoea and a three-day instead of a five-day course of antibiotics for pneumonia, both these measures being based on research findings and having the potential to reduce irrational use of antibiotics
- preparation of a technical document that provides evidence-based information on the use of psychotropic medicines for common mental and substance-use disorders in primary care, particularly in low- and middle-income countries²
- continued operation of the DOTS strategy for tuberculosis, now operating in 183 countries. By 2006, it had enabled 31.8 million cases to be treated. In addition, 46 000 multidrug-resistant tuberculosis patients in 56 countries have been treated with quality-assured second-line antituberculosis medicines after approval of the Green Light Committee. However, over-the-counter availability and misuse of tuberculosis medicines remain major concerns that health authorities and professionals must resolve jointly with consumers.

J. BETTER MEDICINES FOR CHILDREN (resolution WHA60.20)

87. In resolution EB121.R2, the Executive Board decided to establish a temporary subcommittee of the Expert Committee on the Selection and Use of Essential Medicines, in order to prepare a list of medicines for children. The subcommittee met in July 2007 and September 2008, and in October 2007 the Expert Committee approved the report of the July 2007 meeting,³ which contained the first WHO Model List of Essential Medicines for Children. In preparing the List, the Expert Committee took account of the priority diseases identified in resolution WHA60.20 and WHO treatment guidelines. Many important research and product gaps were identified. At its September 2008 meeting the subcommittee recommended further work to maintain and expand the List, but noted that this could be done by an Expert Committee constituted of members with the appropriate technical expertise, rather than requiring the subcommittee to be continued. The subcommittee's report was considered at the meeting of the Expert Committee in March 2009.

¹ *Medicines use in primary care in developing and transitional countries: fact book summarizing results from studies reported between 1990 and 2006*. Geneva, World Health Organization, in press.

² *Pharmacological treatment of mental disorders in primary care*. Geneva, World Health Organization, in press.

³ WHO Technical Report Series, No. 950, 2007.

88. The terms of reference for the subcommittee included consideration of optimal dosage forms of medicines for children and the feasibility of manufacturing them. A report prepared following a technical consultation on this topic was due to be considered by the Expert Committee in March 2009. The Committee will be requested to recommend that flexible oral solid dosage forms should be considered the preferred dosage form of medicines for children and the most feasible for manufacturers.

89. In order to promote application of the List and treatment guidelines, WHO has received donor support for a programme of work that includes promoting both national standards for medicines for children and availability of child-specific medicines, and developing strategies with Member States to enhance access to, and ensure better use of, essential medicines for children.

90. Work on the List has involved several departments: the List includes “ideal” fixed-dose combinations for treatment in HIV/AIDS; similar specifications for medicines against tuberculosis are being developed; and the subcommittee has prepared a list of medicines suitable for use in neonates, which will be considered by the Expert Committee. In the WHO regions, work has begun to promote national adoption of the List following a multicountry survey of availability of medicines for children in Africa, and regional workshops in the South-East Asia and Western Pacific regions.

91. A two-day pre-conference was held before the 2008 International Conference of Drug Regulatory Authorities to discuss regulation of medicines for children. As a result, an international regulatory working group will be formed in order to review existing standards for regulation of these medicines and enhance the availability of good-quality medicines for children.

92. Funding was received for a formulary based on the List, as a source of independent information on essential medicines for children. The formulary will be developed in consultation with Member States, and will be able to be adapted to national needs. Work has begun on updating key treatment guidelines on medicines for children, including the Integrated Management of Childhood Illness guidelines.

93. WHO’s advocacy campaign, known as Make Medicines Child Size, launched in December 2007, was endorsed by the pharmaceutical industry, through the International Federation of Pharmaceutical Manufacturers & Associations, civil society organizations including *Médecins Sans Frontières* and Caritas Internationalis, professional associations and organizations such as UNICEF, the European Medicines Agency and the National Institutes of Health in the United States of America. WHO worked closely with UNICEF to develop the List and the two bodies have jointly issued the first report on sources and prices of medicines for children.¹

K. HEALTH TECHNOLOGIES (resolution WHA60.29)

94. In resolution WHA60.29 the Health Assembly requested the Director-General, inter alia, to provide Member States with technical guidance in implementing policies on health technologies, and with support both in assessing national needs for health technologies, particularly medical devices, and in prioritizing, selecting, and using health technologies. The resolution also requested the Director-General to establish a web-based health technologies clearing house in order to provide

¹ “Sources and prices of selected medicines for children, including therapeutic food, dietary vitamin and mineral supplementation”. Accessible online at http://www.unicef.org/supply/index_47129.html

guidance on appropriate medical devices for different levels of care and intended health interventions. The resolution further requested the Director-General to provide support to Member States in identifying appropriate medical devices that facilitate access to good-quality services in primary health care. The present report summarizes the work undertaken to implement the resolution, the collaboration between WHO, collaborating centres, and international, regional and national partners that this has involved, and the progress made.

95. The extensive deliberations of the Executive Board at its 118th, 120th and 121st sessions shaped and gave a major impetus to a process of consultation with United Nations organizations and industry, and to the mobilization of resources. Funding was obtained in April 2008 from the Bill & Melinda Gates Foundation for a period of three years, which enabled the Secretariat to undertake a more extensive implementation of resolution WHA60.29.

96. The Secretariat is now in the process of developing mechanisms to assess national needs for health technologies, particularly medical devices, in order to identify gaps by levels of care and priority diseases. Once they have been elaborated, the mechanisms will be validated by experts from Member States, and pilot testing will begin in the six regions.

97. The Secretariat is working with other organizations of the United Nations system, academic institutions and professional organizations in order to provide Member States with guidelines and tools, norms and standards for the prioritization, selection and use of health technologies, in particular medical devices.

98. The Secretariat is also reviewing and updating WHO's guidelines for health care equipment donations, and preparing procurement guidelines for medical devices.

99. The various guidelines to support implementation of policies on health technologies, with particular regard to medical devices, are being updated and adapted to Member States' needs.

100. An informal expert consultation, organized with PAHO (Washington DC, June 2008) laid the foundations of the web-based clearing house for health technologies by defining the proposed intended users, the type of information to be included and general management rules. The clearing house is now under development and is intended to provide guidance on medical devices according to the level of care and the intended health intervention.

101. A project for high-priority medical-devices was established in 2007 in collaboration with the Government of the Netherlands. A general methodology was developed to identify where the provision of medical devices for use in the management of the 15 highest-burden diseases worldwide is inadequate. The final report will be published in 2009.

102. The Executive Board at its 124th session in January 2009 noted an earlier version of the above progress report.¹

¹ See document EB124/2009/REC/2, summary record of the twelfth meeting, section 4.

L. MULTILINGUALISM (resolution WHA61.12)

103. In January 2009, the Executive Board noted the timetable for implementation of the plan of action¹ and a table showing the financial implications of the resource requirements for the implementation of the Medium-term strategic plan 2008–2013. This report provides an update.

104. **Translation priorities.** The publishing policy coordination group that was established to advise the Director-General on publishing issues proposed a strategy to set translation priorities.

105. Part of this strategy will be to consult Member States informally on translation priorities for WHO's planned and existing publications. This can be done by making two lists available to Member States. One is a master list of information products across the Secretariat that have been approved for publication. This list includes information on the languages planned for each product. It can be viewed on an electronic platform, which allows searches by health topic and other key terms. It is accessible throughout the Secretariat, and is in the process of being made available to Member States.

106. The second list is an inventory of WHO's existing documents and information products, with details of the official languages in which they are produced. This list is accessible to staff members on the Secretariat's Intranet and is also in the process of being made available to Member States. Member States can use these two lists to help them to decide which publications should be prioritized for translation into their appropriate languages. Initial meetings to discuss priorities for the Russian and Chinese languages were held in 2008.

107. **Multilingual team of web editors.** The number of multilingual web pages published on the WHO web site in official languages surpassed the target goals for 2008. In that year, the number of new web pages published were as follows: Arabic, 582; Chinese, 549; English, 5749; French, 1874; Russian, 518; Spanish, 1365.

108. **Institutional repository.** A global working group composed of librarians, web officers and other experts from across the Organization was established in order to design an institutional repository of information products in official and other languages. The working group agreed on common standards for metadata, systems requirements and contents. A proposal for a repository system was finalized and a software application is being tested. A list is being prepared of documents that are already available in electronic format. These will be among the first documents to be included in the WHO Global Institutional Repository.

109. **Style and terms.** Web style guides for Arabic, Chinese, French and Russian were prepared by web editors based on the English style guide, with input from translation services. They are currently being used to improve the consistency of WHO's web content in these languages. The English and Spanish versions will be finalized in the first half of 2009. The Regional Office for the Eastern Mediterranean has also prepared a new style guide for information products in Arabic.

¹ Document EB124/2009/REC/2, summary record of the eleventh meeting, section 3.

110. **Publications.** WHO produces its own multilingual publications, including more than 100 documents in all official languages each year for the governing body meetings. In addition, the Organization is increasing its collaboration with external partners to publish more multilingual WHO information products, which has resulted in 237 multilingual documents being published in 44 languages by the end of 2008, compared with 153 documents in 2007. Furthermore, increasing numbers of WHO Blue Trunk libraries in Arabic, English, French and Portuguese are being distributed. The goal is to distribute 200 libraries or more during the current biennium in all language versions.

111. **Staff development.** Staff members continued to develop their language skills with 1382 staff from headquarters and the regional offices enrolled for language training during the biennium 2006–2007. At headquarters, the number of language students increased from 493 to 653 between 2007 and 2009.

112. The Executive Board at its 124th session in January 2009 noted an earlier version of this report.¹

ACTION BY THE HEALTH ASSEMBLY

113. The Health Assembly is invited to note the above progress reports.

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¹ See document EB124/2009/REC/2, summary record of the eleventh meeting, section 3.